

Report

**Surgical Care Committee
Board of Medicine
Hyatt Regency Riverfront Hotel
225 East Coast Line Drive
Jacksonville, FL 32202
(904) 588-1234
January 31, 2008**

The meeting was called to order at 6:53 P.M.

Mr. McPherson called the roll and determined that the Committee had a quorum.

Attendees:

Laurie Davies M.D., Chair
Fred Bearison, M.D.
Robert Cline, M.D.
Trina Espinola, M.D.
Onelia Lage, M.D.
Steven Rosenberg, M.D.

Larry McPherson, Executive Director
Ed Tellechea, Assistant Attorney General
Nancy Murphy, Paralegal
Ephraim Livingston, Prosecution Services
Gwyn Willis, Board Staff

Suzette Bragg Peterson, American Court Reporting

Tab #1: Florida Society of Ophthalmology

Expedited Transcript Ordered

Dr. Akbar Hasan and Dr. Jerri Knauer representing the Florida Society of Ophthalmology attended the meeting to provide an update about the project the Society has begun to reduce the incidence of wrong site surgeries performed by their members.

Dr. Hasan stated that their emphasis is to educate their members. The Society also is emphasizing the need for a universal protocol for marking the surgery site and establishing the pause or time-out. At the annual meeting in June, they intend to offer seminars in Risk Management.

Dr. Knauer, represents and has served in several capacities with the American Academy of Ophthalmology, Ophthalmic Mutual Insurance Company(OMIC), and the Florida Society of Ophthalmology. He described the projects underway to raise awareness about the prevention of wrong site surgeries among ophthalmologists. He stated that the American Academy of Ophthalmology (lead), American Board of Ophthalmology and OMIC have joined together to work towards a solution.

They have created two major task forces. The first task force is charged with creating a continuing medical education product that will be distributed to all of the members. This includes

approximately 96-98% of the practicing ophthalmologists. The focus is to change behavior and measure the behavioral change with the CME product. The focus of the second task force to eliminate wrong site surgeries among ophthalmologists during the next three(3) years. They are charged with the task of making the elimination of wrong site surgery happen. This program will branch out to encompass other health care providers and groups. He states it is an ambitious project but is confident that the elimination of wrong site surgery in ophthalmology can be accomplished.

He stated that there are some academic studies related to the prevention of wrong site surgery occurring in the post-graduate training programs around the United States. He also stated that there is a major leadership study in process in Florida.

Dr. Knuauer extended an invitation to a member of the Florida Board of Medicine to attend the annual Florida Society of Ophthalmology meeting in June. Mr. McPherson stated he would be glad to attend if possible or a representative from the Committee would attend in his place.

Mr. McPherson stated that the Florida Society of Ophthalmology responded when the Committee asked for their support in reducing wrong site incidents. They promised to do something and they have done what they said they would do and should be commended for their work and determination to end wrong site surgeries among their members. He suggested that the Committee send letters of commendation to the groups involved in the project. The Committee members expressed their agreement with Mr. McPherson's statement and suggestion.

Action Taken:

The Committee asked the Board staff to write letters of commendation to the Florida Society of Ophthalmology, Ophthalmologic Mutual Insurance Company and the American Academy of Ophthalmology for their commitment and work to end wrong site surgery among their members.

The Board staff advised they are working to assemble and share research data available about wrong site surgery.

Mr. McPherson accepted an invitation to attend the annual Florida Society of Ophthalmology meeting in June or the Committee would send a representative.

Tab #2: Rule 64B8-9.007 F.A.C. Review and Recommendations

The Committee has been asked to define the "notes of the procedure" as used in rule 64B8 (2) (b) and where in the "notes" the pause or time-out should be recorded. The Committee discussed several ways to define the "notes of the procedure" and where the pause or time-out should be recorded in the notes or medical record.

Mr. McPherson recommended that the "notes of the procedure" be changed to "medical record" in the rule.

Dr. Donald Gale, representing the Florida Hospital Association, stated that replacing "notes of the procedure" with the term "medical record" would be the best solution.

Dr. David Shapiro, representing the Florida Society Ambulatory Surgery Centers, agreed that the change in terms was the best solution at this time. He also stated that more could be done in the future.

Dr. Cline made a motion to remove "notes of the procedure" and replace this phrase with medical record.

Mr. Tellechea requested a motion to proceed with rule development.

Dr. Davies asked the Board staff to make the Pause rule form be made available to Florida physicians on the Board of Medicine Web Site.

Action Taken:

Dr. Cline made a motion to remove “notes of the procedure” and replace this phrase with “medical records” in rule 64B8-9.007 (2) (b) F.A.C. Dr. Lage seconded the motion and it passed unanimously.

Dr. Lage made a motion for rule development to make the change to the rule. The motion was seconded and passed unanimously.

Dr. Davies requested that the Pause rule and the Surgical Log forms, which were included in the agenda, be made available to physicians by placing them on the Web Site as “Sample” form for use by the physicians.

Tab #3 FYI: Articles on Wrong Site Surgery

Dr. Cline stated that most states do not discipline physicians for “near miss” wrong site surgery issues and opined that Florida needs to evaluate how such actions are handled and whether there should be a change. He noted the Florida Patient Safety Corporation (PSC) is a good partner to work with the Board of Medicine in how the regulatory/disciplinary process handles and correct systems that produce wrong site surgery violations. The PSC was established to collect data on patient safety issues and offer solutions to these issues. He explained that hospitals are not cooperating with PSC because of confidentiality issues. The AMA established a national patient safety foundation three years ago. PSC has applied for certification by this organization, which offers the member states immunity and allows them to collect the data for analysis and maintain confidentially. Dr. Cline requested approval by the Committee to take part in a dialog with PSC about possible changes to the way wrong site surgery is handled in the future.

Dr. Davies and the Committee did not see any obstacles in allowing Dr. Cline to begin talks with PSC.

Action Taken:

Dr. Cline will begin a dialog with the Patient Safety Corporation on patient safety issues and report to the committee of any progress.

Tab #4 FYI: Statistics

Dr. Davies reviewed the statistics report. It was noted that deaths reported via the Adverse Incident Reports were diverse and were not centered on any particular specialty area, as was the case in the past when most deaths were related to plastic surgery.

Dr. Davies thanked Gwyn Willis for preparing the statistics.

Action Taken:

No action taken.

The meeting adjourned at 7:52 P.M.