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Patient's death after robotic surgery raises questions, results in lawsuit

Is your training, informed consent sufficient with new technology?

(In this first part of a two-part series on new technology, we discuss the training and informed consent issues regarding new technology. Next month, we'll explore how to handle credentialing and how to respond to errors.)

A hospital in Tampa, FL, is being sued in the death of a patient who died two days after his abdominal aorta and inferior vena cava were cut during robotic surgery to remove a cancerous kidney, according to the autopsy report.¹ The problem wasn't noticed for about 90 minutes, according to a news report.²

The lawsuit says St. Joseph's Hospital is responsible because the supervisors didn't make sure the urologist performing the procedure was properly trained on the da Vinci Surgical System robot (Intuitive Surgical, Santa Monica, CA).³

The urologist's experience with the robot was limited to a pig, a cadaver, three kidney removals, and a complicated prostate surgery that left a man incontinent, the lawsuit claims. The hospital had no training protocol for its surgeons or staff and no protocol in place for

EXECUTIVE SUMMARY

A lawsuit has been filed against a Tampa, FL, hospital regarding the death of a patient following robotic surgery. The patient's family claims the robotic approach was pushed and the hospital didn't ensure the urologist performing the procedure was properly trained.

- When new technology is being learned, attendance at a short course involving animals isn't sufficient. Instead, surgeons need a comprehensive course with objective, measurable outcomes. Look to training guidelines from national associations.
- Examine adverse events on the Food and Drug Administration web site.
- Use proctoring and measure outcomes at your facility.

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them to be credentialed to operate the robot, according to the lawsuit.

St. Joseph's was contacted for comment by *Same-Day Surgery* and released a statement by Isaac Mallah, the CEO.

Mallah explained all the doctors had to be certified to perform advanced laparoscopic surgery before they could use the robot, but he added that an additional laparoscopic training

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Editorial Questions

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course has been added for all physicians who use the robotic system.⁴

Marketing concerns were a major driving force behind the hospital's decision to pay \$1 million to purchase the robot, the lawsuit says. The surgeons and the hospital had an implicit agreement to maximize the use of the robot to justify that expense as well as to market the hospital and generate profits, it states. According to the lawyer for the patient's family, the surgeon originally scheduled to perform the surgery the day before was not on the patient's insurance program. The next day, the family was directed to the urologist, he said.² (For an examination of the informed consent issues, see story, p. 28.)

Training can't keep up with technology

The rapid advancement of new technology has raised some significant dilemmas for health care providers that go beyond the particular situation in the Tampa case, says **Robert J. Fitzgibbons Jr.**, MD, FACS, professor of surgery at Creighton University Medical School in Omaha, NE.

"The overriding problem with the system in the United States is that patients have access to all the information about new technology and, therefore, demand it" because they perceive it as the modern care available, he says.

"The dilemma for hospitals is to get their people up to speed quickly to remain competitive, but a terrible problem like this [Florida case] is the result," Fitzgibbons points out.

The problem is with the system, he says. "If you don't keep your ORs up to date, you're going to be left in the dust," Fitzgibbons adds.

There is a gap between the new technologies and the training techniques that are just a few years old and the health care system's ability to implement them in terms of training and privileges, says **Richard M. Satava Jr.**, MD, FACS, professor of surgery at the University of Washington, Seattle.

"Technology's a little too fast, and objective training methods and objective assessment methods, although coming along quickly compared to previous standards, are much slower than emerging technologies," he explains.

Surgeons need two types of training on new technology, he maintains. First, when a system is complicated and sophisticated, physicians need to be trained about the equipment so they can troubleshoot if something goes wrong, Satava says.

Second, physicians need to be trained on the procedure they're going to perform, he explains.

Traditionally, surgeons have attended short courses sponsored by corporations, usually involving procedures on animals, that offer certificates upon completion, Satava adds. "This unfortunately has been misinterpreted by the hospital as sufficient evidence that they had proficiency in the new surgical procedure for which they were asking privileges," he says. Instead, surgeons need sufficient training in a comprehensive course, Satava says. The course should include objective, measurable outcomes that must be achieved and which, by consensus, have been agreed to demonstrate proficiency, he explains.

"In simple terms, surgeons should not operate on a patient with a new piece of equipment or technique until they have been thoroughly trained in the equipment and the new surgical procedure using that equipment to a level that ensures patient safety," he says.

Surgeons may obtain experience in one type of robotic surgery, but there are hundreds, points out Fitzgibbons. "It's crucial that [managers] make sure they understand the normal training requirements to become proficient in an individual procedure."

Managers often are involved in purchasing new technology, he continues. Thus, the manager should take responsibility for knowing how much training and proctoring is needed by a more experienced surgeon before performing the procedure independently, he says. National associations, such as the American College of Surgeons (ACS), and subspecialty groups, such as the Los Angeles-based Society of American Gastrointestinal Endoscopic Surgeons (SAGES) offer guidelines, Fitzgibbons says. [See the guidelines on www.same-day-surgery.com. Click on "toolbox." Your user name is your subscriber number from your mailing label. Your password is sds (lowercase) plus your subscriber number (no spaces). Under "Education and Training," click on individual guidelines.]

The manager's job is to stay abreast of new procedures and new uses for devices and to be aware of what other institutions are doing, says **Mary H. McGrath**, MD, MPH, FACS, chair of the committee on emergency surgical technology and education at the American College of Surgeons and professor of surgery in the division of plastic surgery, at the University of California San Francisco Medical Center.

"The problem is that the training is very device-specific or procedure-specific," she says. "It's difficult to come up with generalities."

Managers and surgeons can check the Food and Drug Administration web site to determine what

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- To examine adverse events that have been reported with new technology, check the Manufacturer and User Facility Device Experience Database (MAUDE). Web: www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMAUDE/search.cfm.
- To report adverse events, go to: www.fda.gov/cdrh/mdr/index.html.

adverse events have been reported with new technologies. (See resource box, above.) Also, managers and surgeons can track outcomes within their own facilities, McGrath adds.

Many institutions require proctoring and keep track of outcomes, she says. "As an overall rule, institutions should be doing this under some parameters for any new technology or new procedure for some period of time," McGrath states.

In the interest of caution, some managers may be tempted to remain with current technology because they and their staffs are comfortable with what they know, she says.

"That's also a mistake that ultimately will hold back advancing, particularly less-invasive procedures," McGrath stresses. (For more information on new technology, see *Same-Day Surgery*, February 2002, p. 13.)

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3. *Greenway v. St Joseph's Hospital Inc.*, No. 0311667, Division G Circuit Court for 13th Judicial Circuit for Hillsborough County, FL (Dec. 16, 2003).
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If you're inexperienced, should you tell patients?

Informed consent an issue in robotic surgery death

A recent Tampa, FL, lawsuit involving a patient who died after robotic surgery to remove a cancerous kidney has raised informed consent issues regarding new technology.

"The conventional surgery was basically jettisoned, and this robotic surgery was not only suggested but really pushed," said a lawyer for the patient's family in a lawsuit filed against the hospital.¹ St. Joseph's declined to comment beyond a statement from the CEO. (**See cover story.**)

With new technology, it's critical to discuss the reason for using the technology, says **Steven Schwartzberg**, MD, director of the Minimally Invasive Surgery Center at Tufts-New England Medical Center in Boston. "When the choices affect the approach to the surgery significantly, such as robotics, then those issues need to be discussed with the patient," he says.

First, the surgeons must have the reasons for use of the new technology firmly planted in their own minds, "because unless that occurs, it's hard to have a coherent discussion with the patient," Schwartzberg explains.

With some technology, such as laparoscopes, the advantage is obvious, even if you just consider cosmetic issues, he adds. "The advantage of using a robot is less obvious for routine procedures such as cholecystectomy but may have a clear role in more complicated procedures," says Schwartzberg.

The point to make with patients is that you want to provide a procedure that is of equal or greater benefit with new technology, but warn them of the possibility of unforeseen outcomes, advises **Mary H. McGrath**, MD, MPH, FACS, chair of the committee on emergency surgical technology and education at the American College of Surgeons and professor of surgery in

SOURCE

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EXECUTIVE SUMMARY

The death of a patient following robotic surgery has raised issues of informed consent and new technology.

- Discuss the reason for the new technology with the patient.
- Inform patients if the technology is new to you, and warn them of unforeseen outcomes.

the division of plastic surgery at the University of California San Francisco Medical Center.

"If I'm trying a new device, a new complex device that I'm not so familiar with, I would share that information," she says.

Honesty is the best policy, Schwartzberg affirms. If you're doing something for the first time, the patient should be informed, he says.

"Although it seems daunting to tell someone [he or she is] going to be [the] first, patients respond better than you can imagine in most cases," Schwartzberg adds.

Reference

1. *Greenway v. St Joseph's Hospital Inc.*, No. 0311667, Division G Circuit Court for 13th Judicial Circuit for Hillsborough County, FL (Dec. 16, 2003). ■

Will robot Penelope replace a scrub nurse?

Robot hears surgeon's request, gives instruments

A portable robot may be available later this year that can stand in for a scrub nurse. Penelope (Manufacturer: Robotic Surgical Tech in New York City) can hand instruments to surgeons during basic general surgeries such as hernias. The robot is awaiting approval from the Food and Drug Administration (FDA).

Penelope, which was developed with a grant from the Arlington, VA-based National Science Foundation, is a cart on wheels that holds a platform including a back tray, front Mayo stand, and side instrument tray.

The robotic arm automatically unpacks a sterile general instrument case from a back tray, arranges the 12 instruments most likely to be used on the Mayo stand, puts the remainder of the instruments on a side tray, and delivers instruments to the surgeon upon request.

EXECUTIVE SUMMARY

Robotic Surgical Tech has developed Penelope, a portable robot that may be approved by the Food and Drug Administration this year.

- The robot is a cart on wheels and holds three instrument trays.
- The robotic arm unpacks an instrument case, arranges the instruments, and delivers them to the surgeon upon request.
- Nurses are free to work on more complex cases and focus on patient care.

The surgeon puts used instruments in a sterile transfer zone, and the robot returns them to the Mayo stand.

Penelope's control software includes routines for speech recognition to listen to the surgeon, machine vision to see the surgical instruments, motion control to move the arm, and speech generation to give the robot a voice.

Counting will be a shared responsibility of the circulator and the robot, says **Michael Treat**, MD, the developer.

"The circulator will communicate with the robot by a handheld PDA [personal digital assistant] that will have the update with the count, so the robot is aware, he says. "The circulator can request and update the count at any time, including at the closing time."

The robot also will be able to provide a photographic or electronic documentation of the items that it has handled, Treat notes.

Penelope also has a memory that allows it to learn what a particular surgeon normally uses. If the surgeon asks for another instrument when he or she normally asks for a Crile clamp, for example, the robot will ask the surgeon if he or she meant to ask for a Crile clamp.

"It learns based on your experiences what you're doing to use in these cases and remembers that, just like a human," Treat says. The information can be transferred from one robot to another one at another facility, he says.

The robot will cost approximately \$7 per hour over its lifetime of five years, based on the estimated price of \$100,000, Treat says.

He estimates that this price compares with a \$30-and-up hourly rate for a scrub nurse, with the hourly rate for surgical technicians not far behind. The software will require maintenance and upgrades, but the company hasn't developed a price for those services, Treat adds.

While some nurses are likely to feel threatened

by the robot, others see Penelope as a positive technological advancement that can free nurses from mundane tasks to use their more advanced skills in caring for patients.

"If you've ever scrubbed a hernia repair or some minor procedures such as breast procedures, if you do that all day every day, what challenge is there to that?" asks **Nancy E. Fox**, RN, BSN, CNOR, nursing educator and consultant with Fox & Associates, a Cincinnati-based consulting firm specializing in perioperative services. "Why not give that up to a robot and use your cognitive skills in a more difficult procedure, such as a cholecystectomy?"

Many nurses are becoming burned out because they aren't showcasing their skill set, she says. "They don't keep refocusing and trying." The robot also could free surgical techs to use more advanced skills in more difficult procedures, Fox says. "I don't think the robot could completely eliminate someone's job," she adds.

To prevent nurses from feeling threatened by this technology, managers should convey their vision for the department and the team and explain this technology allows staff to use their talents in more difficult procedures.

"A nurse has such a broad range of skills: social sciences, psychology, pharmacology, in-depth anatomy, and physiology," Fox says. "They can more actively advocate for the patient, letting family know more information, completing intraoperative records."

For example, every dilation and curettage isn't identical, she says. Different cases have different patients, lab values, etc., she says. "A keen eye and knowledge base helps you understand and advocate for that patient more fully," Fox explains. "If you're fully task-oriented, you miss many significant details."

Nurses are being pulled forward, she adds. "If you go kicking and screaming, it's much harder to deal with the future. If you understand the future and how technology can help you benefit, it can make life easier, allow you to adapt, and allow you to become more of an advocate and shine with a more advanced skill set." ■

SOURCE

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EXECUTIVE SUMMARY

There were 118 severe acute respiratory syndrome (SARS) cases in Toronto in 2003 that were tracked to a single surgical patient. Toronto clinicians have since developed policies for avoiding transmission and handling SARS patients in the OR, which are available at www.same-daysurgery.com.

- Ensure there is clear communication and collaboration between public health, your infection control staff, and frontline clinicians.
- Be vigilant in following infection control practices, particularly when removing personal protective equipment (PPE).
- Keep in mind PPE requires extra time and may necessitate extra personnel. Also, the noise can hinder communication.

Canadian warning: ORs should prepare for SARS

After a group of severe acute respiratory syndrome (SARS) patients in Toronto in 2003 was tracked to a surgical patient,¹ health care providers there realized no guidelines from international or U.S. groups addressed how to handle SARS patients or avoid SARS transmission in the OR.²

After the initial discovery of a cluster of SARS patients in Toronto, a second cluster was discovered May 23, 2003.¹ The second cluster was traced to a patient who had undergone surgery for a fractured pelvis in a hospital April 19, 2003. The patient developed SARS while in the hospital, but it was managed as post-op pneumonia. The patient infected several other hospitalized patients, which eventually resulted in 118 additional SARS cases.

SARS is spread easily, warns **Philip Peng**, MBBS, FRCPC, director of the Anesthesia Chronic Pain Program at University Health Network and Mount Sinai Hospital and associate director of the Wasser Pain Management Center at Mount Sinai, both in Ontario, Canada.

"All it took for the unprecedented health crisis in Toronto to occur was a delay in isolation of a single case of SARS patients, and the initial precautionary measure against that woman was deemed standard at that time," he says. Peng has published *Routine Precautions for Non-Severe Acute Respiratory Syndrome Patients in the OR* and *Management of SARS Patients in the OR*. [These documents are available at www.same-day surgery.com. Click on "Toolbox" and then "Infection Control." Your user name is your subscriber number from your mailing label. Your password is sds (lowercase) plus your subscriber number (no spaces).]

There is no reason to believe that SARS will not come back, Peng emphasizes. Anesthesia providers particularly are at a high risk of being infected with SARS because of their frequent exposure to patients' oral and respiratory secretions, especially during tracheal intubation.² SARS is spread by droplets and contact.

"Most of the patients will receive general anesthesia in the OR, and the risk of spread of droplets is very high during the process of instrumentation of the airway," he says. "A new set of guidelines such as what we proposed . . . is needed to prevent the spread of SARS."

SARS is "incredibly disruptive" in every area of

the facility, says **Ross Edward Grant Upshur**, MD, director of the primary care research unit in the department of family and community medicine at Sunnybrook and Women's College Health Sciences Centre Toronto. Upshur also has authored an article on SARS. (Bevan JC, Upshur REG. Anesthesia, ethics, and severe acute respiratory syndrome. *Can J Anesth* 2003; 50:977-982.)

"The big lessons are to be prepared and make sure infection control practices are in place and well understood by everyone," he says.

When SARS or a similar infectious disease arises at your facility, it is critically important to have clear communication and collaboration between public health, your infection control staff, and the frontline clinicians, Upshur points out. "We've had to learn the hard way," he says. "That's the way you don't want to learn."

In Canada, the level of communication and coordination following the SARS outbreak was suboptimal, Upshur adds. "We had multiple people giving directives," he says. "What you need is a clear path of communication, so everyone is on the same page and knows what to do."

Consider these other suggestions:

- **Follow standard infection control guidelines rigorously.**

What particular steps should you take to avoid SARS transmission? "Vigilance, vigilance, and vigilance," Peng says. Years before the SARS outbreak, Health Canada, the Canadian department responsible for helping the people of Canada maintain and improve their health, had a set of guidelines for patients who might spread of respiratory secretion, he says. "It was seldom followed," Peng adds.

In Hong Kong, health care workers who were infected with SARS usually did not follow the

SOURCES

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precautionary measures completely, he says.

"We can suggest the most stringent measures, but ultimately, the vigilance of the individual is the most important factor," Peng says.

For example, providers must be vigilant in taking off special protective covering, including hoods and the double gowns, he says. "It is very easy to recontaminate oneself," Peng says.

Also, clinicians may hear their pagers beeping and use their glove-covered fingers to stop the pager, he says. "The pager is then contaminated," Peng says.

The risk of spread of droplets is highest when an infected patient coughs, Peng says. "You can put the best available protective mask on patients with SARS when they cough," he says.

- **Use personal protective equipment properly.**

When handling potentially infectious patients, "it takes time, training, and assistance to put on the personal protective equipment and the PAPR [powered air-purifying respirator, EM, Berkshire, UK] system properly," Peng says.

Advance warning of such a patient in need of tracheal intubation is required to prepare properly, he says. Keep in mind that it is difficult to communicate with each other due to the noise generated by the high flow through the PAPR system, Peng says. "This noisy environment may cause errors due to its potential for miscommunication," he adds.

Also, the personal protective equipment must be removed in the proper sequence to avoid contamination, Peng says. "An extra [person] is required for the removal of PAPR to prevent contamination," he adds.

For OR personnel who don't think SARS could spread within their facility, Upshur offers this advice: "Don't be so naïve. If it's not SARS, it will be the next infectious disease emergency," says Upshur, who points to West Nile, influenza, and

other infectious diseases that have spread rapidly in recent years.

"OR people are good about infection control — that's their bread and butter," he says. "But we need to be vigilant at all times." (For more information on SARS, see "Be cautious with SARS, some patients need mask," *Same-Day Surgery*, December 2003, p. 142; "Take steps to prevent spread of SARS cases," *SDS*, June 2003, p. 65; and "Evaluate bronchoscopy patients for SARS," *SDS*, May 2003, p. 49.)

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Same-Day Surgery Manager



Tips on how to adjust your program for downtime

By Stephen W. Earnhart, MS
President and CEO
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Recently at a conference, I was asked about what frustrates me the most out of all the work we do. It took me less than a second to reply: expense adjustment. What we see time and time again are centers and hospital departments that have had lost cases, reimbursement cutbacks, surgeons who retired, bad vacation schedules, and employee raises. These changes have not been offset by expense reductions or adjustments, be they temporary or permanent.

How do you spot if you have a problem? Get your last year's profit-and-loss statement and examine it. If you don't deal with it directly, ask the person in your organization who does to find out certain key information. First, look at your net revenue. This is the money you collect after the insurance companies take back what you

charge them. Some call it stealing; others call it "contractual allowances."

The difference between "gross revenue" and "net collected revenue" can be as much as 70% less than what you bill. It makes you sick, doesn't it? You don't need to care about that amount. You want to look only at what you collect, which is the money that is going to pay the staff and the vendors and make distributions to the owners.

You don't want to make adjustments for short-term downfalls in revenue; instead, you want to look for trends. To me, anything longer than three months is a trend, unless you have a center in a highly seasonal area, such as a plastics center in the summer (typically, a slow period), an ophthalmology facility at the beginning of the year (patients have not yet met their deductibles), or times of historically high numbers of physician vacations. You already should be adjusting for those times in your annual monthly budget.

So what can you do if you have an unexpected downward trend of money coming in? Remember (always) that personnel cost and supplies make up at least 50% of your program's expenses. If your caseload is down, then usually your supplies are lower as well. If that is not the case, then you have a bigger problem.

So what is the greatest opportunity to decrease expenses? Sadly, it is the staffing. I am a huge advocate of a mix of full-time and part-time staff. One reason is just for times like this. Adjusting down to a reasonable staffing level, especially if you can preserve the full-time positions, is a great way to provide job security. Your part-time staff probably are more flexible in their hours. Some great ways to reduce staffing hours during this time is to make sure that there is zero overtime of course, offer staff time off without pay (it might work for some and incense others), compress your surgical schedule into fewer days per week, reduce your hours of operation, offer early retirement for those who are eligible, don't fill vacant staffing spots, and other methods that have worked for you in the past.

One mistake we often see is pulling the trigger too quickly in a short-term downfall and terminating staff, only to have to scurry to rehire them three or four months later when you are busy again. Make sure you don't overreact.

During this time, make sure you can prevent the problem that started this whole mess. Recruit new surgeons, expand your surgical list, try to renegotiate new contracts, and learn to get by with fewer people. Now might be the time to weed out those

time- and staff-consuming procedures that have little, if any, profit margin. Don't cut so deep that you turn away even more surgeons, but if you are consistently losing money on a specialty or a certain surgeon, it might be time to cut them loose for the security of the entire business. It happens.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 8303 MoPac, Suite C-146, Austin, TX 78759. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Knowledge of language is no guarantee of accuracy

Medical interpreters require special training

With 45 million people in the United States speaking a language other than English and another 19 million people with limited proficiency in English,¹ it is more important than ever for same-day surgery programs to make sure that interpreters are available and qualified to translate pre-op and discharge instructions.

In a study conducted in outpatient settings by physicians and staff at the Medical College of Wisconsin in Milwaukee, an average of 31 interpretation errors per pediatric clinical encounter was observed.¹ The study also showed that many of the interpretation errors had potential clinical consequences such as omitting questions about drug allergies before a procedure or prescription

EXECUTIVE SUMMARY

Researchers at the Medical College of Wisconsin found an average of 31 interpretation errors per pediatric outpatient clinical encounter with a non-English-speaking person, even when hospital employees were used.

- Don't use family members, especially children, to interpret clinical questions or instructions.
- Make sure that all employee interpreters, even those who do not interpret as a regular part of their job, take a course on their responsibilities and focus on language specific to health care.
- Have a backup system when employees are not available.
- Document that an interpreter was used and the patient indicated understanding.

or misinterpreting instructions on dose and frequency of medication. The researchers discovered that errors committed by ad hoc interpreters such as family members or friends are more likely to have potential clinical consequences than errors committed by hospital interpreters.

For these reasons, family members and friends are interpreters of last resort for the same-day surgery staff at Gwinnett Health System in Lawrenceville, GA.

"We have five patient representatives who are interpreters," says **Paula Martin**, spokeswoman for Gwinnett Health System.

"These employees are native-speakers, so they know the language well, but they've also taken a course offered through a local immigration services organization that prepares them to translate medical information," she explains. (**See resource box, at right.**)

The course reviews the role of the interpreter as well as techniques for interpreting in addition to making sure the interpreter knows words specific to health care that ensure accurate translation, such as units of measure used for dose, suppository, and orally.

"When one of our patient representatives is not available, or if the patient speaks a language not spoken by the patient representatives, we do have a list of employees throughout the health system who speak different languages," Martin explains.

The employees included on this list also take the medical interpretation class, even though interpretation services are not officially part of their job, she says.

"We want to make sure that the day-surgery nurse who offers to interpret when the patient representative is not available will offer the same quality interpretation service," Martin adds.

Another backup for interpreting information for a patient is a telephone interpreting service to which the health system subscribes, she notes. (**See resource box, at right.**)

"If you choose a service that offers a wide range of languages and certifies that the interpreters are trained for medical interpretation, this is an excellent backup," she adds. "We've even used the service to identify the language being spoken by the patient."

Staff at Gwinnett also document the interpretation, Martin points out. "If the interpreter is one of our employees who has interpreted face to face, the employee signs the discharge papers stating that interpretation was provided by the

SOURCE AND RESOURCES

For more on medical interpreters, contact:

- **Paula Martin**, Director of Marketing and Community Relations, Gwinnett Health System, 100 Medical Center Blvd., Suite 257, Lawrenceville, GA 30045. Phone: (678) 442-3549. Fax: (770) 682-2280. E-mail: pmartin@ghs.net.

For information on medical interpreter training programs, contact:

- **The Cross Cultural Health Care Program** (CCHCP), 270 S. Hanford St., Suite 100, Seattle, WA 98134. Phone: (206) 860-0329 or (206) 860-0331. Fax: (206) 860-0334. Web: www.xculture.org. To find a description of the training programs and the location of upcoming training sessions, choose training programs on the left navigational bar and scroll down to medical interpretation. In addition to describing the course offered by CCHCP, there is a review and a directory of medical interpretation programs offered by other organizations throughout the country.

For information on telephone interpretation as well as document translation services, contact the following companies. Each company charges for telephone interpretation with a per minute charge that varies according to each organization's contract:

- **America Translating Services**, P.O. Box 800272, Santa Clarita, CA 91380. Phone: (800) 535-0555. Fax: (800) 316-2230. E-mail: rj@am-translating.com. Web: www.am-translating.com.
- **Language Line Services**, One Lower Ragsdale Drive, Building 2, Monterey, CA 93940. Phone: (800) 752-0093, ext. 196. E-mail: generalinfo@LanguageLine.com. Web site: www.language-line.com.
- **New World Language Services**, 165 W. Hospitality Lane, Suite 10, San Bernardino, CA 92408. Phone: (800) 873-9865 or (909) 388-1798. Fax: (909) 388-1796. E-mail: misc@newworldlanguages.com. Web site: www.newworldlanguages.com.

health system and that the patient has demonstrated that they understand the instructions," she says. "If we use a telephone interpretation service, the patient's nurse writes the interpreter's name on the form and states that the telephone interpreter has verified that the patient understood the instructions."

Family members may be used to translate simple questions and directions until an interpreter arrives, but they don't translate medical instructions, Martin says. "We also never use children to translate information to their parents," she adds.

Although the children frequently are fluent

in English because they pick up the language so quickly, it is inappropriate for a child to convey personal health information to their parents because it might be uncomfortable for the adult or the child to discuss the timing of their mother's last menstrual period, for example, Martin says. "A child also does not understand the importance of accuracy in medication instructions and may inadvertently convey the wrong information," she adds. (For more information about offering services to non-English-speaking patients, see "Attract Hispanic patients by understanding needs," *Same-Day Surgery*, January 2002, p. 5; and "Be prepared: Hispanics have a variety of needs," *SDS*, February 2002, p. 25.)

Reference

1. Flores M, Laws B, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 2003; 111:6-14. ■

These nurses are trained to perform minor surgery

Nurse practitioners in Glasgow, Scotland, will begin performing minor surgery in dermatology and plastic surgery after completing a credentialing program recently introduced by a large association of hospitals in Scotland and Glasgow Caledonian University.

"The project will see nurse practitioners extensively trained to a level where they are qualified to undertake minor surgical procedures," says Margaret C. Smith, RN, RM, MBA, director of nursing for North Glasgow Trust, an association of 11 hospitals in Scotland. The result of this training will be a reduction in waiting times for the scheduling of some minor procedures, which will bring direct benefits to patients, she says.

Throughout the hospital association, nurse practitioners already run a number of nurse-led clinics, including endoscopy and colonoscopy.

The degree-level course lasts a minimum of six months and is a combination of academic and practical assessment. After the nurses complete the course, they specialize in their chosen field and are mentored and monitored as they begin to perform surgery. A minimum of five years in their chosen specialty is required for admission to the program. The first graduates are expected to begin performing surgery in March 2004. ■

Physician-owned ASCs come under scrutiny

MedPAC to recommend changes to ASC

The Medicare Payment Advisory Commission (MedPAC) will discuss reimbursement for physician-owned ambulatory surgery centers (ASCs) at its March 18-19 meeting.

"I'm disappointed that MedPAC is raising the issue of physician ownership of ASCs," says Eric Zimmerman, JD, partner with McDermott, Will & Emery in Washington, DC.

This issue has been long-settled in favor of physicians owning ASCs, he says. "ASCs have been found by numerous law enforcement and regulatory bodies to be distinct from other services, because there is no risk of abuse."

At MedPac's January hearing, a commissioner asked whether physician investment in ASCs should be scrutinized, similar to the current examination of surgical hospitals. The Medicare Reform Act placed an 18-month moratorium on new physician-owned surgical hospitals. Other commissioners agreed that the ASC ownership issue should be examined.

In other developments, MedPAC will recommend that a new system be developed for ASC payments. It will suggest that ASC payments be linked to the hospital outpatient prospective system (OPPS). MedPAC will suggest that no ASC payment exceed a hospital payment, after accounting for differences in bundles of services. MedPAC also wants the Centers for Medicare & Medicaid Services (CMS) periodically to collect ASC procedure cost data to set the hospital outpatient conversion factor.

After revising the ASC payment system, Medicare should eliminate the current ASC procedure list system and replace it with a list of procedures specifically ineligible for payment due to clinical safety standards and the need for an overnight post-op stay, MedPAC will recommend. This action is supported by the American Association of Ambulatory Surgery Centers; however, the group prefers that the government modernize the ASC list before it revises the payment system.

The Federated Ambulatory Surgery Association (FASA) has recommended that the ASC list be eliminated and that ASCs be reimbursed for all procedures not on the "inpatient-only list" used for hospital outpatient departments.

"FASA is pleased that MedPAC's recommendation takes a step in this direction, but it does not go far enough in that there would still be separate lists for ASCs and [hospital outpatient departments], says **Kathy Bryant**, executive director of FASA. "We are also disappointed that MedPAC recommends waiting until the new payment system is implemented, as this would mean the 2005 update would occur under the current rules."

MedPAC also will suggest eliminating the ASC update for fiscal year 2005.

"The recommendations are a bit of a mixed bag," Zimmerman says. The highlight is the

recommendation to expand the ASC list, which is "long overdue and welcome," he says.

"The recommendation ultimately could persuade Congress and CMS to finally modernize the ASC list," Zimmerman says. "At the same time, the recommendation that ASC rates remain steady for 2005 is unjustified and moot given that Congress just enacted legislation holding rates steady next year." In addition, the recently passed Medicare Prescription Drug Bill freezes ASC rates through 2009.

For hospitals, MedPAC will recommend eliminating the current hospital outpatient outlier policy and providing full cost-of-living payment updates for hospital inpatient and outpatient services. ■



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CE/CME questions

9. As an overall rule, when should facilities track outcomes, according to Mary H. McGrath, MD, MPH, FACS, chair of the committee on emergency surgical technology and education at the American College of Surgeons?
 - A. for any new technology only
 - B. for any new procedures only
 - C. for any new technology or new procedures
10. To prevent nurses from feeling threatened by robotic technology that delivers instruments, what should managers do, according to Nancy E. Fox, RN, BSN, CNOR, nursing educator and consultant with Fox & Associates?
 - A. Explain the cost savings.
 - B. Convey their vision for the department and the team and explain that this technology allows staff to use their talents in more difficult procedures.
 - C. Explain that the robots will replace surgical technicians only.
 - D. Explain that change is inevitable, but attitude is optional.
11. Which clinicians are at a particularly high risk of being infected with SARS?
 - A. anesthesia providers
 - B. nurses
 - C. surgeons
 - D. surgical technicians
12. According to a study conducted in outpatient settings at the Medical College of Wisconsin, how many interpretation errors occurred in clinical events studied by the researchers?
 - A. an average of 31 errors
 - B. an average of more than 40 errors
 - C. an average of between 40 and 45 errors
 - D. an average of 51 errors

CE/CME instructions

Physicians and nurses participate in this CE/ CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the June 2004 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME answers

9. C

10. B

11. A

12. A