

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  250000507	(X2) MULTIPLE CONSTRUCTION A BUILDING B WING -----	(X3) DATE SURVEY COMPLETED  06/01/2007
NAME OF PROVIDER OR SUPPLIER  SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562		

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E 000 Initial Comments E  
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The following reflects the findings of the California Department of Public Health, formerly known as the Department of Health Services during the investigation of Complaint Numbers CA00115208 and CA00116136. The Southwest Healthcare System is comprised of two hospitals under the same licensure (Inland Valley Medical Center and Rancho Springs Medical Center).

Representing the California Department of Public Health:



A0121 1280.1(a) HSC Section 1280 A012

If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.

A 0141 1280.1(c) HSC Section 1280 A014

For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more

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requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.

E 7331 T22 DIV5 CH1 ART6-70415(a)(3) Basic  
Emergency Medical Service, Physician on

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(3) Development of a roster of specialty physicians available for consultation at all times.

Based on interview and record review, the facility failed to provide adequate on-call physician coverage to meet the needs of nine of 56 patients needing emergency services at IVMC (Patients 105, 118, 119, 120, 121, 122, 124, 129 and 202), and seven of 68 patients (Patients 31, 36, 40, 203, 204, 205 and 206) needing emergency services at RSMC.

Findings:

On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice of the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. At this time, the on-call physician coverage remained voluntary.

The meeting minutes for the Emergency Medicine Department were reviewed on May 30, 2007, at 10:50 AM. The minutes, dated September 2006, included a section titled, "Call

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Panel Validation", which specified, "For physicians not on suspension, the ED had been calling to confirm assigned call. The CEO indicated she is working on a plan process for everyone and will give information to ED Medical Directors. The CEO indicated the verification of daily assigned call will not be through the Medical Staff Office."

The meeting minutes for the Family Practice Department were reviewed on May 30, 2007. In the minutes dated November 29, 2006, there was a report by ED Physician B for ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred." The minutes for March 2007, were also reviewed. In the first paragraph of the executive session was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request."

On May 30, 2007, the current Medical Staff Bylaws that were revised on February 26, 2007. were reviewed. The Bylaws specified that, "Each active medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions .... Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions."

On May 30, 2007, the Emergency Department back-up specialty call schedules for April, May and June, 2007, were reviewed. The following specialties had no formal call panel:

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- a. Allergy (one physician on staff);
- b. Dentistry (one physician on staff);
- c. Dermatology (one physician on staff);
- d. Endocrinology (three physicians on staff);
- e. Gastroenterology (eleven physicians on staff); 1.
- Hematology/Oncology (seven physicians on staff);
- g. Infectious Diseases (two physicians on staff); h.
- Nephrology (three physicians on staff);
- h. Neurology (three physicians on staff);
- j. Ophthalmology (three physicians on staff); k.
- Oral Surgery (three physicians on staff);
- L Pain Management (four physicians on staff); m.
- Plastic Surgery (six physicians on staff);
- n. Podiatry (nine physicians on staff);
- o. Psychiatry (one physician on staff);
- p. Pulmonology (four physicians on staff); q.
- Radiation Oncology (three physicians on staff);
- q. Rheumatology (one physician on staff); s.
- Urology (five physicians on staff); and,
- t. Vascular Surgery (two physicians on staff).

During a review of medical records on May 30, 2007, the following was noted:

a. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM, with a chief complaint of multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures while being transported to the ED by ambulance, and on arrival in the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed that Patient 119 and his family were informed of the treatment plan, "including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "spoke to a staff neurologist, however

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he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility, accompanied by a critical care transport team, for neurology care. Patient 119, who required a critical care transport team, experienced a delay in treatment while phone calls were made and arrangements completed for the transfer.

A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two neurologists on active staff, and two neurologists in provisional status seeking active staff membership.

b. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11 :58 PM, with a chief complaint of blindness in the right eye. The triage assessment, completed on April 3, 2007, at 12:24 AM, showed that Patient 120 had a sudden onset of loss of vision in his right eye at 10:30 PM, after hitting his head earlier in the day. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "this institution does not have an ophthalmologist on call." Patient 120 was transferred to another facility for a "higher level of ophthalmological care," at 7:43 AM, nearly eight hours after arrival in the ED for treatment.

A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership.

Further review of IVMC medical records on May 30, May 31 and June 1, 2007 showed:

a. Patient 105, a 77 year old female, presented

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to the ED on March 2, 2007, at 12:36 PM, with a chief complaint of "sent by primary doctor for possible stroke." The triage assessment, completed on March 2, 2007, at 1:05 PM, showed that Patient 105 had a headache, depression, was tired and had a droopy left eye. In the ED, a Computerized Tomography (CT) scan of the head revealed a 7 x 12 mm area of bleeding in the intraparenchymal space (inside of the brain). The ED physician's dictated report dated March 2, 2007, showed that the neurosurgeon on staff was paged, and spoken to at home, but "he does not take call within our hospital, he is out of town and is not available." The ED physician made arrangements to transfer Patient 105 to another facility for a "higher level of care." The ED physician then contacted the house supervisor, "and informed her of the transfer situation ... and spoke to the hospital administrator and informed her of the situation, that the patient will be transferred for a higher level of care, as there is no neurosurgical call panel here." Patient 105 was transferred to another facility for neurosurgical services at 11:20 PM, nearly 11 hours after arriving in the ED for treatment.

A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff.

A review of the ED on-call schedule on May 31, 2007, showed that only one neurosurgeon was taking call.

b. Patient 118, a 33 year old male, presented to the ED on March 4, 2007, at 2:03 PM, with a chief complaint of an injury to the left leg. An x-ray of the left tibia and fibula showed a "closed comminuted displaced fracture of the left tib-fib" (tibia and fibula). A review of the ED physician's

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notes showed that "multiple calls were made to the orthopedic physician on call, with no answer." The ED physician transferred Patient 118 to another facility for orthopedic care. Patient 118 experienced a delay in treatment while waiting for numerous phone calls to be completed and arrangements to be made for transfer.

c. Patient 121, a 54 year old female, presented to the ED on April 28, 2007, with a chief complaint of vomiting blood. The ED physician's notes showed that the patient was transferred to another facility for a "higher level of care, no GI (Gastroenterology) service on call."

Patient 121 was required to wait for phone calls to be completed in the decision process to transfer the patient to another facility because the facility did not have an available gastroenterologist. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six gastroenterologists on active staff

d. Patient 122, a 17 year old male, presented to the ED on April 2, 2007, at 1 :53 AM, with a chief complaint of an eye injury. The triage assessment, completed on April 2, 2007, at 2:13 AM, showed that Patient 122 was hit in his right eye earlier in the evening, his eye was reddened and teary, he was unable to see out of his right eye when checking his visual acuity, and he had a large right hyphema (bleeding in the anterior chamber of the eye). The ED physician's notes showed that Patient 122 had a large right hyphema, and would be transferred to another facility due to "no ophthalmology on call at Inland Valley." Patient 122 was transferred to another facility at 3:58 AM, for a "higher level of care."

Patient 122 experienced a delay in treatment while waiting for the emergency department to

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detennine that no ophthalmologist was available and make arrangements for transfer to another facility. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff. and one ophthalmologist in provisional status seeking active staff membership.

e. Patient 124, a 17 year old female, presented to the ED on April 13, 2007. at 7:03 PM. with a chief complaint of bloody urine and vomiting. The triage assessment completed on April 13, 2007, at 7:19 PM, showed that Patient 124 had lower abdominal pain, with vomiting every 2 hours for a week. She also complained of weakness and dizziness. The ED physician's notes showed that Patient 124 was in Acute Renal (kidney) Failure, and had Anemia (low blood counts). The ED physician called the pediatrician on call, who was not available to care for Patient 124. Patient 124 was transferred to another facility for care and treatment at 2: 11 AM, nearly seven hours after arriving in the ED for treatment.

f. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007. at 8:15 AM. Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist. also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes. Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a



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Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team) was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine).

During an interview with the Director of the ED on May 31, 2007, at 11:35 AM, she stated that she was aware that the ED on call schedule did not include all specialties that were offered by the facility. The ED Director stated that she was aware that patients were transferred out of the ED as a result of not having specialty call coverage, and stated that it occurred approximately twice a month to her knowledge, but she only heard about the "particularly messy patients". She stated that the ED physicians complain regularly about the lack of specialty on call coverage, and that they were supposed to be informing the administrator on call every time a patient was transferred to another facility due to no specialist being available to care for the patient, then do an HPRR. The ED Director stated that this issue had been reported to administration, and administration answered, "we're discussing it". She stated that this is a "closed administration at the senior level". and that they don't share information with the management team.

The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the

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voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician O joined the pulmonary/intensive care team. However, he (Physician D) was only on-call one week every four weeks. He stated that the ED physicians are "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel."

During a review of ED medical records at RSMC on June 1, 2007, the following was noted:

- a. Patient 31, an 84 year old male, presented to the ED on April 20, 2007, at 5:57 PM, with a chief complaint of a syncopal (dizzy) episode and a fall. The triage assessment, completed on April 20, 2007, at 6:06 PM, showed that Patient 31 had a hematoma (blood pocket under the skin) above the left eye and on the left forehead, and had a headache. The nurse's notes showed that the patient's headache continued throughout the ED stay, and he was medicated on five different

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occasions for the pain. The ED physician dictated report showed that Patient 31 had a Computerized Tomography (CT) scan of his head, that showed a subdural hematoma (bleeding in the brain) on the right side. The ED physician noted that the facility neurosurgeon was not on call that day, and "he will be transferred for a higher level of care, we do not have a neurosurgeon on call at this time". Patient 31 was transferred to another facility at 9 PM, with a blood pressure of 195/66, accompanied by a critical care transport team, for a "higher level of care".

A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff, and only one neurosurgeon was serving on the ED backup call schedule.

A review of the April 2007 Emergency Department On-Call Schedule on May 31, 2007, showed that there was a neurosurgeon scheduled to be on call on April 20, 2007.

b. Patient 36, a 60 year old male, presented to the ED on April 4, 2007, at 3:47 AM, with a chief complaint of abdominal pain. The ED physician dictated report showed that the patient had a kidney stone on the right side, and needed to be seen by a urologist. The ED physician contacted a urologist on staff at the facility, who did not come in to see Patient 36. Patient 36 was transferred to another facility at 8:50 AM, for urology care.

Patient 36 waited for arrangements to be made for transfer after the emergency department staff determined by phone calls that no urologist was available, experiencing a delay in treatment. Review of the Medical Staff Roster on May 31,

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2007, showed that the facility had six urologists on active staff.

A review of the ED on-call schedule on June 1, 2007, showed the urology service ED call listed as "voluntary".

c. Patient 40, a 43 year old male, presented to the ED on April 23, 2007, at 10:28 AM, with a chief complaint of sore throat. The ED physician dictated report showed that Patient 40 had a peritonsillar abscess (an abscess around the tonsils), and was having difficulty swallowing. The ED physician noted that he, "discussed transferring the patient for ENT (Ear, Nose and Throat) services, as we have no ear/nose/throat specialist on call today". Patient 40 was transferred to another facility at 12 PM for a "higher level of care for ENT services".

A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff.

A review of the ED on-call schedule on June 1, 2007, showed the ophthalmology service ED call listed as "voluntary".

d. Patient 203, an elderly female, presented to the ED on May 21, 2007, by ambulance, with a complaint of abdominal pain. The patient had a Computerized Tomography (Ct scan of the abdomen, which was normal. A repeat CT with contrast (used to enhance the image) showed gastritis (inflammation of the stomach). The final diagnoses were Elevated Digoxin Level (a medication used to stimulate a failing heart) and Acute Gastritis. The patient was transferred to another facility for treatment. No documentation was present regarding the reason for transfer. Both of the transfer diagnoses were common

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medical conditions, usually treated by a cardiologist and a gastroenterologist. Both services were offered at this hospital, however the Gastroenterologists are on a voluntary call schedule for ED back up. patient 203 experienced a delay in treatment while waiting for arrangements for transfer to be made after the emergency department staff determined no gastroenterologist was available for consultation.

e. Patient 204, an elderly female, presented to the ED on May 21, 2007. The physician's notes indicated that she was to be admitted to the telemetry unit with a diagnosis of Cerebral Vascular Accident (CVA, stroke). The nurses notes also stated "Admit to telemetry". Patient 204 was instead transferred to another facility. No documentation was present regarding why the admission was changed to a transfer. A CVA was a common neurological condition, usually treated by a neurologist. The hospital provides neurology services, but the neurology service has a voluntary call schedule for ED back up.

f. Patient 205, a young man, presented to the ED on May 5, 2007. with a chief complaint of an eye injury. The ED physician noted that there was a laceration to the upper eyelid that would require the services of a plastic surgeon, a specialty service that is offered at this hospital. However, plastic surgery physicians are on a voluntary call schedule. The patient was transferred to another facility for care.

g. Patient 206, a female patient, presented to the ED on May 29, 2007, via paramedics, with a chief complaint of inability to speak and right sided weakness. The ED physician's notes indicated the patient had a probable CVA. This was a common neurological condition usually handled by a neurologist, a service offered at this

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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562		

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hospital. Patient 206 was transferred to another facility. The ED physician's notes stated, "We do not have neurology on call."

During an interview with the ED Unit Secretary (US) on June 1, 2007, at 10:40 AM, the US stated that when she needed to call a specialty physician, she asked the ED physician or the patient's primary care physician (PCP) which specialist they wanted her to call. She then called that specialist and asked them if they would "consider" taking care of the patient. If the specialist declined, she asked the ED physician or the PCP who to call next, and she continued until she found a specialist that was "willing" to take care of the patient. The US stated that she was "usually" able to find somebody to come in. She stated that if they were unable to find a specialist, then the patient got transferred to another facility, but "that doesn't happen very often".

During an interview with ED Physician 2 on June 1, 2007, at 11:13 AM, he stated that the voluntary call system "made the job more difficult". ED Physician 2 stated that he had been using the Internal Medicine (IM) or Family Practice (FP) physician for advice on what specialist to call. He stated that it took longer to get a specialist now that it was voluntary, and he had to make multiple calls, but he could usually get somebody to come in. The facility transfer policy was reviewed on May 30, 2007. The policy stated that, "The policy and philosophy of Southwest Healthcare System (SWHCS), emergency services and care will be provided to any individual who requests services ...." The policy also stated that, "Unless extenuating circumstances are present, no patient will be transferred to another facility if SWHCS has the means to provide the care." Some conditions

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that required transfer to another facility included,  
"If physician specialty is unavailable due to gaps  
in the on-call physician schedule ... "

The Emergency Medicine (EM) minutes were  
reviewed on May 30, 2007, at 10:45 AM, and again  
on May 31, 2007 at 12:55 PM. There was no  
evidence of a discussion regarding the lack of  
availability of specialists on-call on weekends and  
evenings.

The Medical Director of the ED (also a member of  
the Board of Directors) was interviewed on May  
31, 2007, at 1 :20 PM. He stated that the voluntary  
call system was "inconvenient" and that often  
patients were transferred for the lack of an  
available specialist. He stated that "It's a problem"  
and that he had empathy for the patients. He  
stated the primary issue was customer  
satisfaction. He stated that although many  
specialties did not have a physician  
on-call, Urology was the most common specialty to  
have nobody who would come in to see a patient.  
He stated the problem with ventilated patients had  
improved since Physician D joined the  
pulmonary intensive care team. However,  
Physician O was only on-call one week every four  
weeks. He stated that the ED physicians were  
"working with what we have to work with." He  
further stated that no Quality  
Assurance/Performance Improvement (QAPI)  
activities were being done to determine the effect  
the voluntary call system had on patient care,  
transfers or time spent trying to find a consultant.  
The Medical Director stated that he spoke at one  
of the Medical Executive Committee (MEC)  
meetings, and he told the committee about the  
difficulty dealing with the voluntary call system;  
"but until you are in my shoes, looking into the  
patient's eyes, you cannot know how we (the ED  
physicians) feel

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E1166 I T22 DIV5 CH1 ART6-70495(a)(2) Intensive  
Care Service Staff

E1166

(2) Development of a system for assuring  
physician coverage.

Based on staff interviews and facility and patient  
record reviews, the facility failed to have an effective  
system for assuring physician coverage in the 2  
Intensive Care Units for three patients of 62  
reviewed at Inland Valley Medical Center and for  
one patient of 70 reviewed at Rancho Springs  
Medical Center.

Findings:

The medical record for Patient 135 was reviewed on  
May 30, 2007. Patient 135, a 66 year old male, was  
admitted to the Intensive Care Unit (ICU) on May 29,  
2007, after an emergency tracheostomy (a tube into  
the trachea for breathing) was performed in the ED.  
On the "I.C.U. IP.C.U. Flow Sheet", dated May 29,  
2007, at 9:30 PM, the nurse documented that  
Patient 135 became agitated and was fighting the  
ventilator (breathing machine). The nurse also  
documented that the patient's attending physician  
and the pulmonologist were paged for assistance  
and there was no return call from either physician.

During an interview with ICU RN 1 on May 30, 2007,  
at 9:50 AM, she stated that the pulmonologists took  
call for their own patients during the week, and the  
on-call pulmonologist covered on the weekends.  
When she was asked what they did when there was  
no pulmonologist



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on call due to the "voluntary" call system, she stated that they called the ED to see if there was somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them.

During an interview with the Chief Nursing Executive (CNE) on May 30, 2007, at 11 :50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." The CNE declined to give names of the physicians the nursing staff complained about.

Further review of the Medical Staff Bylaws (revised 5/22/06) on May 30,2007, at 3:15 PM. showed that:

a. Section 3.7; "Each member of the medical staff shall retain responsibility, within his or her area of professional competence, for the continuous care and supervision of each patient in the hospital for whom he or she is providing services, or arrange for a suitable alternative to assure such care and supervision."

b. Section 4.2.3; "Each active Medical Staff Member shall actively participate on and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including, but not limited to emergency services and back-up functions ...

c. Section 10.5.3; "A supervisory (departmental)

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committee shall conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department."

d. Section 10.8.5; The duties of department chairs include, "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ... and oversee the effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee," and also, "enforce Medical Staff Bylaws. Rules and Regulations and policies within the department ... " and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement Committee shall, "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety."

Further review of ICU medical records on May 30, May 31 and June 1, 2007, at IVMC, showed the following:

a. Patient 201, a 76-year-old male was admitted to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24, 2007. The transcribed consultation note was

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identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician.

b. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team) was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine).

During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until

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approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received approximately two calls per month from the ICU nursing staff related to this problem. She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were supposed to write an HPRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department.

The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly".

During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty", She stated that the problem had not

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improved yet.

During an interview with ICU RN 3 on May 31, 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the physicians.

The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to a page, the respiratory therapist would call their Medical Director, Physician F. Physician F is board certified in Pulmonology and in Critical Care. If he was not available, then the "chain of command" was initiated.

During a review of ICU medical records at Rancho Springs Medical Center, on June 1, 2007, the following was noted:

Patient 44, a 91 year old male, was admitted to the ICU on May 31, 2007, on a ventilator (breathing machine). On June 1, 2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30 AM, Pulmonologist #1 called back and said

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he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse.

During an interview with ICU RN 4 on June 1, 2007, at 11:50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors.

Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los Angeles. Physician B recommended the survey team review the chart of Patient 201.

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Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the admitting physician that he would be out of town. When a neurologist was urgently needed, the contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201.

During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology, so call that physician instead. ICU RN 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no".

In the ICU on June 1, 2007, at 2:52 PM, in the presence of four ICU nurses and three ICU managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot",

Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007 at 3:25 PM at RSMC. He stated that there had been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a

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pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration.

E19121 T22 DIV5 CH1 ART7-70703(f) Organized  
Medical Staff

E1912

(f) The medical staff shall provide for availability of staff physician for emergencies among the in-hospital population in the event that the attending physician or his alternate is not available.

Based on interview and record review, the facility failed to ensure that the medical staff enforced their bylaws/rules and regulations in regard to physician on-call coverage by specialists with active and provisional privileges at the facility, for 3 of 62 patients at IVMC (Patient 135, 201, and 202) and one of 70 patients at RSMC (Patient 44).

Findings at IVMC:

On May 30,2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two



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separate occasions. The current on-call physician coverage for the facility was voluntary.

The meeting minutes for the Family Practice Department were reviewed on May 30, 2007. In the minutes dated November 29, 2006, there was a report by Emergency Department (ED) Physician B for ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred. The minutes for March 2007, were also reviewed. In the first paragraph of the executive session was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request."

On May 30, 2007, the Medical Staff Bylaws, that were revised on February 22, 2007, were reviewed. The Bylaws specified, "Each active medical staff member shall ... Actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions .... Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions."

On May 30, 2007, a review of the current Medical Staff Rules and Regulations, that were revised May 22, 2006, showed that

a. Section 1.3.2; "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or arrange for an alternate practitioner who has equivalent clinical privileges at the hospital."

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b. Section 2.1.1; "A call panel has been established for referring patients who need hospital care to qualified medical staff members. Service on the call panel is not a privilege, but is an obligation of staff membership."

c. Section 2.2.1; "Practitioners on call must respond promptly when requested to see a patient. Practitioners, including specialty consultants, must respond initially by phone or in person within approximately 30 minutes of the time the request to respond is made."

d. Section 2.2.3; "When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred ... "

e. Section 2.2.4; "The on call specialist must also be available for inpatients. If no other specialist in that specialty is willing or able to provide care for a particular inpatient, the on call specialist has the obligation to see that patient to treat, stabilize or appropriately transfer the patient in a timely manner."

f. Section 2.2.7; "A patient will be admitted in the name of the call panel practitioner. The call panel practitioner must be notified about each admission to his service prior to the patient leaving the Emergency Department, and following a discussion with the Emergency Department physician."

The medical record for Patient 135 was reviewed on May 30, 2007. Patient 135, a 66 year old male, was admitted to the Intensive Care Unit (ICU) on May 29, 2007, after an emergency tracheostomy (a tube into the trachea for breathing) was performed in the ED. On the "I.C.U./P.C.U. Flow Sheet", dated May 29, 2007,

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at 9:30 PM, the nurse documented that Patient 135 became agitated and was fighting the ventilator (breathing machine). The nurse also documented that the patient's attending physician and the pulmonologist were paged for assistance and there was no return call from either physician.

During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that the pulmonologists took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. When she was asked what they did when there was no pulmonologist on call due to the "voluntary" call system, she stated that they called the ED to see if there was somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them.

During an interview with the Chief Nursing Executive (CNE) on May 30, 2007, at 11:50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." The CNE declined to give names of the physicians the nursing staff complained about.

Further review of the Medical Staff Bylaws (revised 5/22/06) on May 30, 2007, at 3:15 PM. showed that:

a. Section 3.7; "Each member of the medical staff shall retain responsibility, within his or her

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area of professional competence, for the continuous care and supervision of each patient in the hospital for whom he or she is providing services, or arrange for a suitable alternative to assure such care and supervision."

b. Section 4.2.3; "Each active Medical Staff Member shall actively participate on and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including, but not limited to emergency services and back-up functions ...

c. Section 10.5.3; "A supervisory (departmental) committee shall conduct patient care reviews for the purpose of analyzing and evaluating the Quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department. ••

d. Section 10.8.5; The duties of department chairs include, "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ... and oversee the effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ... " and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement Committee shall, "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety."

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Further review of ICU medical records on May 30, May 31 and June 1, 2007, at IVMC, showed the following:

a. Patient 201, a 76-year-old male was admitted to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24, 2007. The transcribed consultation note was identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician.

b. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team)

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was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine).

During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received approximately two calls per month from the ICU nursing staff related to this problem.

She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were supposed to write an H PRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department.

The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first

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causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly".

During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty". She stated that the problem had not improved yet.

During an interview with ICU RN 3 on May 31, 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the physicians.

The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to a page, the Respiratory Therapist would call the Respiratory Medical director, Physician F. physician F is board certified in pulmonology and Critical Care. If he was not available, then the "Chain of Command" was initiated.

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The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1 :20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician O joined the pulmonary/intensive care team. However, Physician O was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel."

Findings at RSMC:

During a review of ICU medical records on June 1, 2007, the following was noted:

Patient 44, a 91 year old male, was admitted to the ICU on May 31,2007, on a ventilator (breathing machine). On June 1,2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator



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management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30 AM, Pulmonologist #1 called back and said he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse.

During an interview with ICU RN 4 on June 1, 2007, at 11 :50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors.

Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted

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neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los Angeles. Physician B recommended the survey team review the chart of Patient 201. Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the admitting physician that he would be out of town. When a neurologist was urgently needed, the contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201.

During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology, so call that physician instead. ICU RN 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no".

In the ICU on June 1, 2007, at 2:52 PM, in the presence of four ICU nurses and three leu managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot".

Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007

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at 3:25 PM at RSMC. He stated that there had been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration.