June 2016
Chicago Lawyer®
Volume 39 Number 06 • chicagolawyermagazine.com

Med-Mal Matters

Double checking hospitals' double-booking

Picture a patient on a gurney in the preoperative unit of one of the best academic medical centers in the country. She needs a complex and extensive surgical procedure and knows there is a risk of potentially devastating complications.

So she does her homework. She goes to a famous tertiary care center and seeks out the best surgeon in the area — the one to whom tough cases are referred. The patient is nervous as she waits in the preoperative suite but takes comfort in the knowledge that one of the best surgeons in the country will be with her through the whole ordeal.

Then her peace of mind disappears when she overhears a nurse talking about the surgeon's schedule and realizes he is responsible for two other operations at the same time.

According to *Outpatient Surgery Magazine*, this double-booking is euphemistically called "concurrent surgery" and it occurs when the same primary surgeon is responsible for critical or key components of two or more surgeries simultaneously. The practice came to light after the *Boston Globe*'s Spotlight Team published an expose on "rampant" double-booking at Massachusetts General Hospital.

The Spotlight Team profiled a Massachusetts General surgeon, Dennis Burke, who — along with a small group of anesthesiologists — blew the whistle on numerous patient safety problems he believed were related to concurrent surgeries between 2005 and 2015. Hospital officials have disputed the validity of the complaints, claiming no evidence exists to link any untoward event with double-booking.

Burke and his compatriots, however, produced evidence of cases where surgeons were in patient B's operating room when an "urgent need" arose in patient A's room; cases where surgeons did not show up for one of several concurrent surgeries, leaving residents or fellows to proceed; cases where patients were subjected to unnecessarily prolonged anesthesia (with attendant risks of positioning injuries), waiting for a surgeon to finish with another patient; and cases where operating room staff were not even sure which doctor was supposed to be operating.

As often happens when insiders speak out, Massachusetts General circled the wagons. It called Burke a hypocrite, claiming he was the most frequent double-booker on its staff. Burke responded by collecting his patients' operative records, blacking out identifying information and giving them to the *Globe*.

Confronted with documented proof that its position was false, Massachusetts General saw the light and apologized to Burke, opening an important dialogue on patient safety ... just kidding. Massachusetts General revoked Burke's privileges for allegedly violating federal and hospital privacy rules.

Burke's crusade, as reported by the *Globe*, did at least prompt the American College of Surgeons to publish revised guidelines earlier this year.

The new guidelines define procedures as concurrent if key or critical components of the procedures for which the primary attending surgeon is responsible occur all, or partly, at the same time. Under the revised guidelines, a primary attending surgeon's involvement in concurrent or simultaneous operations on two different patients in two different rooms is "not appropriate."

The *Globe* quotes Dr. L.D. Britt, a former president of the American College of Surgeons who served on the committee that drafted the new rules, describing the guidelines as a "wake-up call" to physicians whose "feet will (now) be held to the fire."

However, others disagree, calling the new guidelines inadequate because they leave it to the attending surgeon to determine which components of each procedure are critical.

Dr. James Rickert, president of the Society for Patient Centered Orthopedics, describes them as a regurgitation of existing Medicare billing rules that will not change the current practice. In short, the new guidelines require a surgeon to be in an operating room only when that surgeon determines he or she needs to be there. Burke argues the new guidelines will do nothing to promote patient safety and calls them "a total capitulation to professional self-interest."

In its Statements on Principles, the American College of Surgeons says that a patient's primary attending surgeon is personally responsible for his patient's welfare throughout an entire operation.

What happens, then, when a surgeon's skill and experience are needed in both of his double-booked rooms at the same time? If he is elbow-deep in a second patient while the first is crashing? That seems like a situation in which a person has a duty to more than one patient but can't do justice to the actual or potentially adverse interests of both patients — the very definition of a conflict of interest.

Back to our patient. She demands to see the surgeon, and he explains that he will only be in the operating room for the portions of the surgery he deems "critical" and, indeed, may be performing "critical" portions of another patient's surgery while she is still under the knife. Upon hearing this, the patient gets up and walks out. We would, too. ■

TAD@corboydemetrio.com
KTL@corboydemetrio.com

Thomas A. Demetrio is a founding partner of Corboy & Demetrio, representing victims of medical malpractice and personal injury.

Kenneth T. Lumb is a medical-malpractice attorney and partner at Corboy & Demetrio.