Double-booked: When surgeons operate on two patients at once

July 28 2017, by Sandra G. Boodman, Kaiser Health News

The controversial practice has been standard in many teaching hospitals for decades, its safety and ethics largely unquestioned and its existence unknown to those most affected: people undergoing surgery.

But over the past two years, the issue of overlapping surgery - in which a doctor operates on two patients in different rooms during the same time period - has ignited an impassioned debate in the medical community, attracted scrutiny by the powerful Senate Finance Committee that oversees Medicare and Medicaid, and prompted some hospitals, including the University of Virginia's, to circumscribe the practice.

Known as "running two rooms" - or double-booked, simultaneous or concurrent surgery - the practice occurs in teaching hospitals where senior attending surgeons delegate trainees - usually residents or fellows - to perform parts of one surgery while the attending surgeon works on a second patient in another operating room. Sometimes senior surgeons aren't even in the OR and are seeing patients elsewhere.

Hospitals decide whether to allow the practice and are primarily responsible for policing it. Medicare billing rules permit it as long as the attending surgeon is present during the critical portion of each operation - and that portion is defined by the surgeon. And while it occurs in many specialties, double-booking is believed to be most common in orthopedics, cardiac surgery and neurosurgery.

The issue was catapulted into public consciousness in October 2015 by

an exhaustive investigation of concurrent surgery at Harvard's famed Massachusetts General Hospital by The Boston Globe. The validity of the story has been vehemently disputed by hospital officials who defend their care as safe and appropriate.

The article detailed concerns by some doctors and other hospital staff about complications - including one patient who was paralyzed and two who died - possibly linked to double-booking over a 10-year period. It described patients waiting under anesthesia for prolonged periods and surgeons who could not be located, leaving residents or fellows to perform surgeries without supervision.

Patients who signed standard consent forms said they were not told their surgeries were double-booked; some said they would never have agreed had they known.

The practice has also figured prominently in cases in South Florida, Nashville and, most recently, Seattle.

Critics of the practice, who include some surgeons and patient-safety advocates, say that double-booking adds unnecessary risk, erodes trust and primarily enriches specialists. Surgery, they say, is not piecework and cannot be scheduled like trains: Unexpected complications are not uncommon.

All patients "deserve the sole and undivided attention of the surgeon, and that trumps all other considerations," said Michael Mulholland, chair of surgery at the University of Michigan Health System, which halted double-booking a decade ago. Surgeons might leave the room when a patient's incision is being closed, Mulholland said. A computerized system records the doctor's entry and exit.

"It doesn't do any good to check out your surgeon if they're not even

going to be in the room," said Lisa McGiffert, director of Consumers Union's Safe Patient Project. "We all know about the dangers of multitasking. This adds a layer of danger if you have the most expert person coming in and out."

Indiana orthopedic surgeon James Rickert regards double-booking as a form of bait-and-switch. "The only reason it has continued is that patients are asleep," said Rickert, president of the Society for Patient-Centered Orthopedics, a doctor group.

"Having a fellow so you can run two rooms helps augment your income," he added. "You can bill for six procedures: You do three and the fellow does three." The critical portion of the operation required by Medicare and designated by the surgeon can mean "running in and checking two screws for 10 seconds."

Defenders of the practice, which has been the subject of a handful of studies with mixed results, say it can be done safely and allows more patients to receive care.

"It's extremely important for us to make sure (all surgeries are) done with the highest quality," said Peter Dunn, Mass General's executive medical director of perioperative administration. Officials at his hospital, Dunn said in a recent interview, have "never traced back a quality issue" to concurrent surgery, which involves a minority of procedures.

Mass General complies with all applicable guidelines and regulations, Dunn said. The hospital now explicitly requires doctors to inform patients if an operation will overlap as part of the consent process, which may occur just before the start of surgery.

In January, a Boston jury found that a Mass General spine surgeon who

failed to inform a 45-year-old financial analyst that he was running two rooms was not responsible for the patient's subsequent quadriplegia.

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No one knows how many of the nation's 4,900 hospitals that receive Medicare payments - about 1,000 of which are teaching hospitals - allow the practice, the Senate Finance Committee noted in a recent report. The committee called on hospitals to adopt stronger policies and consent forms that go beyond opaque boilerplate statements that grant broad permission without specifying who is doing what. And the report noted that concurrent surgery may also occur in outpatient surgery centers and non-teaching hospitals and that it can involve patients who are not covered by Medicare.

The practice surprised some primary care doctors and a veteran medical ethicist.

"I certainly knew that for many procedures, residents might be involved," said Arthur Caplan, a professor of bioethics at NYU School of Medicine. (NYU Langone Medical Center does not permit concurrent surgery.) "But I was a little taken aback that the attending surgeon was not in the room."

Proponents say that overlapping operations can improve efficiency and better utilize a surgeon's valuable time.

"Much of surgery is team-based," said David Hoyt, executive director of the American College of Surgeons (ACS), which last year issued guidelines governing concurrent surgery. Largely similar to Medicare rules, the guidelines state that surgeons should inform patients of overlapping operations.

Robert Cima, a colorectal surgeon and medical director of surgical outcomes research at the Mayo Clinic, agrees. Overlapping surgery has been used safely since Mayo's inception more than 100 years ago, he said. A recent study he co-authored found that 11,000 overlapping operations at Mayo did not have a higher death rate than non-overlapping surgeries.

Allowing qualified junior doctors to perform parts of an operation, Cima said, is vital in "training the next generation of surgeons." Determining what portion of an operation is critical should be left to the individual surgeon, he said, not defined by Medicare or insurers, because it can vary from patient to patient.

But L.D. Britt, a past president of the ACS and chairman of surgery at Eastern Virginia Medical School in Norfolk, says that efficiency has little to do with concurrency. "Unless you're closing, that surgeon should be there," he said. "Most (surgeons) are doing it for lifestyle."

Indiana's Rickert and Britt say they are troubled by what they regard as a double standard: Very few surgeons would consent to the practice for themselves or a relative. "This happens to the Medicaid patient," Rickert said, "not the partner's wife."

He advocates that Medicare and insurers define the critical portion requiring the presence of an attending surgeon as being everything between the making of an incision and the start of its closure, a task frequently performed by residents. "The critical components should not depend on whether the surgeon has opera tickets that night."

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Some surgeons say they are troubled by the resemblance of double-booking to a practice known as "ghost surgery," in which patients learn,

usually after something goes wrong, that someone other than the surgeon they hired performed their operation.

In April, a Seattle jury awarded an anesthesiologist and her husband $8.5 million for botched abdominal surgery that disfigured his penis. After his operation, the couple discovered that a crucial part of the procedure was performed by a fellow, not the senior surgeon to whom he had explicitly granted consent.

"I always prided myself in telling patients I would be there from the moment they went to sleep to the moment they woke up," said Stanley Shapshay, a head and neck surgeon in Albany, N.Y., who co-authored a 2016 editorial opposing simultaneous surgery.

Many things can go wrong during "noncritical" portions of an operation, particularly if a resident or fellow is unsupervised, said Shapshay, a professor of otolaryngology at Albany Medical College. A major artery or nerve can be cut accidentally, he said. "By the time the surgeon (arrives, the damage) has already been done."

Trainees, Shapshay observed, vary. "Some are very good, some are OK and some need more experience."

His view was reinforced by his experience at a hospital in the Southeast several years ago. A senior surgeon he was visiting left in the middle of an operation, after telling a family that surgery had gone well. While he and Shapshay were having coffee, the surgeon received an urgent page and had to rush back to the OR to deal with a serious breathing problem. The family was later told only that an unexpected event had occurred, not that the attending had been out of the room.

"That illustrated to me very clearly that you don't leave the OR until the patient has left the OR," Shapshay said.

Adequate informed consent is essential, said Robin Diamond, senior vice president for patient safety and risk management at the Doctors Company, a California-based malpractice insurer that has begun tracking malpractice claims related to overlapping surgery. She expects such lawsuits will increase.

"I think it can be done safely and has been safe in many cases," said Diamond, who has degrees in nursing and law. But surgeons who plan to run two rooms should obtain explicit consent from patients at least a week ahead of surgery, she said, not the day before or the day of, as is common, to allow time to reconsider.

"It's a basic patient right to know" who is doing their operation, Diamond said.

Patients don't seem enamored of overlapping surgery. A recent study based on an online survey by Harvard researchers found that fewer than 4 percent of 1,454 people had heard of concurrent surgery and that only 31 percent supported the practice; 95 percent said it should be disclosed in advance.

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After the fallout at Mass General, officials at U.Va. decided it was time to largely eliminate concurrent surgery in all specialties; the practice had been most common in orthopedics.

In return for an end to simultaneous surgeries, hospital executives agreed that orthopedic surgeons would not be "disadvantaged," said Richard Shannon, executive vice president for health affairs at U.Va. Part of the process involved overhauling the way surgeries were scheduled.

"It was an important wake-up call," Shannon said of the controversy.

"We wanted to redesign our system to eliminate the risk" as part of a larger patient-safety push.

Eliminating most concurrent procedures, Shannon said, actually resulted in an increase of 560 surgeries in 2016 over 2015, using the same number of operating rooms. "Concurrency was masking an efficiency problem," said Shannon, who plans to publish the results of U.Va.'s efforts. "There was a lot of waste."

"This debunks the urban legend" that overlapping surgery is more efficient, he said. "Like many things in health care, if you apply a rigorous, disciplined approach, you may get an answer you didn't expect."

Rickert and others advise patients who want to avoid overlap to ask detailed questions well in advance and to put their request in writing and on the consent form.

"If you say, 'I want only you to do the surgery,' doctors will typically do it," Rickert said. "They want the business."

He also recommends asking, "Are you going to be in the room the entire time during my surgery?" and then repeating that statement in front of the OR nurses the day of surgery. "If the doctor's not willing to say yes, vote with your feet."

If a surgeon says he or she will be "present" or "immediately available," a patient should ask what that means. It may mean that the surgeon is somewhere on a sprawling hospital campus but not in - or even near - your operating room.