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Double-booked Surgeries: New Guidelines Clarify Key Issues

Double-booking of surgeries – i.e., the participation of surgeons in more than one operation at the same time – has long been considered a way to more effectively deploy surgeons and reduce operating room (OR) downtime. In addition to improving efficiency, healthcare organizations authorize the practice in order to:

- *Improve daytime access to high-volume surgical specialties and vital services*, such as fully staffed clinical laboratories.
- *Provide educational opportunities for fellows and residents* under a system of incrementally increasing responsibility.
- *Respond to emergency situations* when multiple trauma patients require the expertise of surgical subspecialists.

Simultaneous surgeries are not without peril, however, especially when operations overlap for extended periods. Incidents have been reported of surgeons failing to return to an OR when summoned, delegating surgical care to an unqualified resident or nurse, or subjecting waiting patients to prolonged anesthesia time, resulting in serious complications or even death.*

In response to media coverage highlighting the dangers of double-booking of surgical procedures, the American College of Surgeons (ACS) recently issued guidelines designed to clarify key issues regarding this practice. The guidelines clearly advise against the practice of *concurrent* surgeries, in which the primary attending surgeon is responsible for simultaneously performing the critical or key components of more than one operation. However, ACS acknowledges that contemporary surgical care may require multi-disciplinary operations involving more than one surgeon. In such situations, it may be appropriate for surgeons to be present only during the part of the operation that requires their particular surgical expertise, thus permitting them to perform *overlapped* procedures, in which critical portions of the surgeries are sequenced to avoid simultaneous occurrence.

This *AlertBulletin*® highlights the clinical indications for overlapping surgeries. It also offers recommendations with respect to new restrictions and documentation requirements in the areas of written policy and informed consent.

CLINICAL INDICATIONS

Whereas simultaneous surgeries on multiple patients in different operating rooms are not deemed appropriate under the ACS guidelines, overlapping surgeries are permitted in two limited circumstances:

1. *When the key or critical elements of the first operation have been completed, and there is no reasonable expectation that the primary attending surgeon will be required to return to that procedure.* In this circumstance, a second operation may be started in another operating room while another qualified practitioner performs non-critical components of the first surgery, such as wound closure.
2. *When the key or critical elements of the first operation have been completed, and the primary attending surgeon moves to another operating room in order to perform key or critical portions of a second procedure.* As the primary attending surgeon cannot return to the first patient, responsibility for supervising the first operation must be immediately assigned to another attending surgeon.

ACS further opines that the performance of overlapping procedures "should not negatively impact the seamless and timely flow of either procedure." However, the guidelines specify neither the types of surgical procedures that can be safely double-booked nor the permitted degree or length of overlap, leaving these questions to the judgment of individual hospitals and surgical departments.

POLICY CONSIDERATIONS

By drafting a comprehensive written policy regarding the practice of overlapping or sequenced surgeries, hospitals can enhance consistency while preventing potentially dangerous and costly errors. When developing policy and procedures, healthcare organizations should consider including the following measures:

Specify the clinical indications for overlapping surgeries within medical staff bylaws, rules and regulations. Emphasize that critical components of the first operation must be completed before the surgeon can move on to the second surgery.

Define "critical components." According to the ACS, "critical components" refer to those segments of the operation that require a high level of technical expertise and surgical judgment in order

* See Abelson, J. et al. "Concurrent Surgeries Come Under New Scrutiny." *Boston Globe*, December 20, 2015.

to achieve an optimal patient outcome. At present, these components are determined by the primary attending surgeon. Critics of the ACS guidance believe a more definitive description of "critical components" is needed, in order to avoid excessively narrow interpretations by surgeons who may be prone to abuse overlapping surgery privileges.

Identify "qualified practitioners." As previously noted, a qualified practitioner may be delegated non-critical components of the operation, as long as the practitioner has sufficient training to conduct the assigned portion without the need for more experienced supervision and is approved by the hospital to perform the task. Examples of qualified practitioners include, but are not limited to:

- Surgical residents and fellows
- Anesthesiologists
- Nurse practitioners
- Operating room nurses
- Physician assistants
- Surgical assistants
- Attending physicians

Ensure that covering surgeons are immediately available. Before the primary surgeon moves to an overlapping operation, as in the second scenario noted above, an attending surgeon must be appointed to cover the first operation. The covering surgeon should be reachable through a pager or other electronic device and able to report to the first OR swiftly upon request.

Permit only the most seasoned and capable surgeons to supervise and manage two operating rooms. The chief of the surgical department or division, in conjunction with perioperative leadership, should make the determination based upon the surgeon's experience, surgical team staffing and capabilities, types of surgeries involved and availability of operating room resources.

Review surgeon compliance through established performance evaluation processes. Surgeons who do not consistently follow guidelines should have their overlapping surgery privileges suspended or rescinded.

INFORMED CONSENT

The revised surgical guidelines are intended to promote full disclosure to patients regarding overlapping procedures. Existing informed consent provisions should be revised to incorporate the following safeguards:

- *Patients undergoing overlapped surgeries are informed of this fact at the earliest possible point in the pre-operative process*, giving them sufficient time to select another surgeon, if desired.
- *The operation's critical components are defined and documented*, as are the non-critical portions to be performed by a qualified practitioner.
- *The qualified medical providers who will participate in the operation are identified to patients*, and their roles are clearly explained.
- *The patient is informed that the primary attending surgeon will personally perform the key or critical components of the operation*, and this assurance is documented.
- *If for any reason the attending surgeon cannot perform a critical portion of the operation, the patient must be informed subsequently of the identity of the substitute surgeon,* and the reason for the change should be documented in the health record.

The updated ASC guidelines indicate the increased attention being paid to the hazards associated with overlapping surgeries. Leadership should reevaluate policies and procedures in view of these new recommendations, in order to protect patients, clarify roles and responsibilities, and minimize liability exposure.

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