www.medscape.com

# Double-booked Surgeries Roil Medicine

Robert Lowes | |December 23, 2015

A recent *Boston Globe* investigation into overlapping or double-booked elective surgeries at the venerable Massachusetts General Hospital (MGH) in Boston has provoked debate and soul-searching in the medical profession.

The newspaper reported in October that MGH patients routinely were not told that their attending surgeon would be in charge of two operations at the same time, which is an informed consent issue. Surgical residents and fellows sometimes performed entire operations while a double-booked attending surgeon was elsewhere, according to the *Boston Globe*. Other times, attendings could not come to an overwhelmed trainee's rescue promptly because they were delayed in another operating room (OR). Similarly, patients lay in prolonged states of anesthesia while the OR team waited for a double-booked surgeon to arrive from another room, the newspaper reported.

Some physicians, including Medscape readers, view overlapping surgeries as one of medicine's dirty little secrets, driven by economics. "As a resident, I was assigned to a surgeon who routinely booked two cases at the same time at two different hospitals," one reader said, commenting on a previous Medscape article about the practice. "He got away with it most of his career — and it was all about the money."

Other physicians defend the scheduling practice, saying it improves access to surgical care and challenges trainees to work independently when the attending leaves the room. "It is how the next generation of surgeons learns to operate," another reader wrote.

The physicians on this side of the debate also assert that double-booked surgeries can be performed safely if well-orchestrated, a skill that comes with experience.

"It's remarkable how safe complicated stuff gets when you do it over and over and over," said Hunt Batjer, MD, president of the American Association of Neurological Surgeons, in an interview with *Medscape Medical News*. Safety issues with double-booked surgeries "have not surfaced as a major problem in my recollection."

MGH also has defended the safety of its overlapping surgeries, calling the *Boston Globe* story an "inaccurate picture." It states on its website that complication rates for overlapping surgeries and nonoverlapping surgeries are the same, and that complications in the former kind are not linked to how the procedure is scheduled.

The hospital also cites the benefits of double-booking. In addition to reducing wait times and giving trainees more responsibility, the practice allows surgeons to pack more procedures in daytime hours, when radiology, pathology, and laboratory departments are fully staffed, MGH says. The practice also accommodates emergency trauma cases, as it did during the Boston Marathon bombings of 2013. The hospital notes that the American College of Surgeons (ACS) has called the hospital's policy on overlapping surgeries a "best practice" that exceeds national standards.

Despite that endorsement, concerns raised by the *Boston Globe* article are prompting the ACS to reexamine its own policies on overlapping surgeries, said the group's executive director, David Hoyt, MD, in an interview with *Medscape Medical News*.

"We will take an in-depth look and publish a report," Dr Hoyt told *Medscape Medical News*. "I don't think the problems are widespread at all, but we have no way of knowing."

The ACS committee will discuss whether the society's guidance on overlapping surgeries needs to be more precise. It will also foray into the matter of informed consent. "This is quality improvement," Dr Hoyt said.

Meanwhile, the propriety of double-booked surgeries at MGH remains an open question, at least for the Department of

Justice. Last month, the *Boston Globe* reported that federal prosecutors have subpoenaed hospital records and interviewed physicians there, seeking evidence of possible Medicare billing irregularities.

**Medical School Settled Federal Case on Double-booking**

Overlapping surgeries typically are elective procedures with staggered start times that allow an attending surgeon to move between ORs for key parts of a procedure, such as implanting screws in a spinal surgery or replacing a faulty heart valve. That surgeon may or may not be in the room while trainees open or close. The gap between the start times — 15 minutes, say, or an hour — depends on the nature of the surgery and the surgeon's confidence that the OR team can stick to the surgical schedule.

The ACS's Dr Hoyt estimates that roughly 10% of all surgeries overlap to some extent. MGH states on its website that in 2014, 15% of its surgeries were concurrent, with most overlapping during the time before the incision or after closure. Only 3% "involved any overlap when the actual procedure is underway."

The ACS has published principles of surgery that apply to double-booking. Attending surgeons may delegate work to residents or associates, but patients must know that ahead of time. And attendings must be "active participants" during the key parts of the procedure. If they leave the OR, they must remain in the immediate vicinity, and "a qualified substitute...must stay with the patient for the duration of the absence."

The Medicare program pays attending surgeons for double-booked procedures in teaching hospitals, but only under certain conditions that mirror ACS guidance. Most important, the attending must be present for the critical or key portions of both operations and document that in the patient record. When the attending is not there for less-important stages, but is in a second OR, he or she must arrange for a qualified back-up surgeon to assist trainees, should the need arise. In so doing, the attending can get reimbursed by Medicare Part B. In contrast, the work of the residents is covered by Medicare Part A payments to the teaching hospital.

The federal government turns prosecutorial when attending surgeons at teaching hospitals are not present during critical points of procedures to justify Medicare reimbursement. In the 1990s, the Department of Health and Human Services and the Department of Justice came across no-show attendings in its well-publicized Physicians at Teaching Hospitals (PATH) audits, although the absences did not necessarily stem from double-booked surgeries. Four of the hospitals paid the government nearly $68 million to settle false-claim charges.

Double-booking definitely figured into a recent false-claims suit filed by a whistleblowing resident against the Medical College of Wisconsin and later joined by the Department of Justice. The whistleblower alleged that the medical school billed Medicare and TRICARE for the services of teaching physicians who did not fulfil their supervisory requirements during overlapping surgeries. The Medical College of Wisconsin agreed to pay the government $840,000 to settle the case in March, but nevertheless denied the allegations.

**How Often Are Trainees Left in the Lurch?**

Proper supervision of residents in overlapping surgeries is not just a matter of billing, but also a matter of patient safety, as the *Boston Globe* emphasized in its investigative reporting. Residents and fellows with no one at their elbow or readily available can get in over their head, often setting off a frantic search for their attending in other ORs.

Several Medscape readers attested to the problem of forlorn trainees in their comments on a previous Medscape article on overlapping procedures. One surgeon recalled a senior resident mistakenly performing a gastroileostomy instead of a gastrojejunostomy when the attending was tied up in another case. And an anesthesiologist said the notion that residents learn when they are working alone — said to be a virtue of overlapping surgeries — is "self-serving."

"I have seen dozens of double rooms, and residents and fellows operating alone for long periods," the anesthesiologist

wrote, "and when the primary surgeon returned, he was not a happy camper about the job the trainees had done in his absence."

But how widespread is the problem of residents left in the lurch by concurrent procedures? If any group could answer that question, it is arguably the Accreditation Council for Graduate Medical Education (ACGME), which accredits residency and fellowship programs, and the institutions that sponsor them. "We have not received any complaints about it," said John Potts III, MD, the ACGME's senior vice president of surgical accreditation, in an interview with *Medscape Medical News*. If anything, the opposite is true: Attendings do too much, and residents and fellows too little.

"We hear complaints about trainees not given enough independence to learn," said Dr Potts. "A lot of [medical] societies are talking about that."

One of the reasons behind this trend is that teaching hospitals want to avoid both the kind of lawsuits that hit the Wisconsin College of Medicine and PATH-style audits that arise from inadequately supervised trainees.

"They do not want an investigation for Medicare fraud," said Dr Potts. He said some teaching hospitals, overreacting to the threat of prosecution, misinterpret the requirement for the attending to be present at key parts of the surgery to mean he or she must perform those key parts.

Then again, close, if not smothering, supervision of trainees is old school in medicine.

"I think that the ideal situation for a resident and patient is for the presiding surgeon to stay in the room from intubation to skin closure," said Jack Lewin, MD, a veteran executive in organized medicine who is now president and chief executive officer of the Cardiovascular Research Foundation. "I think it's in the best interest of the patient."

Although not extremely common, overlapping procedures have been on an upswing, in part because "there aren't enough surgeons in some places," Dr Lewin told *Medscape Medical News*. Another reason is economic. "From a number-cruncher point of view in the [hospital] back office, this could be more efficient, assuming everything goes well."

**Multitasking and Its Risk**

"Assuming everything goes well," as put by Dr Lewin, may be the Achilles heel of double-booked surgeries. After all, no one can predict when clinical assumptions veer off to become emergencies.

Orthopedic surgeon Matthew Putnam, MD, in Minneapolis, Minnesota, said he gave up working two ORs at the same time around 7 years ago after deciding he did not want to take any more chances. He had never encountered the kind of surgical crises described in the *Boston Globe* article, but he said he finally concluded that what he had been doing — risking, rather — was unethical.

"People can have things happen at the end of the case," Dr Putnam told *Medscape Medical News*. "Maybe they need to be resuscitated as they come off the table. I never wanted to be in a situation where I was in another case, and I couldn't be there."

Double-booked surgeries made him more money, and made the hospitals more money, too. However, switching to consecutive surgeries made him a happier surgeon, Dr Putnam said.

His decisions to perform surgeries consecutively underlines an issue raised in the *Boston Globe* article: How much can surgeons multitask before clinical care degrades?

"I don't believe in multitasking," said David Teuscher, MD, president of the American Academy of Orthopaedic Surgeons. "Those who do are fooling themselves."

That stance does not necessarily mean that Dr Teuscher opposes overlapping surgeries in principle or practice. In an interview with *Medscape Medical News*, Dr Teuscher said such procedures are typically well-choreographed and, as elective procedures, "pretty predictable, like flying airplanes &mdash emergencies are rare." Double-booking can benefit patients by maximizing the limited number of surgeons and ORs "so that patients don't have to wait months to get their surgery done."

For his part, Dr Teuscher practices largely in a nonteaching hospital called the Beaumont (Texas) Bone and Joint Institute, where he operates on patients one at a time — and avoids multitasking. "The whole point is, when a surgeon is operating on a patient, there's only one patient," he said.

No matter how operations are scheduled, patient safety must be a top priority, Dr Teuscher said. "The AAOS is a national leader in that. You can't have great outcomes unless you're preoccupied with safety."

**What Do You Tell the Patient?**

Another priority for surgeons, Dr Teuscher said, is informing the patient who exactly will participate in the procedure, and what each member of the team will do. "Patients have the right to know," he said.

Other surgeons interviewed by *Medscape Medical News* stressed the importance of full-fledged informed consent for double-booked surgeries, something the *Boston Globe* said was lacking at MGH (the hospital encourages, rather than requires, physicians to make such disclosures, according to the newspaper). Dr Batjer, from the American Association of Neurological Surgeons, said that when he works two ORs concurrently, his patients know ahead of time that he may be in another room during parts of their operation, and that a resident will be closing a wound after he has performed a critical step such as clipping a brain aneurysm.

The ACGME's Dr Potts said that when he practiced at a teaching hospital, he had a standard way of explaining this team concept.

"I'd introduce the resident by saying, 'This is Dr So and So. A lot of the operation will be done with his hands. I'm doing the operation, but I'm using his hands.'

"Patients understood that. I rarely got questions."

But there is always the possibility of questions, and objections. The *Boston Globe* quoted one MGH patient as saying that if he had known his surgeon's double-booked schedule beforehand, he would not have agreed to the procedure.

A study published in *JAMA Surgery* in 2012 suggests that such patient attitudes are more common than physicians might think. The study, based on a patient questionnaire at a military teaching hospital, found that although 94% would consent to residents participating in a surgical procedure, the consent rate dropped as residents played a greater hypothetical role. Only 18% said they would consent to a surgery in which a resident "acts as the operating surgeon with or without direct staff observation" — conditions akin to those in double-booking.

As it is, informed consent about resident responsibilities is often sketchy, given no widely accepted guidelines or policies about how to obtain it, according to the study. "It is not uncommon to have little to no relevant discussion regarding the role of the trainee, or to have this issue addressed only by vague blanket statements in the written consent form.... This information is rarely volunteered or provided by the counselling physician."

At the same time, the study found that the vast majority of patients surveyed want to know what roles residents and fellows will play in a scheduled surgery.

In their posted comments on the controversy, a number of Medscape readers said in no uncertain terms that surgeons who schedule overlapping operations owed their patients full disclosure. They seemed as angry about lack of informed consent as they were about the feasibility of double-booking itself.

One clinician wrote, "If this is really justifiable (and I'm not talking about overlapping rooms during closure to speed turnover — I'm talking about truly concurrent procedures), then why aren't we telling the patients that we are doing it?

"That is the clearest evidence that this is wrong."



Send comments and news tips to news@medscape.net.

Cite this article: Double-booked Surgeries Roil Medicine. *Medscape*. Dec 23, 2015.