Right Care Alliance
21 Longwood Avenue
Brookline, MA 02446

T. 617.992.9322
E. info@LownInstitute.org

www.RightCareAlliance.org

TO: Senate Finance Committee
FR: James Rickert, MD, Selwyn Rogers, MD, and the Right Care Alliance
RE: Simultaneous Surgery
DATE: July 27, 2016

Introduction

Surgeons routinely perform multiple surgeries in different operating rooms. This practice, known as concurrent or simultaneous surgery, is a common occurrence in both teaching and community hospitals, yet most patients are never informed that their surgeon will not be in the operating room at all times. There is reason to worry that this practice puts patients at risk of harm. Moreover, the failure to inform patients violates the legal doctrine of informed consent.

We believe simultaneous surgery should not continue except in emergency situations, when there are multiple patients in need of surgery and too few surgeons to perform necessary procedures. At the very least, patients should be informed fully, long before their day of surgery, that their surgeon may not be present during the entire procedure.
We urge the Centers for Medicare and Medicaid Services (CMS) to set a uniform, transparent, and patient-centered standard for the practice of simultaneous surgery and for informing patients of the possibility of simultaneous surgery. We also urge Congress to request that CMS refuse reimbursement for elective surgeries performed simultaneously if these patient-centered standards are not met.

Background

Simultaneous surgery is a longstanding practice that permits hospitals to maximize the efficient use of operating rooms and allows surgeons to increase the number of procedures they can complete in a set period of time. Currently, surgeons, acting at their sole discretion, determine what components of any patient's surgery are "critically important" and worthy of their attendance in the operating room.

Patients care deeply about their choice of surgeon, as evidenced by the fact that their willingness to consent to procedures performed in teaching hospitals by residents or other surgeons in training is associated with patients' belief that the trainee will be under direct supervision in the operating room.[1] Yet there is no uniform standard for informing patients that their surgeon will not be present in the operating room for their entire procedure. There is also no standard for informing patients about which component of their surgery may be

performed by someone other than the surgeon they have chosen. In practice, some surgeons provide such information, while many do not, and only some hospitals require that surgeons provide it. We believe failing to inform patients undergoing elective procedures that their surgeon may not be present during their entire surgery violates the intent of informed consent.

American surgeons in multiple subspecialties, such as general or orthopedic surgery, already have a poor track record for informing their patients in order to obtain consent. Studies show that only a minority of patients receive information adequate to consent fully to treatment. In one large recent study, only 9% of patients received sufficient information to make a truly informed consent decision; only 0.5% of patients making a complex decision about their treatment received adequate information.[2] When discussions about simultaneous surgery are held, they undoubtedly involve euphemisms, incomplete information, and a dialogue that skirts around the central, but difficult fact that the surgeon whom the patient believes and expects will perform the procedure will in reality be performing surgery on patients in other operating rooms for potentially lengthy periods of time.

Only a minority of hospitals mandate informed consent about simultaneous surgery, and they leave themselves the option of informing patients at any time right up to the patient's day of surgery—on the grounds that it allows greater operating room efficiency. The reality in these cases is patients may be informed just before they are wheeled into the operating room.

This sort of last minute discussion is terribly unfair to patients; on the day of surgery, patients are emotionally ready to proceed and do not wish for any delay. Additionally, family is gathered, and work arrangements have been made. This is not the time to present patients with disconcerting new information and ask them to accept it quickly. At this point, patients will worry, with good reason, that their surgery will be cancelled or subject to lengthy delay if they do not agree to a simultaneous procedure. For these reasons, we do not believe that simply requiring informed consent by patients is sufficient to address the question of simultaneous surgery.

Remedy

We believe the CMS should adopt a uniform, transparent, and patient-centered standard for the practice of simultaneous surgery, and for informing patients of the possibility of such surgery. First, such a standard would recognize that simultaneous surgery may be necessary in emergency situations. In cases of elective surgery, a patient-centered standard for the attending surgeon's participation in surgery would reassure patients that any such variables would have no effect on their care. These include time of day, surgical delays, patients' insurance status, and other demands upon the surgical team would not affect their surgeon's participation in their surgery. If the surgeon wishes to conduct simultaneous surgeries, CMS would require that the patient be fully informed of that possibility at a time and in a way that ensures the patient understands exactly when the surgeon would and would not be present. Such a standard for informed consent to simultaneous surgery would be transparent and easily understood by all involved, including the patient and his/her family. It would allow the patient to participate in the discussion equally with the surgeon. CMS should pay for simultaneous surgery only if both the patient-centered standards for surgery and informed consent are satisfied.

An example of a patient-centered standard for simultaneous surgery would be the following:

For planned elective surgical procedures, CMS will reimburse for surgery in which the attending surgeon has been present from the time the surgery was initiated until such time that the surgery and final closure has been completed. With written permission of the patient, received at least 24 hours prior to the start of the surgery, a surgical fellow may position the patient under anesthesia and perform the initial opening and final closure, while the attending surgeon remains in the room to observe the fellow and the patient.

Everyone in the operating room would understand such a standard and know what to expect, including the surgeon, assistants, the anesthesiologist, operating room nurses, and, most importantly, the patient who places his life in the care of others.

The adoption of this type of standard places patient interests and understanding above all other concerns. It solves the problems of the difficulty of informed consent. It eliminates variability in defining "critical elements" of a surgery and also the attending surgeon's participation in the procedure. Most importantly, it will ensure that all patients know exactly what to expect when they are unconscious and vulnerable.

Medical care exists for the sake of patients, and it is patients (or their representatives), not surgeons, who should ultimately decide the standards for simultaneous surgery. We feel that the adoption by CMS, and, ultimately, other insurers of a uniform, transparent, and patient-centered standard governing the reimbursement of elective surgeries performed simultaneously with other surgeries would facilitate more knowledgeable and equal discussions between patients and their surgeons regarding the practice, lead to greater patient understanding of their surgical procedure, and ensure that extrinsic factors, such as the time of day of surgery, the insurance status of patients, and other demands upon the operative team bear no influence upon decision making regarding simultaneous surgery. Rather, all patients would know exactly what they can expect while they are unconscious and place their lives in the hands of others.

We urge the Senate Finance Committee to direct CMS to adopt such a patient centered standard.

Sincerely,

James Rickert, Advisor, RCA Musculoskeletal Care Council
Selwyn Rogers, Chair, RCA Surgery and Perioperative Care Council
Vikas Saini, President, Lown Institute
Shannon Brownlee, Senior Vice President, Lown Institute
Alan Roth, DO, Chair, Primary Care Council
Kimberly DiGioia, MSPH, Chair, Women's Health Council
Ricardo Quinonez, MD, Chair, Children's Health Council
Katherine Hikel, MD, Chair, Women's Health Council
Hyung (Harry) Cho, MD, Chair, Hospital Medicine Council
Brandon Combs, MD, Chair, Healthcare Education Council

Alan Schroeder, MD, Chair, Children's Health Council
Theresa Ojala, RN, Chair, Nursing Council
Surafel Tsega, MD, Chair, Hospital Medicine Council
Mysha Mason, MD, Chair, Advanced Illness Council
Casey Quinlan, Council Member, Community Engagement
Ben Moulton, Community Engagement Council Member
Diana Greywolf, PhD, Council Member, Community Engagement
David Andrews, Council Member, Community Engagement and Healthcare Education
Geoff DePaula, Council Member, Community Engagement
Mario Reyes, Council Member, Community Engagement
Bill Adams, Council Member, Community Engagement and Cardiology
Chad Sutliffe, MHA, MEd, NHA, Council Member, Community Engagement
Poppy Arford, Council Member, Community Engagement and Health Care Education
Anne Peticolas, Council Member, Community Engagement
Stephanie Bonne, MD, FACS, Council Member, Community Engagement and Surgery and Perioperative Care

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[1] http://archsurg.jamanetwork.com/article.aspx?articleid=1107313#ref-spc110001-8
[2] http://jama.jamanetwork.com/article.aspx?articleid=192233
