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INSIDE

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Malpractice premiums rise, and some can't obtain insurance: How to survive

In this unstable market, you must sell your program to insurers

When the insurer covering Bristol (TN) Surgery Center got out of the medical malpractice business, the prospects were not good. Initially, the manager thought the facility might have to pay $36,000 just for tail coverage.

The University of Pennsylvania Health System has seen its insurance premiums for the facility and physicians increase $20 million, according to **David W. Kennedy**, MD, FACS, professor and chairman of the department of otorhinolaryngology: head and neck surgery at the University of Pennsylvania Medical Center in Philadelphia.

The story is similar in same-day surgery programs and in other facilities across the country. Many primary carriers have stopped writing medical malpractice coverage. Prices are up, and limits of liability are capped.

Keep up with EMTALA via audio conference

EMTALA rules continue to change. Are you up-to-date?

Keep abreast of all the latest changes with "EMTALA Update 2002," an audio conference sponsored by American Health Consultants. The conference, scheduled for Tuesday, June 4, 2002, from 2:30 to 3:30 p.m. EDT, will be presented by Charlotte S. Yeh, MD, FACEP, and Nancy J. Brent, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Co. Brent is a Chicago-based attorney, with extensive experience as a speaker on the Emergency Medical Treatment and Labor Act (EMTALA) and related health care issues.

The conference will outline a new report that puts a national spotlight on inadequate emergency department (ED) on-call coverage. There is a growing trend of specialists refusing to take call for the ED, partly due to increased liability risks for medical malpractice and violations of EMTALA. If you don't take steps to ensure appropriate on-call coverage for your ED, you're at risk for violations and adverse outcomes.

(Continued on page 84)

EXECUTIVE SUMMARY

Same-day surgery programs across the country are experiencing rising insurance premiums and, in some cases, loss of their carrier. Consider these suggestions:

- Start shopping for insurance at least four months before your renewal date.
- Demonstrate the quality of care by attaching a copy of your risk management plan to your bid, showing your accreditation, and touting your involvement with national and state associations.
- Consider using technology, such as active electrode monitoring.
- A national medical malpractice program for surgery centers and surgical hospitals may be organized by August 2002.

Some carriers are getting out of the medical malpractice insurance business altogether, including St. Paul, MN-based The St. Paul Companies, which was the largest facility writer and provided coverage in all states.

"Their sudden exit has created great anxiety and instability in the [medical malpractice] market," says **Brad Shannon**, vice president of James G. Parker Insurance Associates, a Fresno, CA-based network of independent insurance agents and brokers.

"Remaining insurers are struggling with the flow of business and the capacity to provide coverage," says Shannon, who spoke on this topic at the April meeting of the Federated Ambulatory Surgery Association (FASA).

Bristol Surgery Center wasn't alone. Quail Surgical and Pain Management Center in Reno, NV, is facing a November deadline to find a new carrier because the facility's current carrier is St. Paul. And Lebanon (PA) Outpatient Surgery Center lost its carrier, and now it's facing the possibility of losing a couple of "excellent" physicians who may move out of the state due to insurance premiums, says **Anita Fuhrman**, RN, director of the center and president of the Pennsylvania Ambulatory Surgery Association.

Physicians' premiums have risen 15% to 40% in Pennsylvania, Kennedy says.

So what are the reasons behind the dramatic changes? One is that the number and value of severe claims are up dramatically, Shannon says. "Claim value has increased from $2.2 million in 1999-2000 to $3.6 million in late 2000 to present," he says. "This dramatic sudden increase in claim value has caused insurers to view their pricing as inadequate."

Freestanding surgery centers generally have had limited malpractice losses, so many centers have been able to maintain reasonable prices for their insurance, Shannon says.

However, surgery centers are not considered a separate group from an insurer's perspective. Instead, these centers are pooled with large regional hospital systems, teaching hospitals, physicians, nursing homes, and other entities that together have experienced significant malpractice losses, he says.

"I think it's a ripple effect," Fuhrman says. "All health care providers are really going to have to help pay for those payments to plaintiffs." She points to payments in malpractice cases in some Pennsylvania counties that have been higher than payments for entire states elsewhere in the country.

So what can surgery centers do? Consider these suggestions:

• **Explain your active involvement in risk management.** "Show it to the underwriter," Shannon suggests. "When sending in a bid, attach a copy of your risk management plan."

• **Demonstrate your accreditation.** Show insurers that you have been accredited by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, or the American Association of Ambulatory Surgery Centers in San Diego, Shannon advises.

• **Demonstrate your involvement with national and state associations.** "All of these serve to promote good loss experience, which will positively affect underwriting decisions and pricing by insuring companies," Shannon says.

• **Start at least three months before your renewal date.** Start working with your carrier or broker well in advance of your renewal date, Shannon advises. "You have to give enough time for them to go to the market and make

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sure underwriters have plenty of time to evaluate the risk," he says.

Carriers are overloaded with business because of narrowing of the market, Shannon warns. "It may take 30 days for them to begin to look at it," he says. "They'll come back with questions, and you'll go back and forth."

• **Consider technology that will reduce your premiums.** Some same-day surgery programs have been advised by their insurance companies to consider active electrode monitoring (AEM) as a way to boost safety and reduce premiums. AEM reduces the risk of injury during surgery with electrosurgical instruments because the shielded and monitored instruments are continuously directing stray energy away from the patient via a protective shield, sources say.

The "Recommended Practice for Endoscopic Surgery" in *the Standards, Recommended Practices & Guidelines (2002)* from the Denver-based Association of periOperative Registered Nurses states, "Use of active electrode monitoring devices minimizes the chance of insulation failure, direct coupling, and capacitive coupling."[1] **(See story on AEM, p. 76.)**

A program specifically for surgery centers

Help may be on the horizon. Shannon is working to establish a national medical malpractice program for surgery centers and surgical hospitals. There are three potential carriers, and he hopes to have something finalized by August 2002. He maintains that such a program could accomplish two goals:

1. It could establish specific loss experience that, on a large scale, could lead to "appropriate" pricing.

2. It could provide a profitable volume of premiums to give surgery centers leverage for coverage and pricing.

In the meantime, medical malpractice markets are changing daily, Shannon says. "Insurers and reinsurers are indicating additional rate increases," he warns.

Also, expect some regional carriers to fail and additional companies to have their "A.M. Best" rating downgraded, Shannon says. "Some have gone from A to C in one year," he says.

This will affect all areas of professional liability coverage, including directors and officers (D&O) coverage, which already has seen large price increases, Shannon says. "The staggering number of dot.com failures and the resultant lawsuits by investors has created additional loss-ratio hardships for insurers, especially in D&O insurance," he says.

Also on the agenda is a legislative effort, "The Help Efficient Accessible, Low-cost Timely Health Care Act" (HEALTH Act), which is modeled after California's Medical Injury Compensation Reform Act of 26 years ago. The HEALTH Act would include the following: a $250,000 limit on noneconomic damages, limited plaintiff attorney contingency fees, limited statute of limitations, and damage awards based on culpability, among other reforms, according to the Chicago-based American Hospital Association (AHA). At press time, it wasn't certain whether the legislation would pass. In April, Sen. Jay Rockefeller (D-WV) said there was no chance of liability reform passing in the Senate this year.

Trying to predict what will happen long term is like trying to forecast the weather, "only more difficult," Shannon says. "Hopefully, within two years, the market will stabilize for primary carriers and re-insurers," he says. "As capacity problems ease for insurers, more insurance companies will participate in providing medical malpractice coverage."

SOURCES

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Reference

1. Rohlf S. Electrosurgical safety consideration for minimally invasive surgery. *Minimally Invasive Surgical Nursing* 1995; 9:26-29. ■

AEM improves patient safety, reduces liability

Risk of stray electrosurgical burns decreases

EXECUTIVE SUMMARY

As the number of laparoscopic procedures that use electrosurgical tools increases, so does the risk of patient burns and injuries from stray electricity. Active electrode monitoring (AEM) reduces the risk of two of the three types of stray energy.

- Capacitive coupling and insulation failure are not likely to occur because AEM directs stray energy away from the patient through shielded instruments.
- The patient is protected from insulation failure because AEM equipment will shut down if energy readings reach a dangerous level.
- Direct coupling is not prevented by AEM because it occurs when the surgeon touches metal instruments to each other.

The number of laparoscopic malpractice claims filed between 1995 and 1999 totaled 1,426, almost double the number filed between 1990 and 1994, according to the *Laparoscopic Injury Study* published by the Physicians Insurers Association of America in Rockville, MD. The total award amounts in laparoscopy cases also increased dramatically from $42.3 million for 1990 to 1994 to more than $104 million between 1995 and 1999.

The increasing amount of malpractice claim awards and the anticipated increase of laparoscopic procedures to more than 3 million in the year 2010,[1] are good reasons to reduce as much risk as possible in your same-day surgery program now, says **Kay Ball**, RN, MSA, CNOR, FAAN, perioperative consultant and educator in Lewis Center, OH.

"The best way to protect your patients from injury and your same-day surgery program from malpractice suits is the implementation of active electrode monitoring [AEM]," Ball emphasizes.

Many laparoscopic injuries are caused by burns from stray electrosurgical current, she says. "The limited view of the surgeon in laparoscopic procedures prevents him or her from seeing the injury if it occurs outside the surgical field," Ball adds.

She says there are three categories of thermal injuries that occur during laparoscopic surgery:

• **Direct coupling.** Also referred to as "pilot error," direct coupling occurs when the active electrode touches or arcs to another metal instrument, Ball says. The electricity subsequently travels through the second instrument, and it can burn tissue that is touching the instrument.

• **Capacitive coupling.** Stray electrical current can travel through the insulation of an active electrode to any surrounding conductor such as a metal trocar sheath or even blood in the surgical field, she explains.

• **Insulation failure.** Even if you scan your equipment after re-processing, you can miss a microscopic crack, Ball says. Also, the insulation might not be cracked but can have a weak spot that can be blown open with the increased voltage during surgery. If you are not monitoring the equipment during surgery, you'll never know about the potential patient injury, she adds.

AEM was introduced in 1996 by Boulder, CO-based Encision (then known as ElectroScope), but the initial instruments utilized a 7 mm port when most surgeons were using 5 mm or 10 mm ports, says **Vangie Dennis**, RN, CNOR, advance technology coordinator at Promina Gwinnett Health System in Lawrenceville, GA.

"About three years ago, Encision reproduced every laparoscopic instrument that is commonly used, so we opted to switch completely to [AEM]," Dennis says. Because the instruments were identical to those they had been using, the change was transparent to the surgeons, she adds.

AEM removes the risk of capacitive coupling and insulation failure during surgery because the shielded and monitored instruments are continuously directing stray energy away from the patient via a protective shield, Dennis says. If insulation failure occurs or energy readings reach dangerous levels, the electrosurgical unit automatically shuts down, she explains.

Dennis' facility made the switch to AEM after a committee composed of clinical and financial staff members evaluated three options to protect patients from thermal burns. Visual inspection of instruments before and after surgery as well as utilization of an insulation-testing device before and after each procedure were two options that were dismissed, she says.

Visual inspection won't catch microscopic cracks that actually can be the most dangerous since they will concentrate energy on one area, she explains. Scanning the insulation after a procedure will discover a hole created during surgery, but the patient may already have been injured, Dennis adds.

SOURCES

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For information about active electrode monitoring equipment, contact:

- **Encision**, 4848 Sterling Drive, Boulder, CO 80301. Telephone: (303) 444-2600. Fax: (303) 444-2693. E-mail: info@encision.com. Web: www.encision.com.

Cost was not a significant issue because the AEM instruments do not cost significantly more, and they are sturdier, she points out. "We also decided that our risk for a costly medical malpractice suit was higher if we did not take advantage of a technology that can increase patient safety," Dennis says.

The cost of injuries due to stray electrical burns easily can reach $2 million, according to reports from the Laparoscopic Litigation Group of the Association of Trial Lawyers of America in Washington, DC, says **Janet A. Lewis**, RN, MA, CNOR, administrative director of surgical services at Integris Baptist Medical Center in Oklahoma City. Because the benefits of AEM technology are known and recommended for use by professional organizations,[2,3] same-day surgery programs can be responsible for punitive awards because they had knowledge of safety concerns related to electrosurgical injuries but did nothing to protect the patient, she adds.

Her facility switched to all AEM instruments after surgeons and the hospital's patient safety committee endorsed the change, Lewis says. Staff concerns about the switch involved modification of connections and interactions with trocars, but all of these issues were addressed through education and refinements that Encision is making, she adds.

More than 200 facilities have converted to AEM, says **Jim Bowman**, president and chief executive officer of Encision. That number will continue to increase since the range of AEM instruments now makes it easy to implement with no impact on the surgeon's ability to perform procedures, he adds.

Injuries from stray electrosurgical injury include bowel perforation or a burn that can lead to bowel perforation, Dennis says. Other complications can include organ damage and vessel hemorrhage, she says. The real danger of these injuries is that they aren't identified at the time of surgery and the delay can result in serious infections, she explains.

Dennis says that conversion to AEM made sense for her high-volume facility. It is a matter of good judgment and risk management, she explains. "We did not want to wait until someone was injured before we implemented AEM."

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2. Association of periOperative Registered Nurses. *Standards, Recommended Practices, and Guidelines*. Denver; 2001.
3. Brill AI, Feste JR, Hamilton TL, et al. Patient safety during laparoscopic monopolar electrosurgery — principles and guidelines. *Journal of the Society of Laparoendoscopic Surgery* 1998; 2:221-225. ■

Laparoscopic technique is effective for cancer

Procedure moves to same-day surgery programs

Laparoscopic techniques moved from the gynecological field into general surgery and have now become the preferred method for some urologic surgeons to treat prostate cancer.

Not only does the procedure offer the benefits of the less-invasive technique and quicker recovery from the surgery, it also is just as effective in cancer control as the open procedure, according to a study presented at the 2001 Clinical Congress of the Chicago-based American College of Surgeons.[1]

The study shows that no evidence of cancer was found at the margins of prostate tissue removed at surgery in 89% of the patients undergoing laparoscopic prostatectomies as compared to no finding of cancer in margins in 68% of the patients undergoing traditional open prostatectomies.

EXECUTIVE SUMMARY

With laparoscopic prostatectomy, patients experience less discomfort, earlier return to normal activity, and an earlier removal of catheter. Surgeons appreciate the magnified field of vision that enables a more precise dissection and less damage to nerves.

- The procedure requires two to three times more operating room time while surgeons perfect their technique.
- Surgeons who are credentialed for the open procedure and for complex laparoscopic procedures should be qualified to perform the procedure.

The first laparoscopic prostatectomies were performed in the United States in 1997, says **Benjamin Lee**, MD, director of the laparoscopic section of urology at North Shore — Long Island Jewish Medical Center in New Hyde Park, NY.

"The benefits to the patients include smaller incisions, less blood loss, and an earlier catheter removal than with open prostatectomy," Lee says. "The benefits from the surgeon's perspective include a magnified field of vision that enables the surgeon to see the nerves in the area that results in a more precise dissection." Because it is a relatively new technique, surgeons are just beginning to study issues such as the five-year survival rate, incontinence, and erectile dysfunction following the laparoscopic procedure as compared to the open procedure, Lee says. For this reason, many surgeons are cautious about recommending the technique to some patients, he adds.

"We typically perform the laparoscopic technique on men who are 60 years of age or younger, physically fit, not overweight, and have had no prior abdominal surgery," says **Inderbir S. Gill**, MD, director of the section of laparoscopic and minimally invasive surgery at the Cleveland Clinic Urological Institute. "Laparoscopic patients also typically have prostate glands that are between 30 g and 40 g and must fully understand the procedure and be motivated to ambulate soon after surgery."

While the patients at Long Island Jewish are typically staying in the hospital a few days following surgery, 80% of the Cleveland Clinic patients are discharged fewer than 24 hours after admission. "We've been performing this procedure for more than two years and are comfortable with our skill level and our educational preparation of the patient," Gill says.

Surgeons at Long Island Jewish have been performing the laparoscopic procedure since late March 2001, and Lee agrees that as more surgeons become comfortable with the technique and the results of the procedure, more patients will be treated on a same-day surgery basis.

Patients are given information about the laparoscopic and the open procedure during their pre-op consults, Gill explains. The benefits and disadvantages of both approaches are explained, and patients are told what they can expect during the recovery process, he adds.

"Even the laparoscopic procedure is a major operation, so we want our patients to have realistic expectations in terms of what they may be able to do following surgery," Gill says. These expectations are related to pain, incontinence, and erectile dysfunction, he adds.

Even though the laparoscopic procedure is newer, 90% of Gill's patients request it, he says.

"There is no restriction on activity unlike the open procedure, which limits lifting for six weeks, and the catheter is removed three days after surgery rather than two to three weeks later as in the open procedure," he explains.

While a same-day surgery program does not have to make any significant changes in equipment purchases, there is a time element to consider, Gill says. "While I average three hours per procedure, surgeons do have a learning curve and make take five or more hours to perform the procedure in the beginning," he says.

This compares to an average of two hours for the open procedure, Gill says. The long operating room time is the most significant disadvantage to this procedure, he explains.

Gill and Lee point out that a laparoscopic prostatectomy is a complex procedure for which care should be taken in the credentialing process.

SOURCES

For more information about laparoscopic prostatectomy, contact:

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- **Inderbir S. Gill**, MD, Director of the Section of Laparoscopic and Minimally Invasive Surgery, Cleveland Clinic Urological Institute, 9500 Euclid Ave., Cleveland, OH 44195. Telephone: (800) 553-5056, ext. 51530 or (216) 445-1530. E-mail: gilli@ccf.org.

"The surgeon should be credentialed in the open procedure but should also have credentials to perform advanced laparoscopic procedures such as laparoscopic nephrectomy and laparoscopic adrenalectomy," Lee says.

While there are a relatively small number of surgeons performing the laparascopic procedure, Gill sees the procedure's popularity growing.

"Early studies show that removal of the cancer is the same as the open procedure, and anecdotally, patients are experiencing fewer problems with incontinence," he says. "Patients also want to return to normal activity sooner and enjoy a better quality of life."

Reference

1. Paid V, Dahl D, Trainer A, et al. Evaluation of surgical margins achieved by laparoscopic radical prostatectomy. Presented at the 87th Annual Clinical Congress, American College of Surgeons. Chicago; 2001. ■

Colonoscopy discomfort affects patient satisfaction

Correlation between pre-op meds and results

[Editor's note: Same-Day Surgery *attended the 2002 annual meeting of the Federated Ambulatory Surgery Association (FASA). We covered one of the financial benchmarks sessions, and we've added details and suggestions on how to improve. This information is on our web site: www.same-daysurgery.com. Click on "archives," then click on "Coverage of FASA Financial Benchmarks Session" underneath the search box.]*

In a diagnostic colonoscopy study conducted by the Institute for Quality Improvement (IQI), a subsidiary of the Accreditation Association for Ambulatory Health Care (AAAHC) in Wilmette, IL, 3% of the patients surveyed following their colonoscopies said they would not undergo another colonoscopy.

This statistic concerns providers because colonoscopy is an effective way to detect cancer, as well as remove polyps and lesions. More than one-third of these patients reported pain levels of 4 and 5 during the procedure. One represented no discomfort, and 5 represented severe discomfort. Of the patients reporting severe discomfort, 28% did not receive preoperative pain medication, as compared to 16% of patients reporting no discomfort or lower levels of discomfort.

EXECUTIVE SUMMARY

In a diagnostic colonoscopy benchmarking study, the Institute for Quality Improvement links preoperative medication and discomfort levels during colonoscopies. Twenty-eight percent of patients reporting severe discomfort didn't receive pre-op medication, compared to 16% reporting no discomfort or lower levels of discomfort. Other findings:

- The median pre-procedure time for colonoscopy was almost 37 minutes for the 33 facilities.
- The median procedure time was 16.6 minutes.
- The median discharge time was 43.5 minutes.
- The median time for when the patient arrives at the facility to discharge from recovery was 125.7 minutes.

"Ninety-five percent of our patients report little or no discomfort with the procedure," says **Howard J. Goldberg**, MD, medical director of Montgomery Endoscopy Center in Wheaton, MD. His program uses midazolam in conjunction with meperidine or fentanyl. Colonoscopy is an inherently uncomfortable procedure, and every patient tolerates pain differently, Goldberg says. "Patients are uncomfortable during the procedure, but with the use of midazolam, they don't recall the discomfort," he points out.

Goldberg's program has an average discharge time of 31.4 minutes. Discharge time is defined as from the time the patient is out of the operating or procedure room to the time the patient is ready for discharge from the recovery area. Goldberg attributes that benchmark to several reasons. "We don't oversedate the patients, and we get them moving 10 minutes after the procedure is completed," he says.

Patients sit up, talk, and walk to the waiting room or doctor's office, with a family member, as soon as possible, he adds. "We also have healthier, younger patients than a hospital-based endoscopy program would see, so they do recover more quickly," Goldberg admits.

The median pre-procedure time for all 33 survey respondents was almost 37 minutes. **(For information on ordering the report, see resource box, p. 80.)** The pre-procedure time is defined as the time the patient enters the facility to the time the patient is in the operating or procedure room. However, the staff at Redding (CA) Endoscopy Center reported an average pre-procedure time of fewer than 25 minutes. "We call our patients the day before their procedure to get medical history

SOURCES AND RESOURCE

For more information about use of the colonoscopy study results within same-day surgery programs, contact:

- **Patty Benton**, LVN, Administrator, Redding Endoscopy Center, 1825 Sonoma St., Redding, CA 96001. Telephone: (530) 246-7000.
- **Howard J. Goldberg**, MD, Medical Director, Montgomery Endoscopy Center, 12012 Veirs Mill Road, Wheaton, MD 20906. Telephone: (301) 942-3550.

The study, *Diagnostic Colonoscopy*, is $50 plus $10 for shipping. To order, contact:

- **AAAHC Institute for Quality Improvement**, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091-2992. Telephone: (847) 853-6060. Fax: (847) 853-9028. Web: www.aaahciqi.org.

information as well as billing information," says **Patty Benton**, LVN, administrator of the endoscopy center. "Everything is filled in and ready for a quick review and signature when the patient arrives, so our check-in time is usually only five minutes." After checking in, the patient is directed to a changing room, then into the procedure room where a nurse re-checks the medical history, starts the intravenous line, and hooks up the patient to monitors, Benton says. "We run two rooms, and our staff work well together to keep the process moving smoothly," she says.

Because pre-procedure time is affected by how early or late patients arrive, Benton's organization looked at how they instruct the patients. Many of the patients are traveling a great distance, so Benton's staff tell them to be at the facility 30 minutes before the procedure. "This gives them time to get stuck at the train crossing or be delayed by bad weather without being late to the appointment," she explains. "It also does not have them arrive so early, they have to wait a lengthy time before going to the procedure room."

The overall median procedure time for survey respondents was 16.6 minutes, but Goldberg's facility reported a procedure time of slightly longer than 10 minutes. "The fact that we are a dedicated endoscopy unit contributes to our efficiency," Goldberg points out. The number of polyps and other abnormalities identified, removed, or biopsied also can affect procedure time, he adds.

Goldberg's and Benton's facilities reported overall facility times of fewer than 100 minutes, which is lower than the 125.7-minute median facility time. The facility time is defined as the time the patient enters the facility up to the time the patient is ready for discharge from the recovery area.

All of the physicians are experienced gastroenterologists who are owners of this facility, Benton says. "They want to make the center run smoothly so they show up on time for all of their procedures," she explains. "If one of the surgeons does arrive late on a regular basis, I include it in reports to the physician-owners, and they handle it among themselves." ■

Same-Day Surgery Manager

'You're not the boss of me' — or are you? Part II

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart and Associates
Dallas

We discussed last month who is really in charge of the center and how you respond in certain difficult situations. I gave real examples of such situations, and the reader was to formulate a plan and then compare it to how the real center responded. Here are the actual outcomes:

1. It is late in the day. One of your surgeons calls you and says he has a patient in his office who drove a very long way to see him. He says he would like to do a "simple, quick" procedure right now. What do you do? The patient is going to be "severely inconvenienced" by driving back home and then coming back in two days to get on the schedule. (It is snowing.) The surgeon tells you if you don't put the patient on, he will take the case down the street to another facility that understands the needs of the patient — or, he will change the case to an "urgent" case and do it anyway.

Outcome: This surgery center administrator explained to the surgeon that she understood the uniqueness of the situation but that the last case of the day must be out of the operating room by 3 p.m. as described in the medical staff bylaws. He replied, "I am an investor in the center, and I will just call it an urgent case and get it on right now." The administrator explained that "urgent" cases

were not performed in the surgery center anyway, **but** she would call the medical director and see what they could do. She asked the surgeon to give her five minutes to call him back with an answer. The surgeon said not to bother as he was on his way to the center with the patient right then.

The administrator called the medical director and explained the situation. She knew that the bylaws of the center call for the medical director to be the person to handle peer compliance, not the administrator. The medical director sighed and said, "OK, let him do the case, and I will reinforce the rules with him at a later date." According to the administrator, the medical director never did confront the surgeon.

What would you have done in this situation? Most of the people I asked said that they would not have provided the staff for the case or would have admonished the surgeon for the break in protocol. I think the administrator in this situation acted correctly. She reminded the surgeon of the rules, but she deferred to the appropriate source for the ultimate decision. **(Editor's note: For more information on dealing with difficult physicians, see *Same-Day Surgery*, June 2000, p. 71, "Do you have a difficult physician in your OR?")**

2. A staff member walks into your office and tells you that your favorite surgeon is sexually harassing him. Where do you go, and whom do you call? Or do you do anything? Should you simply document the complaint and send the staff member back into the room with the surgeon — potentially in harm's way? What do you do?

Outcome: Men can be sexually harassed as well as women. You must have a policy on the proper protocol. Once it occurs, it's too late to try to determine what to do. In this case, the administrator told the surgeon that the employee had complained to her about her "advances." The surgeon had the employee terminated for another reason. The employee is suing the center, the administrator, the surgeon, the medical director, and the board of directors of the center. The reason? Procedure was not followed.

Always follow these steps:

- Record the complaint.
- Protect staff.
- Investigate.
- Act firmly.
- Monitor the situation. **(For information from Earnhart on how to handle sexual harassment, see *SDS*, September 1998, "How do you handle sexual harassment?")**

3. A staff member in anesthesia passes a patient in the holding area who appears to be in "distress." She discovers the patient is a "local only" case and thinks the patient should be medically evaluated before going into the operation room. The staff member locates the patient's surgeon and discusses it with him. He tells her that the patient is fine, he is doing the patient under local only, he is not using the services of anesthesia, he is doing the procedure anyway, and she should mind her "own business." ("You're not the boss of me now. . . .") It turns into a shouting match. Who is right? Are you sure?

Outcome: Everyone loses when something goes wrong with a patient. In this case, the certified registered nurse anesthetist called the medical director (an anesthesiologist) and explained the situation. The director called the surgeon and told him the case could not be done until the patient was evaluated. The surgeon took the patient out of the center to another center where he had privileges and did the cases there that afternoon. The patient did fine — but imagine what *could* have happened! The first center did the right thing by denying the case.

4. An anesthesiologist on your surgical staff (but not on the staff of anesthesia) does pain management cases. The case is over, and the patient is in the recovery room waiting for a ride home. The "surgeon" (anesthesiologist) used local sedation. Your medical director refuses to stay with the patient and says that "it is the responsibility of the anesthesiologist who did the case" to stay with the patient, not your anesthesia staff. Really? What do you think?

Outcome: In this case, the anesthesiologist is

doing a procedure (not anesthesia). Even though the case is under local sedation, the contract with the anesthesia department (who employs the medical director) requires that their staff stay until the last patient leaves the center. The nurse manager on duty called the chief of the anesthesia department at home and told him the situation. While he was upset about the circumstances, he honored the terms of the contract and told the medical director to stay with the patient.

5. A plastic surgery patient shows up 30 minutes before her case (on time) and is told that the cash up front required by the center is $1,800. She becomes indignant and tells your front-desk staff that her surgeon (and your busiest plastic surgeon) told her that she could pay for the procedure in three payments and that she was not going to pay anything now. Your staff member approaches the surgeon and explains the situation to him.

He freaks out and confirms the patient's story and is yelling to get her processed and into the operating room. Sitting down in your office with an ice bag on your head, you are fighting a killer of a headache when your front desk calls you in a panic. What do you do?

Outcome: The administrator allowed the case to be done but reported the infraction at the next board meeting. She was within her rights to cancel the case if she did not receive payment up front. She elected to break the rules under the circumstances and let the case proceed. (The front-desk staff were furious with the administrator for not "backing them up.")

The surgeon apologized to the administrator for acting out the way he did. He told her that he was put into a bad situation, and he did not want to look bad in front of his patient. He explained that he would "follow the rules" going forward. The same thing happened the following week. A front-desk staff member resigned. Life goes on. ■

2002 topics listed for unannounced surveys

The Joint Commission on Accreditation of Healthcare Organizations has announced its 2002 topics for random unannounced surveys (RUSs). Five percent of Joint Commission-accredited organizations will undergo an RUS. The Joint Commission selects organizations between nine and 30 months after their full surveys. The surveyor stays for one day, and there is no charge.

The Accreditation Association for Ambulatory Health Care in Wilmette, IL, also conducts RUSs on a sample of organizations from nine to 30 months after the regular surveys. There is one surveyor, and the surveys last up to one day. There are no fees, and the topics are not announced. For hospitals, the RUS topics from the Joint Commission are:

- Environment of Care: planning;
- Assessment of Patients: initial assessment;
- Management of Information: patient-specific data and intervention;
- Care of Patients: medication use;
- Management of Human Resources for a Patient: training and education of staff.

The Joint Commission RUS topics for ambulatory organizations are:

- Human Resources: credentialing and privileging of licensed independent practitioners;
- Performance Improvement: performance improvement;
- Management of the Environment of Care: implementation;
- Care of Patients: medication use;
- Human Resources: competence assessment.

The RUS can be a positive experience for providers, says **Ginger Whitlock**, RN, MSN, CNA, consultant and educator with Joint Commission Resources, a subsidiary of the Joint Commission that provides consultation. Why?

"Because the surveyors come in and, while they're looking at standards that have been challenging in the previous year for the field, they're also looking at the organization's previous survey accreditation report," she says. "They find the process is very educational and consultative, and that the folks doing this are fair-minded and eager to make this a good experience and not a frightening experience." If the center is open for business, a RUS can be conducted, even if your top managers aren't there, Whitlock warns.

If you're a hospital-affiliated center, you'll want to notify the hospital leaders immediately if you're undergoing a RUS, she advises.

"There may be documentation that they need to get from the main site, such as credentialing," Whitlock says. "Hospitals need to be ready to respond immediately. It should be part of the ongoing state of readiness." ■

SOURCE

For more information on random unannounced surveys, contact:

- **Linda Siegler**, Joint Commission Resources, One Lincoln Center, Suite 1340, Oakbrook Terrace, IL 60181. Telephone: (630) 268-7400.

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(Continued from cover)

This program also will update you on any legislative efforts to compel managed care plans to reimburse hospitals for EMTALA-related services.

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CE/CME *questions*

After reading this issue the CE/CME participant will:

- Identify the length of time needed to prepare for malpractice insurance renewal (See *"Malpractice premiums rise, and some can't obtain insurance: How to survive."*)
- Identify the three categories of thermal failure and understand how active electrode monitoring prevents injuries in two of the categories. (See *"AEM improves patient safety, reduces liability."*)
- Discuss the effects on same-day surgery processes as a result of the introduction of laparoscopic prostatectomies (See *"Laparoscopic technique is effective for cancer."*)
- Identify some of the benchmarks presented in the Diagnostic Colonoscopy Study produced by the Institute for Quality Improvement (See *"Colonoscopy discomfort affects patient satisfaction."*)

Use the enclosed Scantron to submit your answers for the January-June 2002 CE/CME test and return the Scantron and CE/CME survey in the enclosed envelope.

21. How far ahead of your malpractice insurance renewal date should you approach your carrier or a broker, according to Brad Shannon, vice president of James G. Parker Insurance Associates?
    A. at least two weeks
    B. at least one month
    C. at least two months
    D. at least three months

22. According to Kay Ball, perioperative consultant and educator, what two categories of thermal injuries can be prevented by active electrode monitoring?
    A. direct coupling and capacitive coupling
    B. capacitive coupling and insulation failure
    C. insulation failure and direct coupling
    D. direct coupling and inadequate power source

23. According to Inderbir S. Gill, MD, director of the section of laparoscopic and minimally invasive surgery at the Cleveland Clinic Urological Institute, a same-day surgery manager needs to be prepared for which of the following when surgeons begin performing laparoscopic prostatectomies?
    A. capital expenditure for new equipment
    B. older, sicker patients
    C. longer times in the operating room for one procedure
    D. none of the above

24. The median facility time reported in the diagnostic colonoscopy study conducted by the Institute for Quality Improvement was:
    A. 97.4 minutes
    B. 125.7 minutes
    C. 136.3 minutes
    D. 146.8 minutes

BIOTERRORISM WATCH
Preparing for and responding to biological, chemical and nuclear disasters

They don't call it bio*terror* for nothing: Fear is the foe when anthrax spores are found within hospital walls

'We feel we were able to ward off a panic . . .'

Clinicians nationwide were beset with hoax powder scares last year at the height of the anthrax attacks, but at one hospital, the threat turned out to be real. Positive cultures for *Bacillus anthracis* were found within hospital walls, setting off a wave of anxiety that threatened to descend into panic.

"There was a mounting level of anxiety among our health care workers," said **Maureen Schultz**, RN, infection control coordinator at Veterans Affairs (VA) Medical Center in Washington, DC. "It had to be dealt with before we could work out any other aspect of the situation."

The events began to unfold last October, when it was discovered that the anthrax letter sent to Sen. Tom Daschle (D-SD) might have contaminated other federal buildings through cross-contamination of mail processed at the Brentwood postal building in Washington, DC.

"It was several days before the contamination was discovered, and by that time, several downstream facilities, including our VA hospital, were contaminated," she said recently in Salt Lake City at the annual meeting of the Society for Healthcare Epidemiology of America (SHEA).[1] In light of the situation, it was recommended that mailrooms in federal buildings be cultured for anthrax.

"One of the things we found frustrating was that we were not given any guidance as to how we should screen the mail," Schultz said. "So we [took] cotton swabs and ran each swab over an approximately 10 to 50 square inch area."

Four of 34 environmental swabs taken in the hospital mailroom grew *B. anthracis*, with colony counts varying from one to 11. The anthrax was found on a canvas mail tote, a cardboard box that had been mailed, on the top of a mailroom speaker, and on a canvas mail cart.

The fear factor

"Even before the contamination was discovered, [we] decided to take some action because of the growing concern among our employees," she said. "So [we] convened a group from the emergency response team, infection control, safety, and public affairs."

The focus of the response was to determine risk level, provide prophylaxis as needed, decontaminate the environment, and get accurate information to all 1,700 health care workers, patients, and visitors, Schultz said. In order to reduce the high level of anxiety, a series of educational sessions were held, information was posted on the hospital web page, press releases were distributed, and printed materials were given to staff, patients, and families. In addition, a series of "town-hall" meetings was held to fully air the concerns of employees.

"These were informal sessions that we had in our auditorium where many health care workers could come and interact on an informal basis," Schultz said.

The risk to hospital workers was determined to

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be low, and only eight staff members were started on prophylactic antibiotics. Those included five mailroom employees who were encouraged to take full 60-day regimens. Another three workers, considered at lower risk, were given 10-day regimens due to possible contact with contaminated mail. The mailroom and surrounding area were decontaminated by an outside contractor.

Overall, some 500 health care workers attended the education sessions, and each town-hall meeting drew more than 200 staff members. With the colony counts low and the contamination limited, the decision was made to limit prophylaxis to only the eight aforementioned employees. That approach was not well received by other health care workers who feared they could have been unknowingly exposed.

"We refused treatment to all other employees, and initially, this created a lot of anxiety among the health care workers, particularly in these large town-hall meetings," Schultz said. "They were demanding ciprofloxacin or doxycycline in case they had come in contact with something contaminated. But we did hold firm on this, and we did not provide prophylaxis to any other employees."

Still, at the SHEA meeting, the Centers for Disease Control and Prevention (CDC) conceded that many of its initial assumptions about anthrax turned out to be false, including the perception that mail handlers were not at risk for inhalational anthrax. Given that acknowledgment, *Bioterrorism Watch* asked Schultz if she would now reconsider the decision to limit antibiotic prophylaxis to a few workers. "Based on the information we have now, no. I don't think we would change that decision." There really was no evidence that any widespread contamination had occurred, she added.

A total of 34 workers reported to the occupational health service for clinical evaluation, but there were no reports of staff refusing to work, and patient care was not interrupted. The initial level of fear and anxiety among many of the workers eased off under the continuous education and communication effort.

"We feel we were able to ward off a panic situation by the actions that we took," she said.

NYC hospital faces similar situation

A similar contamination incident was feared at Memorial Sloan Kettering Institute, a 431-bed cancer center in New York City. Some 1,200 health care workers at Sloan Kettering work in the same building as Gov. George Pataki's Manhattan office, which was reported to be the target of anthrax mailing. On Oct. 17, possible anthrax (positive by polymerase chain reaction test) was discovered in the governor's office. Pataki and staff vacated their part of the building, and infection control staff and hospital administration at Sloan Kettering developed a response plan to protect their workers.

The hospital employees worked on 10 floors of the 40-story building, including three floors that shared an air-ventilation system with the governor's offices. The response was honed to focus on mailroom staff and some 250 employees who worked on the three floors with shared air. With incomplete information on the scope of potential contamination of Pataki's offices, hospital clinicians decided to perform nasal cultures on the employees on the three floors, **Janet Eagan**, RN, an infection control professional at Sloan Kettering reported at the SHEA conference.[2] All of the 245 cultures taken were negative.

"I think the nasal swabs were more to allay fear," she said. "We wanted to do something that was proactive."

Public health investigators first used the nasal swab approach after the first anthrax case in Florida, but the CDC would later advise against routine use of the practice. The reliability of the swabs came into question, in part, because even those exposed may test negative as the nose clears of spores. At a Nov. 1, 2002, press briefing, the CDC advised against using nasal swabs "as a nonspecific probe to determine whether anthrax has ever been present in an environment."

Of course, clinicians at Sloan Kettering were dealing with a situation before that clarification was issued, but even then there were doubts about the wisdom of swabbing the workers.

"By the time we agreed to do the nasal swabs, I was kicking myself, thinking what on earth are we going to do with this information," **Ken Sepkowitz**, MD, epidemiologist at the hospital told SHEA attendees. "The nasal swabs was a screw-up, but with the information we had . . ."

With all the swabs negative, no antibiotics were administered. Additional efforts were needed to reassure the "worried well" that they were not at risk. Personnel from infection control, safety, security, and social work all met with the staff. Building management conducted an independent environmental survey of the building.

"E-mails went to all staff that all 245 employees tested had negative results," Eagan said.

"Communication is key. We believe that by having a hands-on approach — actually being there meeting with staff — prevented panic in employees that were very vulnerable."

Then word came that the original specimen from the governor's office had been found culture negative on retesting. The hospital had been through an intense false alarm drill, but overall had met the challenge, Eagan said.

"Decisions were made using incomplete information at a time-sensitive pace," she said. "Staff responded in a positive manner to the high visibility of administrative leadership, infectious disease, and infection control in numerous educational sessions and e-mail alerts."

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APIC: Smallpox plan uses outdated infection control

Designating patient facilities a mistake

The Centers for Disease Control and Prevention (CDC) has based its smallpox bioterrorism response plan on "outdated concepts," and entire sections need to be revised to reflect current epidemiologic strategies, the nation's leading group of infection control experts warned.

The Association for Professionals in Infection Control and Epidemiology (APIC) commented on the *CDC Interim Smallpox Response Plan and Guidelines*, which has been released as something of a work in progress.

"In general, we are concerned that the draft guidelines appear to be based on outdated strategies used to control this disease decades ago and do not appropriately integrate those infection control strategies and environmental controls utilized in our hospitals today," the APIC letter stated.

The CDC response plan calls for investigators to rapidly immunize a "ring" around the first cases. The ring concept uses isolation of confirmed and suspected smallpox cases followed by contact tracing, vaccination, and close surveillance of contacts. The ring approach was used to successfully eradicate smallpox from the world in 1980. But the ring concept was effective when the demographics of smallpox were very different, when few were infected, and the vast majority of people already were immune.

As part of the ring response, vaccine would be administered to people involved in the direct medical care, public health evaluation, or transportation of confirmed or suspected smallpox patients.

"Vaccination, like any preventive strategy, is more effective if given prior to exposure," APIC argued. "If health care workers are not immunized prior to case identification, these individuals [especially emergency department staff, direct caregivers, and laundry personnel] should be vaccinated immediately upon documentation of a case in their community. It is crucial that we not wait for a case to present in the facility before taking preventative action."

In addition, it may not be possible to distinguish between febrile response to vaccine or actual exposure in health care workers, APIC warned.

"Approximately 20% of vaccinated employees will develop fever and not be able to work if vaccine is given in response to a suspect or confirmed case," the association stated. "We need to develop strategies for dealing with staffing shortages whether they are due to febrile reaction to vaccination, true infection / disease, or refusal to care for patients in a smallpox emergency."

'Misuse of resources'

APIC also questioned the CDC concept of a "Type C isolation facility" for smallpox patients. As proposed, the sites would be facilities that are at least 100 yards from any other occupied building, or those that have nonshared air-ventilation systems with filtered exhaust.

"We believe it would be a misuse of resources to design, build / retrofit, and maintain a designated facility that is not integrated with the existing health care system," APIC stated. "Using alternative structures rather than enhancing the current infrastructure is not a wise use of our limited resources."

Instead, existing facilities could substantially

benefit from dedicating resources to ensuring appropriate air handling and ventilation systems for existing clinics, emergency departments, and isolation rooms. "This would provide the added benefit of controlling more likely exposures to infectious droplet nuclei [tuberculosis, disseminated zoster, chicken pox, measles, etc.] in addition to minimizing or eliminating the likelihood of intrafacility transmission of smallpox," APIC stated.

The association expressed concern that health care delivery might be compromised in separate Type C facilities, particularly if they are not designed to provide services such as intensive care, ventilator support, dialysis, and laboratory resources. Rather then designate facilities for smallpox patients, each hospital should be prepared in advance to activate its program when the first case is identified, APIC argued.

"There needs to be a predetermined area [building or wing, etc.] that meets the 'Type C' facility requirements for isolation," APIC noted. "Part of a facility's planning would include a determination regarding the number of patients that could be housed in the designated area."

Some of the cleaning and disinfection recommendations in the document are out of date with current sterilization principles and practices. That includes "fogging" rooms to disinfect environmental surfaces, the association charged.

"CDC has not recommended the fogging of rooms for many years," APIC stated. "We strongly suggest the deletion of any archaic references to fogging." ■

Stanford sets the standard for bioterrorism planning

A separate piece: Stand-alone plan advised

It's not enough merely to update the bioterrorism component of your current disaster preparedness plan, experts say; you must create a detailed bioterrorism response plan that stands on its own.

That's precisely the philosophy behind the Stanford (CA) Hospital and Clinics (SHC) & Lucile Packard Children's Hospital (LPCH) Bioterrorism Response Preparedness Plan, which is gaining widespread recognition as a model for such plans. In fact, several Kaiser Permanente facilities in California already have adopted the plan.

"You need a separate [bioterrorism] plan," asserts **Eric A. Weiss**, MD, assistant professor of emergency medicine at Stanford, associate director of trauma at Stanford Hospital, and chairman of the disaster committee and bioterrorism task force. "During most disasters, for instance, you don't rely on the microbiology lab to identify pathogens. Also, infectious disease and infection control staff take on a major, heightened role."

In disasters such as an earthquake, Weiss notes, you generally don't have to worry about the quarantine of patients or the spread of infectious agents. Similarly, you may not have to put on protective clothing or worry about cross-contamination of existing patients who may be immunosuppressed.

A bioterrorism plan had been in place prior to 2001, Weiss says, "but it was really just a skeleton plan — not very comprehensive. It was part of a larger disaster preparedness plan, but a plan to deal with mass casualties from bioterrorism is very different."

When you have a major disaster such as the collapse of the World Trade Center, Weiss notes, local health care providers are likely to come to the hospital and offer to chip in and help wherever they can.

"But what happens when the word goes out that patients are walking around with smallpox?" he asks. "Are providers going to want to stream down to the hospital and potentially infect themselves and their families? You need a response plan to address the safety of health care providers, so they will feel comfortable and want to show up for work."

To create such a plan, the Bioterrorism Planning Task Force was formed, incorporating personnel from 30 or more different departments at both facilities. Those departments include infectious diseases, infection control, emergency medicine, pediatrics, critical care, intensive care units, nursing and hospital administration, dermatology, psychology, social services, and environmental health and safety.

"We began putting the plan together when we identified the fact that the current plan was not adequate," notes Weiss. "We accelerated our activities after Sept. 11. After Sept. 11, *everybody* wanted to be part of it."

[Editor's note: The bioterrorism plan is available on the Stanford web site at www.stanfordhospital.com.] ■