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INSIDE

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AHC Media

Are sexual abuse and harassment happening in your operating rooms?

Case involving surgical tech, CRNA, and urologist highlights liability

In light of recent high-profile cases of sexual assault and harassment in healthcare facilities, managers should assess whether their policies and procedures are strong enough to produce an adequate response when staff members or patients report these incidents, one risk management expert suggests. The policies must lead to disciplinary action when appropriate, she says.

"It needs to be a policy that has teeth," says **Delphine O'Rourke**, JD, in-house general counsel and chief advocacy officer of Our Lady of Lourdes Memorial Hospital in Binghamton, NY, and managing partner of the Philadelphia, PA, office of the law firm Hall, Render, Killian, Heath & Lyman.

"IT NEEDS TO BE A POLICY THAT HAS TEETH."
— DELPHINE O'ROURKE, OUR LADY OF LOURDES MEMORIAL HOSPITAL

One recent case in the news drew attention to the problem of sexual abuse and harassment. It involved a surgical tech accusing a nurse anesthetist and urologist of sexually harassing her. The incident resulted in a lawsuit against the facility and others. *(See the story in this issue for more information on that incident.)*

In this case, "there were allegations that hospital administrators didn't respond or didn't investigate," O'Rourke says. "The policy has to be strong enough to create a culture of compliance, to communicate to physicians and staff that we take this seriously and there are concrete identifiable consequences to this behavior. [Have] zero tolerance for this type of behavior."

There also should be a process to

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facilitate concerns about sexual abuse and harassment, such as a hotline dedicated to staff concerns or even to this particular concern, O'Rourke says.

Anonymous reporting is critical because staff members cite fear of retaliation as one of the main reasons they do not report sexual misconduct, as victims or witnesses. Particularly with the physician/staff dynamic in healthcare, employees can be very fearful that a physician will retaliate in the workplace, even if there are no negative consequences from administration in a formal way, she says.

"They won't get the high-paying shifts, they'll be cut off from surgeries with that physician, moved from their units, subject to greater harassment by the person they report," O'Rourke explains. "That fear of retaliation can be a powerful disincentive even when the person knows that what is happening is wrong and shouldn't be tolerated."

Reasons for reluctance

Victims also can be dissuaded from reporting because they think nothing will be done to stop the behavior.

There is some justification for that thought because even when physicians are accused of sexual misconduct, state boards rarely take any disciplinary action, according to the first study using information on physician sexual misconduct from the National Practitioner Data Bank (NPDB). *(See the story in this month's issue for more information on that report.)*

Though allowing anonymity, the process for reporting concerns must give administrators enough information to investigate and act. Achieving both requires a delicate balance, O'Rourke says. It is not unusual for hotlines to receive calls that indicate a serious problem but provide too little information for follow up, she says.

Any information promoting the hotline, and the recording the caller hears, should emphasize the need for enough detail to allow administration to respond. That information must be paired with assurances that any retaliation in the workplace will not be tolerated.

O'Rourke notes that encouraging people to report concerns directly to the person responsible for risk management may not be the best choice. Like it or not, many employees and patients perceive risk management as working to protect the facility rather than them, so they

EXECUTIVE SUMMARY

A high-profile case of sexual misconduct illustrates the need for good risk management in this area. The case led to the facility being sued, as well as a physician and nurse anesthetist.

- Policies and procedures regarding sexual abuse and harassment must be rigidly enforced.
- Employees and patients need an anonymous method for reporting their concerns.
- The facility cannot allow retaliation against anyone reporting claims of sexual misconduct.

may be discouraged from reporting, she says. Even if the reports go directly to the person responsible for risk management, it probably is not a good idea to promote that point, she says.

It also is not enough to sit back and wait for the calls to come in. Managers should proactively monitor some areas where sexual misconduct is more likely because patients are more vulnerable, she says. Those areas include surgery and anywhere patients are anesthetized. O'Rourke recommends talking with staff in these areas frequently to get a feel for the culture, what is tolerated and what is not, and how comfortable people might feel reporting a problem.

Another strategy is to randomly audit charts of vulnerable patient populations by contacting those patients and asking about their experiences, O'Rourke suggests.

Failing to have a meaningful, effective process for reporting and investigating sexual misconduct claims opens up the facility to liability on several levels, O'Rourke notes.

The facility can be sued for retaliation even if the administrators did not formally discipline the employee for reporting. The employee can show that he or she was denied higher paying shifts, promotions, or otherwise suffered as a result of reporting, O'Rourke explains. The facility also can be sued for failing to act after receiving a report and for failing to follow its own policies and procedures.

"Regardless of who the alleged harasser is, the [facility] should follow the same policies and procedures," O'Rourke says. "Employees are very attuned to that because this is an environment in which there is a hierarchy, and it's very clear and acknowledged by everyone. If employees don't think the system will treat them equally when they report these things, problems will go unreported, and you're creating a hostile work environment where sexual harassment is tolerated, if not encouraged."

O'Rourke notes that in a California case in which a surgical tech claims a nurse anesthetist was exposing himself to her during procedures, the administration allegedly refused to review the OR surveillance video after she reported the incidents or turn over the video without a court order. If that accusation is true, O'Rourke says, the facility sent a bad message to employees by implying that it was not willing to investigate serious claims of misconduct.

> "I'VE HEARD COUNTLESS TIMES, 'WHAT HAPPENS IN THE OR STAYS IN THE OR.' THAT CULTURE HAS TO CHANGE."

"I've heard countless times, 'What happens in the OR stays in the OR,'" O'Rourke says. "That culture has to change. Whether it has to do with sexual harassment or infection control, the OR cannot be an environment where rules are broken or rules are bended because of a historic culture."

State medical boards are failing to protect the public from many doctors already known to have committed sexual misconduct, according to a recent report from Public Citizen, a non-profit, consumer rights advocacy group and think tank based in Washington, DC.

Seventy percent of U.S. physicians (177 out of 253) who had engaged in sexual misconduct that led to sanctions by healthcare organizations or malpractice payments were not disciplined by state medical boards for their unethical behavior, according to the research. The study is the first published one that used information on physician sexual misconduct from the NPDB.

"It's clear that medical boards are allowing some doctors with evidence of sexual misconduct to continue endangering patients and staff," said **Azza AbuDagga**, MD, health services researcher for Public Citizen's Health Research Group and lead author of the study.

Public Citizen for years has pushed state medical boards to do a better job of disciplining problem doctors. "These boards must pay more attention to sexual misconduct that leads to health care organizations cracking down or to lawsuits," AbuDagga said.

When state medical boards do act on sexual misconduct, though, they take severe measures in the vast majority of cases. For the 974 NPDB reports of medical boards disciplining physicians in response to physician sexual misconduct, the boards took serious licensure actions — such as revoking, suspending, or restricting the medical license — in 89% of cases. In contrast, state medical boards took such severe actions in only about two-thirds of cases involving other types of misconduct.

Sidney Wolfe, MD, founder and senior adviser of Public Citizen's

Health Research Group and coauthor of the study, said, "These numbers show that when state medical boards take action, the action rightly tends to be much more severe for physicians who engaged in sexual misconduct than other offenses. Now, the medical boards need to pay increased attention to sexual misconduct that led to health care organizations cracking down or to lawsuits. State medical boards have full access to the NPDB data. The boards must protect the public."

While the study provides important new information, it likely highlights a possible overall underreporting or inaction related to sexual misconduct. The authors caution that because sexual misconduct-related reports accounted for only 1% of the total reports in the NPDB, their study "represents only the tip of the iceberg of physician sexual misconduct in the U.S."

The full report is available at http://tinyurl.com/z4ft236. ■

Facility sued over claims of sexual abuse, harassment

A healthcare facility is facing a lawsuit, as is a physician and a nurse anesthetist, in a case in which professionals are accused of sexual abuse and sexual harassment.

A surgical technician at Adventist Medical Center – Hanford in California took a cellphone video of a nurse anesthetist that she claims shows him exposing himself and masturbating during a surgical procedure.

The woman's attorney, John Little, JD, of Fresno, CA, released the video publicly after she filed a lawsuit accusing the hospital of ignoring her reports of sexual harassment by the anesthetist and a urologist. She alleges that urologist Seetharaman Ashok, MD, touched and kissed her without her consent and made inappropriate sexual comments about her. Some physical contact was recorded by surveillance cameras, the lawsuit says.

The lawsuit also claims that the doctor made a false allegation of misconduct and incompetence against a friend and co-worker of the woman who had witnessed the harassment. The woman's attorney stated in a news conference that she had reported the harassment to hospital leaders, but the attorney said nothing was done. When the hospital also didn't respond to her reports that nurse anesthetist Richard McGrory was exposing himself to her during surgeries, she decided to record him, the lawsuit says.

The woman and her co-worker friend are seeking unspecified damages for sexual harassment, unlawful sexual battery in the workplace, and retaliation. According to their attorney, the urologist still has privileges at the hospital and the anesthetist was allowed to resign. The hospital provided favorable recommendations to the anesthetist for use in obtaining another job, according to the complaint.

The complaint against Adventist Medical Center – Hanford is available online at http://tinyurl.com/hdbpa7q. Adventist Health spokeswoman **Christine Pickering** issued a statement saying the allegations of cover-up were "false and misleading" but that the organization does not discuss pending litigation. ■

Details of the report on physician sexual misconduct

Public Citizen, a non-profit, consumer rights advocacy group and think tank based in Washington, DC, recently released a report on sexual misconduct-related licensure, clinical privileges, and malpractice payment reports for physicians, including medical doctors, osteopathic doctors, and intern/resident physicians.

A "licensure" sanction refers to an action, such as revocation or restriction of a doctor's medical license, taken by a medical board. A "clinical privileges" sanction refers to actions such as revocation or denial of clinical privileges, voluntary surrender of privileges, and restrictions on a doctor's ability to practice. These actions are taken by hospitals, nursing homes, or managed care organizations.

The group studied physician reports in the National Practitioner Data Bank from Jan. 1, 2003, through Sept. 30, 2013. The analysis found that 1,039 physicians had one or more sexual misconduct-related reports, and of these, 786 (76%) had been disciplined only by a medical board.

The study also revealed that the remaining 253 physicians had one or more clinical privilege reports or malpractice payment reports related to sexual misconduct, but 177 did not have a report of state medical board licensure action for such misconduct. ■

The Joint Commission issues *Sentinel Event Alert* on preventing suicide in all settings

The Joint Commission has issued a *Sentinel Event Alert* on preventing suicide in healthcare settings. The *Alert* says that the information applies to all patients in all settings.

"It's imperative for health care providers in all settings to better detect suicide ideation in patients, and to take appropriate steps for their safety and/or refer these patients to an appropriate provider for screening, risk assessment, and treatment," the *Alert* says.

The *Alert* points out that Parkland Memorial Hospital in Dallas became the first hospital in the United States to have universal screenings to determine whether patients are at risk for suicide. *(For more information, see "Health system is thought to be first to provide universal suicide screenings" that ran in* Healthcare Risk Management*, also published by AHC Media, at bit.ly/1Rawpen.)*

"Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk," says the *Alert,* basing its figures on a report in *The Dallas Morning News*.[1]

The *Alert* aims to assist providers in better identifying and treating individuals with suicide ideation. The *Alert* also provides screening, risk assessment, safety, treatment, discharge, and follow-up care recommendations for at-risk individuals.

The Joint Commission is bringing attention to this issue because its Sentinel Event Database received 1,089 reports of suicides occurring from 2010 to 2014. The most common root causes documented were shortcomings in assessment, most commonly psychiatric assessment. In addition, 5.14% of Joint Commission-accredited hospitals, for which a related National Patient Safety Goal (NPSG) was applicable, were non-compliant in 2014 with conducting a risk assessment that identifies specific patient characteristics and environmental features related to suicide risk. *(For more on that NPSG, see the* Same-Day Surgery *article "New Patient Safety Goals added for next year" at bit.ly/24TzsSz.)*

"We are shining a light on this issue because the tragic reality is that many healthcare providers do not detect suicidal thoughts of individuals who eventually die by suicide, even though most victims of suicide received healthcare services in the year prior to death," said **Ana Pujols McKee**, MD, executive vice president and chief medical officer at The Joint Commission. "As a result, it is crucial for at-risk patients to receive timely and supportive care. Healthcare organizations are encouraged to develop clinical environment readiness by identifying, developing, and integrating comprehensive behavioral health, primary, and community care resources to ensure the continuity of care for at-risk individuals."

Steps to take

All healthcare providers play an important role in detecting suicide ideation, according to the *Alert*. It recommends these steps.

• Review each patient's personal and family medical history for suicide risk factors, screen all patients for suicide ideation, and review screening questionnaires before patients leave or are discharged.

The Joint Commission says providers can use a waiting room questionnaire including a question asking if the patient has had thoughts

EXECUTIVE SUMMARY

The Joint Commission's *Sentinel Event Alert* on preventing suicide in healthcare says that the information applies to all patients in all settings.

- Parkland Memorial Hospital in Dallas has universal suicide screenings, including at outpatient clinics. The hospital has found 1.8% of patients to be at high suicide risk and up to 4.5% to be at moderate risk.
- Review each patient's personal and family medical history for risk factors, screen all patients for suicide ideation, and review screening questionnaires before patients leave.
- Take immediate action for patients in acute suicidal crisis, and conduct safety planning for all patients with suicide ideation.
- Manage evidence-based treatments and discharge plans that directly target suicide, educate staff about how to identify and respond to at-risk patients, and document decisions on care and referral.

about killing himself or herself.

Some practices use the Patient Health Questionnaire 2 (PHQ-2),[2] which asks about depression symptoms, and some providers add another question about suicidal thoughts. If a patient answers "yes" to any of these questions, providers can administer the PHQ-9.[3] Another brief screening tool mentioned in the *Alert* includes the Suicide Behaviors Questionnaire-Revised (SBQ-R).

• Take immediate action for patients in acute suicidal crisis, and conduct safety planning for all patients with suicide ideation.

Patients in acute suicidal crisis should be observed continuously. Give them immediate care through an emergency department, inpatient psychiatric unit, respite center, or crisis resources, the *Alert* says. Check the patient, as well as their visitors, for items that could be used to hurt or attempt suicide. Don't let these patients near anchor points that could be used for hanging. Also, keep them away from materials that could be used for self-injury, including bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing, and oxygen tubing.

Patients who are at lower risk of suicide should be given personal, direct referrals and links to outpatient behavioral health and other providers, to be seen within one week. Don't leave it to the patient to make the appointment, the *Alert* advises. Also, give each of these patients the number to the National Suicide Prevention Lifeline (800) 273-TALK (8255).

"For patients who screen positive for suicide ideation and deny or minimize suicide risk or decline treatment, obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers," the *Alert* says. "If the patient declines consent, HIPAA permits a clinician to make these contacts without the patient's permission when the clinician believes the patient may be a danger to self or others."

• Manage evidence-based treatments and discharge plans that directly target suicide, educate staff about how to identify and respond to at-risk patients, and document decisions regarding care and referral.

The education should cover environmental risk factors, how to find help in emergencies, and policies for patients at risk of suicide. The Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention developed *Suicide Prevention and the Clinical Workforce: Guidelines for Training*.[4] Other resources recommended in the *Alert* are TJC's *Standards BoosterPak Suicide Risk for National Patient Safety Goal 15.01.01* for accredited organizations (Web: bit.ly/1u6pY4z) and the *QPR Institute and the VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013)*.[5]

Providers should document decisions about patients with suicide risk. "Thoroughly document every step in the decisionmaking process and all communication with the patient, his or her family members and significant others, and other caregivers," the *Alert* says. "Document why the patient is at risk for suicide and the care provided to patients with suicide risk in as much detail as possible ... ."

A documentation checklist is available on page 21 of *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments*.[6]

Risk Factors for Suicide

- Mental or emotional disorders, particularly depression and bipolar disorder
- Previous suicide attempts or self-inflicted injury
- History of trauma or loss, such as abuse as a child, a family history of suicide, bereavement, or economic loss
- Serious illness, or physical or chronic pain or impairment
- Alcohol and drug abuse
- Social isolation or a pattern/history of aggressive or antisocial behavior
- Discharge from inpatient psychiatric care, within the first year after discharge and particularly within the first weeks and months after discharge
- Access to lethal means coupled with suicidal thoughts.

Source: The Joint Commission. Detecting and treating suicide ideation in all settings. *Sentinel Event Alert* 2016; 56. Accessed at bit.ly/1R2riNr. ■

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RESOURCE

The full *Alert*, an infographic, and a chart of related standards from The Joint Commission can be accessed at bit.ly/1h0HsER. ■

Total hip cases said safe and effective on the right patients at surgery centers

Outpatient total hip arthroplasty can be safe and effective when performed at an ambulatory surgery center (ASC) when the procedure is performed on appropriately screened patients, according to a presentation at the annual meeting of the American Academy of Orthopaedic Surgeons.

The authors say that while outpatient total hip arthroplasty (THA) is thought to be beneficial for patients, payers, and the overall healthcare system, the safety of outpatient total joint procedures has not been qualified.

To determine the safety, the researchers examined the records of 549 patients who underwent surgery at a freestanding, independent ASC between 2008 and 2014. Factors that played a role in the decision to have an ambulatory procedure included the patient's age, comorbidities, and how motivated the patient was to have a rapid recovery. The mini-posterior approach was used for the procedure, and the patients received a short-acting spinal with lidocaine.

The patients had an average age of 54.4 years, but they ranged from 27 to 73 years old. The average American Society of Anesthesiologists Physical Classification Score was 1.6, but it ranged from 1 to 3. Three patients (0.5%) were admitted from the surgery center to a hospital. One admission was for pain control after the patient failed to disclose that he had long-term high-dose narcotic dependence, the authors said. Another patient was admitted for an acetabular component migration that was identified on a postoperative X-ray. The third patient was admitted for hypotension, bradycardia, and an acute polyarthralgia exacerbation. A fourth patient was seen at an emergency department two days after surgery for oversedation secondary to narcotics. That patient was discharged home.

Ten (1.8%) patients were hospitalized postoperatively at an average of 15.7 days who needed irrigation and drainage for hematoma or delayed wound healing. Five (0.9%) postoperative infections were identified on average at postoperative day 35 that were treated with surgery. Six (1%) patients had dislocated hips between days 0 and 77. One of the patients had a postoperative X-ray that identified the dislocated hip. That patient had an immediate revision and was discharged that day. Three (0.5 %) patients had venous thromboembolism.

"Same day discharge THA in an ambulatory surgical center is safe and reproducible," the authors conclude. *(Readers can view the abstract online at bit.ly/1T7zjX0. For more infomation about outpatient hip arthroplasty, see our* SDS Manager *column, "Can you offer total hips and knees in 23 hours? Yes!"* Same-Day Surgery*, May 2015, at bit.ly/1Ub6bQ7.)* ■

PNBs tied to better outcomes in hip and knee cases

The use of peripheral nerve blocks (PNBs) is associated with better medical and economic outcomes in patients receiving hip and knee replacement, according to research presented at the annual Regional Anesthesiology and Acute Pain Medicine Meeting.

An estimated 1 million people undergo hip or knee replacement each year in the United States. Patients may be kept awake during the procedure using neuraxial anesthesia, which is associated with fewer complications than general anesthesia.

The use of PNBs is on the rise, but still is not used routinely in hip and knee arthroplasty. In the study, about 18% of patients had received PNBs.

Researchers looked at more than 1 million cases of hip and knee arthroplasty over seven years. They compared the rate of complications such as heart attack; lung, gastrointestinal, and kidney complications; stroke; infection; wounds; clots; inpatient falls; and mortality in those receiving a PNB to those without the intervention. They also looked at resource use such as the need for blood transfusion, admission to intensive care, opioid consumption, length of stay, and cost of hospitalization.

In terms of complications and resource use, PNBs were tied to better outcomes than when the intervention was not used irrespective of anesthesia type chosen. The researchers concluded that increased use of PNBs in patients receiving knee and hip reconstruction and replacement could have a significantly positive impact on medical and economic outcomes.

The study was titled "The impact of peripheral nerve blocks on perioperative outcome in hip and knee arthroplasty – a population-based study." The abstract (no. 1,623) was selected as a "Best of Meeting" winner. The findings were presented by primary author Stavros G. Memtsoudis, MD, PhD, FCCP, clinical professor of anesthesiology and public health at the Weill Cornell Medical College and senior scientist and attending anesthesiologist at the Hospital for Special Surgery, both in New York City. *(For more information, go to bit.ly/1o8MRV7.)* ■

SDS Manager

7 pressing questions in outpatient surgery

By Stephen W. Earnhart, MS
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I always get a great response from readers when I do these Q&A articles. Here are some ones from the past six months.

Question: Our new surgeon wants to do total joints in our facility. (He read your article. Thanks, and I am being sarcastic!) We just cannot do these on all these old, sick patients, and it is going to make us fail! You need to be careful what you write about, because these docs read it and then put it in our face and tell us to do it!

Answer: Well, not really a question, more of a statement, but let me share a little bit of info. According to the 2010 numbers from the National Center for Health Statistics, there were 148,000 total hip replacements done at hospitals in the United States on patients 45-64 years of age. There were 168,000 done on patients 65 and older.

Regarding 2010 statistics on knee replacement: There were 317,000 done at hospitals on patients 45-64 years of age, and 385,000 done on patients 65 and older. Our personal experience suggests that about 20% of eligible candidates for joint replacement are too "sick" to be done in ambulatory surgery centers (ASCs).

When you consider that all insurance payers are looking to "bundle bill" these procedures, the advantage goes to ASCs because of their lower overhead cost on the facility fee. Almost all of our new facilities will include joint replacement. I think your surgeon is giving you good advice. (*To read my previous column on total joints, go to bit.ly/1Ub6bQ7.)*

Question: We are a not-for-profit hospital that is considering doing a surgery center and letting local surgeons join us. We have had several meetings with the docs, but the only ones who seem interested are the local plastic surgeons. We are offering surgeons up to 40% ownership, and the hospital will bill for the ASC and manage it. We also will rotate the hospital surgical team through the center. What are we doing wrong that no one is interested?

Answer: Consider changing your terms to the following: Hospital 30%, surgeons 70%. Outsource billing to a professional ASC billing company. Outsource management to a professional ASC management company. Have 100% dedicated ASC staff, with no rotating hospital staff members.

Question: This question came up at a staff meeting last week at our ASC: How much profit-sharing should the ASC staff request of our surgeon investors (who are open to suggestions — shockingly)?

Answer: Congratulations on getting there! Now, don't get greedy. I usually recommend 3% of the profit (be prepared for negotiations) be placed in an employee distribution pool. That arrangement usually works. Do not look to take it off the top (revenue). Your surgeons will want it off of the bottom line (profits).

Question: Is it a good idea to

hire family members of current employees?

Answer: While I am sure it works well for some, in my experience, nepotism is not a good idea in a small work environment like a surgery center. It frequently can lead to animosity among other staff members, especially when it deals with pay rates and work schedules if other staff members believe there is favoritism between the parties, whether that favoritism is real or not.

Question: We want to set aside a dollar amount for birthday presents for staff members each year. What are other facilities contributing?

Answer: Nothing. Why would you do that?

Question: I am thinking of getting out of healthcare for a career path that is more secure. What would you recommend?

Answer: Healthcare.

Question: It was recommended that our front office staff, receptionist, intake staff, and scheduler become certified in BLS (basic life support). Is that common, and what would you recommend?

Answer: I recommend it. First of all, it is inexpensive. Almost every one of your front desk staff members will welcome it, and it provides a higher level of commitment to patient safety. Remember that most facilities have a large number of patients sitting in their waiting rooms. Wouldn't it be a great service to have those staff members recognize when a visitor is in distress and be prepared to offer assistance to your other staff members?

Thanks to everyone who continues to submit great questions! *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Phone: (512) 297-7575. E-mail: searnhart@earnhart.com. Web: www.earnhart.com]* ■

FDA moves to ban powdered gloves in healthcare

(AHC Media, publisher of Same-Day Surgery*, first published this news on March 21. To keep up with breaking news, go to AHCMedia.com and follow us on Twitter @SameDaySurgery.)*

The Food and Drug Administration (FDA) has announced a proposal to ban powdered gloves, and it cites the ongoing "dangerous" risk of allergic reactions to healthcare workers and patients.

While use of these gloves is decreasing, the FDA decided they "pose an unreasonable and substantial risk of illness or injury to health care providers, patients and other individuals who are exposed to them, which cannot be corrected through new or updated labeling."

The ban, which is open for comment for 90 days from March 22, 2016, applies to powdered surgeon's gloves, absorbable powder for lubricating surgical gloves, and powdered patient examination gloves. Non-powdered surgeon gloves and non-powdered patient examination gloves won't be included in the ban.

"This ban is about protecting patients and health care professionals from a danger they might not even be aware of," **Jeffrey Shuren**, MD, director of FDA's Center for Devices and Radiological Health said in a statement. "We take bans very seriously and only take this action when we feel it's necessary to protect the public health."

Powder can spread latex allergens if aerosolized and inhaled. Reported allergic reactions have included severe respiratory problems in healthcare workers and others with latex allergies.

Although powdered synthetic gloves don't present the risk of latex allergic reactions, the FDA noted, these gloves "are associated with an extensive list of potentially serious adverse events, including severe airway inflammation, wound inflammation, and post-surgical adhesions, which are bands of fibrous scar tissue that form between internal organs and tissues. These side effects have been attributed to the use of glove powder with all types of gloves."

Deciding the risk cannot be mitigated through new or updated labeling, the FDA is moving forward with the proposal to ban powdered gloves. The agency cited information gathered in a 2011 review of the literature and request for comment on the issue in determining the gloves "are dangerous and present an unreasonable and substantial risk."

In addition, given the critical role medical gloves play in protecting patients and healthcare providers, the FDA also conducted an economic analysis that showed a powdered glove ban would not cause a glove shortage and the economic impact of a ban would not be significant. The ban also is not likely to impact medical practice, because many non-powdered protective glove options are available.

The FDA has determined that the banning standard would not apply to powdered radiographic protection gloves. The agency is not aware of any powdered radiographic protection gloves that are on the market. *(To see the proposal, go to 1.usa.gov/1UBPRau.)* ■

Researchers show rising opioid prescriptions following low-risk surgeries

Physicians are prescribing more opioid painkillers than ever to patients undergoing common outpatient surgeries, according to research.

The research was published online in *The Journal of the American Medical Association*. The research is from the Department of Anesthesiology and Critical Care at the Perelman School of Medicine at the University of Pennsylvania in Philadelphia.

Opioid abuse and addiction is a growing concern in the United States, with the National Institute on Drug Abuse estimating that about 2.1 million Americans suffer from substance use disorders related to prescription opioid pain relievers and an estimated 467,000 Americans are addicted to heroin, with increasing recognition of the strong relationship between opioid use and heroin abuse.

The study, which included researchers from the University of Toronto, analyzed insurance claims from 2004 through 2012 for 155,297 adults undergoing four common outpatient surgeries:

- carpal tunnel release;
- laparoscopic cholecystectomy;
- knee arthroscopy;
- inguinal hernia repair.

In an analysis of patients who had not received an opioid prescription in the six months preceding surgery, the researchers observed that four out of every five patients in the study filled a prescription for an opioid pain medication within seven days after surgery. The percentage of patients who obtained those drugs increased from 2004 to 2012 for all four surgical procedures.

Most notably, the amount of opioid medication dispensed to patients after surgery also increased markedly between 2004 and 2012 for all procedures studied. Among patients undergoing knee arthroscopy, for example, the investigators estimated a greater than 18% increase in the average total amount of opioid dispensed, driven by a change in the average daily dose.

"These data show us a concerning trend," said the study's senior author, **Mark Neuman**, MD, MSc, an assistant professor of anesthesiology and critical care and director of the Penn Center for Perioperative Outcomes Research and Transformation. "The growth we observe over time in opioid prescribing after surgery occurs against the backdrop of a major public health crisis of prescription opioid abuse. Additional work is needed to understand how postoperative opioid prescribing patterns might play into this epidemic, and to define better strategies for treating postoperative pain safely and effectively in the future." *(To access the abstract, go to bit.ly/1R9gLkq. For more information on this topic, see this published article: "American Pain Society publishes guideline for post-surgical pain management,"* Same-Day Surgery*, April 2016, at bit.ly/1XNBWwi.)* ■

T&A in inpatients versus ambulatory patients

There are a significant number of pediatric patients who have tonsillectomy and adenoidectomy (T&A) in ambulatory settings despite the higher rates of complications in younger patients and patients with more comorbidities, according to recently published research.

The researchers say that a large number of pediatric T&A patients have been triaged to the inpatient setting, which they say is appropriate. More research is needed to clarify which subgroups need postop hospitalization, according to the study in *JAMA Otolaryngology – Head & Neck Surgery*. The researchers were from Stanford (CA) University.

The purpose of this study was to determine risk factors for postoperative complications based on age and facility type among children undergoing T&A. The study looked at 115,214 children who had T&A in hospitals, hospital-based facilities (HBFs), and freestanding facilities (FSFs) in California from 2005 to

COMING IN FUTURE MONTHS

- Could you be liable for employee assaults on patients?
- Quality indicators for outpatient surgery nursing
- Tips on how to schedule procedures more accurately
- Improving employee health in ambulatory surgery

2010. The researchers used state data. There were 18,622 inpatients and 96,592 outpatients. The inpatients had a mean age of 5.4, and the ambulatory patients had a mean age of 7.6.

Inpatients had more comorbidities (eight or fewer, compared with four or fewer for HBFs and three or fewer for FSFs). Generally, inpatients had higher complication rates than patients at HBFs (2-5 times higher) and FSFs (more than 10 times higher).

T&A had an increased risk for all types of complication in both settings, the researchers said. Inpatients who were ages 0 to 9 years had higher rates of airway and respiratory complications. *(To view the abstract, go to bit.ly/1nd337d.)* ■

Surgeons help patients quit smoking before surgery

A recent pilot study of vascular surgery patients found that patients facing surgery were more likely to quit smoking when their physician offered the right kind of assistance. The study's investigators were particularly interested because patients who smoke often will have fewer post-surgical complications if they quit ahead of time.

While it's somewhat common for surgeons to mention that their patients should quit smoking before an upcoming surgery, in most cases, there is no actual assistance, such as offering nicotine patches or referral to a smoking quitline. However, in this pilot study nicknamed "VAPOR," 156 patients were offered advice from physicians for smoking cessation, nicotine replacement medications, and information about phone counseling, or usual medical care.

Researchers found that most patients wanted a personalized approach to help them quit, even during impending surgery. "We wanted one approach that would be expedient and work in every setting and every patient," said **Philip P. Goodney**, MD, MS, assistant professor of surgery at the Geisel School of Medicine and affiliated faculty at The Dartmouth Institute for Health Policy and Clinical Practice, both in Hanover, NH. "What we found was the opposite. Patients wanted to customize a smoking cessation program to fit their own needs. They would say, 'I have been smoking a long time and have health problems. I need something to help me individually.' Patients know a lot about their own challenges."

The pilot study was so successful that the program was adapted for use among the researchers' colleagues at Boston Medical Center, including outpatient surgery, says **Alik Farber**, MD, chief of the Division of Vascular and Endovascular Surgery, associate chair for clinical operations, Department of Surgery at Boston Medical Center. ■

MedPAC urges payment updates for ASCs, HOPDs

The Medicare Payment Advisory Commission (MedPAC) released its March report and recommended a 0% update for Medicare payments to ambulatory surgery centers and, as dictated by law, a 1.75% increase for hospital outpatient departments.

MedPAC also called for ambulatory surgery centers to release cost data.

MedPAC also recommended a 0.5% payment rate increase for physician and other health professional services. The Medicare Access and CHIP Reauthorization Act of 2015 provides for a 0.5% increase in Medicare physician fee schedule rates through 2019. *(The entire report is available online at 1.usa.gov/1VET2hg.)* ■

Reader Survey has 2 options

This year, we offer you the option of taking the *2016 Reader Survey* in print, enclosed in this issue, or online, at svy.mk/1RqGh8o.

Your responses will guide future issues of *Same-Day Surgery*. We look forward to receiving your feedback on how to make *SDS* as useful as possible. ■

CE/CME OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identifiy how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

SAME-DAY SURGERY

CE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to AHCMedia.com then select "My Account" to take a post-test. *First-time users must register on the site.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE/CME QUESTIONS

1. **Why is it important to offer anonymous reporting of sexual misconduct to victims and witnesses?**

   A. Because staff members cite fear of retaliation as one of the main reasons they do not report sexual misconduct
   B. Because it is an accreditation requirement
   C. Because it is a federal requirement

2. **Which of the following are recommended in all settings by The Joint Commission in its *Sentinel Event Alert* on suicide?**

   A. Review each patient's personal and family medical history for suicide risk factors.
   B. Screen all patients for suicide ideation.
   C. Review screening questionnaires before patients leave or are discharged.
   D. All of the above

3. **According to recent research in *The Journal of the American Medical Association*, how did the amount of opioid medication dispensed to patients after common outpatient surgery procedures 2004-2012 change for the procedures studied?**

   A. The amount of opioids decreased markedly.
   B. The amount of opioids increased for all of the procedures studied.
   C. The amount of opioids increased, but only for some of the procedures studied.

4. **Surgery clinics at Boston Medical Center have adopted what approach to deliver smoking cessation help to their patients?**

   A. Brief surgeon advice
   B. Prescription therapy
   C. A referral to telephone counseling
   D. All of the above

Same-Day Surgery

2016 Reader Survey

In an effort to learn more about the professionals who read *Same-Day Surgery*, we are conducting this reader survey. The results will be used to enhance the content and format of *SDS*.

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. Either fax the completed questionnaire to 678-974-5419, or return it in the enclosed postage-paid envelope. The deadline is **July 1, 2016.**

In future issues of *SDS*, would you like to see more or less coverage of the following topics?

A. more coverage B. less coverage C. about the same amount

1. Risk management	O A	O B	O C
2. New surgical procedures	O A	O B	O C
3. Infection control	O A	O B	O C
4. Cost containment	O A	O B	O C
5. Reimbursement/finance	O A	O B	O C
6. Accreditation	O A	O B	O C
7. Quality improvement/ benchmarking	O A	O B	O C
8. Federal regulations	O A	O B	O C
9. Staffing/staff satisfaction	O A	O B	O C
10. Other. Please list: _____			

Please rate your level of satisfaction with the following items.

A. excellent B. good C. fair D. poor

11. quality of newsletter	O A	O B	O C	O D
12. article selections	O A	O B	O C	O D
13. timeliness	O A	O B	O C	O D
14. length of newsletter	O A	O B	O C	O D
15. overall value	O A	O B	O C	O D
16. customer service	O A	O B	O C	O D

17. On average, how many people read your copy of *SDS*?

O A. 1-3
O B. 4-6
O C. 7-9
O D. 10-15
O E. 16 or more

18. How would you rate your overall satisfaction with your job?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

19. How would you describe your satisfaction with your subscription to *SDS*?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

20. What is your title?

O A. Director/CEO
O B. Administrator
O C. Ambulatory Surgery Manager
O D. Nurse Manager
O E. Other _____

21. Do you plan to renew your subscription to *SDS*?

O A. yes
O B. no If no, why not? _____

_____

22. To what other publications or information sources about same-day surgery do you subscribe?

23. Including *SDS*, which publication or information source do you find most useful, and why?

24. Which web site related to your position do you use most often?

25. Please list the top three challenges you face in your job today.

26. What do you like most about *SDS*?

27. What do you like least about *SDS*?

28. What are the top three things you would add to *SDS* to make it more valuable for your money?

Contact information