Minutes/Report
Surgical Care Committee/Board of Medicine
Rosen Centre Hotel
9840 International Drive
Orlando, FL 32819
October 2, 2008

The meeting was called to order at 6:00 P.M.

Larry 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, Senior Assistant Attorney General
Nancy Murphy, Paralegal
Ephraim Livingston, Esq. Prosecution Services
Donna McNulty, Assistant Attorney General
Gwyn Willis, Board Staff

Suzette Bragg Peterson, American Court Reporting

Tab #1 Surgical Robots
Dr. Davies asked the members for their thoughts on the use of surgical robots.

Dr. Espinola stated that there is a learning curve required when adjusting to new technology and that the adjustment for surgical robots would be no exception.

Dr. Cline stated that the regulation of a surgical robot was outside the scope of the Board. It was noted that the surgical robots are being used by hospitals and ambulatory surgery centers licensed by the Agency for Health Care Administration.

Action Taken: None. The members decided not to take any action on this subject.

Tab #2 Standard of Care Statistics
The members noted that the total number of standard of care violation was less than one hundred per year for the years of 2003-2007.

Action Taken: None. Tab for information only.

Tab #3 Statistical Information from JCAHO
The members discussed the statistics and issues related to wrong site surgery. They agreed that the cases seen recently were less severe than cases that precipitated the creation of the pause rule.

After the members reviewed the statistics, Dr. Cline suggested a meeting with interested parties to discuss wrong site surgery. Concern was expressed that health care practitioners other than the physician were not disciplined in wrong site cases.

Dr. Cline asked Mr. McPherson about the status of a meeting with leadership from the Hospital Association, Nursing Association, Osteopathic Physicians and other parties to discuss a better way to approach wrong site surgery instead of the current discipline approach.

Action Taken: FYI: Recommended a meeting with the Hospital Association, Nursing Association, Board of Nursing, Board of Osteopathic Medicine and other interested parties. Board staff will coordinate a date for the meeting.

Tab #4 Wrong Site Surgery Spreadsheet referred to the Committee by the Finance and Statistics Committee

The Committee reviewed a hard copy of data collected at request of the Finance and Statistics Committee with a view to determine whether making major/minor distinctions in wrong site cases would help the Board make penalty determinations.

Dr. Davies expressed concern that by making a determination of minor or major harm in the wrong site cases could cause unintended consequences. She explained that the types of procedures performed by some specialty physicians offer a higher risk for serious harm.

Dr. Rosenberg stated that it make sense to look at the cases for type, cost, time involved, and consequences. He also referred to previous research provided to the members about other State's position on wrong site surgery.

Dr. Lage stated that this could be a study of fact-finding and observation, to look at policies and research guidelines developed by other states and organizations.

Dr. Rosenberg reminded the members that the committee had surveyed the other states with a variety of scenarios, from minor to serious and asked how they would discipline their physicians who performed wrong site surgery under the conditions.

Dr. Cline stated that most states would only discipline wrong site surgery if it was egregious.

Dr. Davies added that they would use a standard of care violation. She also stated that we have a statute that states that wrong site surgery is a violation and it has nothing to do with standard of care.

Mr. Tellechea stated that the issue came up because the physicians were being charged under a standard of care violation and cases were being dismissed because experts were stating that it was not violation of standard of care, recognized complication and no patient harm. The legislature responded with a per se violation and created the statutory provision which took the standard of care issue out of it. Patient harm was relegated to mitigation.

Dr. Chizner stated that the issue came up at the July meeting when the members were discussing possibility of uniformity in disciplinary activity. He added that the State of Virginia used a point system to grade the wrong site surgery severity and suggested that this type system may help determine the penalty.

Dr. Rosenberg stated that the fines and penalties varied from case to case when presented before the Board.

Mr. Tellechea stated that Florida had created the wrong site violation from the standard of care violation due to many high profile wrong site surgeries in Florida. He also explained that penalties depended on the type case and were affected by the agreement reached by the Department and the physician.

Mr. McPherson stated that the Prosecution Services Unit had developed a policy to determine the factors involved with each case and would begin using the policy during their case presentation at this meeting. He felt that the system would help determine the mitigating and/or aggregating circumstances, if any, and improve the process of applying penalties.

Ms. Willis advised that additional data is being added to the matrix.

Dr. Cline opined that the benefits do not support the time and energy that would be expended. Dr. Davies, Dr. Bearison and Dr. Espinola agreed.

Dr. Espinola stated that by trying to determine minor or major harm, we may change the psyche of everything that has been implemented about due processes in the operating room to prevent these things from happening.

Action Taken: The Committee would review the spreadsheet and wait for further information from the Finance and Statistics Committee**.**

Tab #5 Office Surgery Physician Specialties requested by the Committee
The Committee was provided with an Excel Spreadsheet that contained the office surgery facilities with the physician's training and Board certification if held. The members were pleased to see that most of the physicians were practicing medicine within their scope of medical training.

Action Taken: None

Tab #6 Office Surgery Inspection Update
At the April 2008 Surgical Care Committee meeting, the members had expressed concern with the number of outstanding Department of Health inspections.

Ms. Willis reported to the members that almost all of the office surgery inspections had been completed during the fiscal year 2007-2008. The remaining 5-10 facilities that had not been inspected were facilities that were either closed, the physicians were no longer available or no contact information could be found.

The Chair expressed compliments for the office (Gwyn Willis, LaShonda Knight, Melinda Gray, and Crystal Sanford) in getting the inspections done expeditiously.

Action Taken: None

Tab #7 Adverse Incident Statistics
The members reviewed the statistics and determined that there were no noticeable trends in any of the specialty areas.

Action Taken: None

New Business:
Dr. Cline stated that in Broward County that one new pain clinic is opened each week and currently there are 93 active pain clinics. He also shared that the top 25 physicians prescribing

OxyContin the United States were located in Broward County. He asked about proposing a statute requiring licensing of pain clinics. He also stated that there was documented evidence that thousands of Kentucky residents came to Florida and obtained Florida drivers licenses in order to legally obtain prescriptions at the pain clinics. He also stated that persons are dying as a result. Dr. Cline included that the State of Louisiana had enacted a rule that regulated the pain clinics.

Mr. Tellechea stated that requiring the pain clinics to be licensed would require statutory authority. He also stated that Chapter 458.331 (1) (v) Florida Statutes, gave the Board the authority to make rules to act as guidelines for medical practice.

Dr. Davies stated that a prescription electronic database would helpful in preventing the abuse of prescribed substances.

Chris Nuland, Esq. who represents several Florida medical groups, agreed with the committees suggestion that developing an electronic database and possible rule development related to the pain clinics would be a good choice.

Dr. Lage stated the she would like the Committee to consider rule making for med spas and pain clinics.

Action Taken: Dr. Davies instructed Board staff to invite the Board of Osteopathic medicine, Department of Health investigators, Health Care Clinic representatives and some reputable pain medicine physicians for an open discussion on pain clinics. She also requested data from the other states about their policies and rules about pain clinics.

The meeting adjourned at 7:15 P.M.