

1 **Meeting Report**

2
3 **Board of Medicine Surgical Care/Quality Assurance Committee**

4
5 **Renaissance Orlando Airport**
6 **5445 Forbes Place**
7 **Orlando, FL 32812**
8 **(407) 240-1000**

9
10 **December 2, 2010**

11
12 Roll Call 5:42 pm

13
14 **Members Present:**

15 Trina Espinola, M.D., Chair
16 Jason Rosenberg, M.D.
17 Tully Patrowicz, M.D.
18 Robert Nuss, M.D.

14 **Members Absent:**

15 Brigitte Goersch, Consumer Member, excused

19
20 **Staff Present:**

21 Larry McPherson, Executive Director
22 Ed Tellechea, Board Counsel
23 Donna McNulty, Board Counsel
24 Nancy Murphy, Paralegal
25 Crystal Sanford, Administrator

20 **Others Present:**

21 American Court Reporting

26
27 Also present was Deputy Secretary Kim Berfield ad Lucy Gee, Division Director,
28 Medical Quality Assurance.

29
30 **Tab 1 – Review of Wrong Site Surgery/ Retained Foreign Object and Related Case Data**

31 The Committee reviewed data presented regarding companion cases in wrong site surgeries
32 and retained foreign body cases and noted only 6% of wrong site surgery cases resulted in
33 companion cases and no retained foreign body cases resulted in companion cases.

34
35 Dr. Espinola noted that the sponge or equipment count is exclusively a nursing function. She
36 recommended the Committee continue to review this data.

37
38 Ms. Sanford was asked what previous efforts had been made related to these issues. She
39 advised that the Board of Medicine had previously met with the Board of Nursing and the
40 Agency for Health Care Administration (AHCA) but nothing new has been done in recent years.

41
42 Mr. Tellechea advised he previously served as counsel to the Board of Nursing and their
43 position is the physician is responsible.

44
45 Dr. Rosenberg stated it was imperative to have cooperation between our Board, the Board of
46 Nursing and AHCA to make changes to the system. He strongly suggested working together to
47 find solutions to system errors.

1 Dr. Patrowicz agreed and stated it is imperative to find solutions to these patient safety issues.
2 He felt there was a difference between system errors and lack of physician competence. He
3 referenced an older report called "To Err is Human".
4

5 Carol Lanfri, Esquire with the First Profession Insurance Company, suggested the Board of
6 Nursing might be charging nurses under a different violation other than wrong site surgery or
7 retained foreign body. She also said a newer report has been issued since "To Err is Human"
8 which indicates there has been a slight increase in the number of wrong site surgery errors even
9 though significant safety measures have been put in place on a national level.
10

11 Lanfri was asked to provide a copy of that report for the next meeting.
12

13 Dr. Espinola stated she would like to hear from the Department (PSU) regarding the companion
14 cases.
15

16 Mr. McPherson advised that Board staff will review how disciplinary actions of others involved in
17 wrong site and foreign body cases might be classified in the data base other than as a "related
18 case" to the 456 foreign body or wrong site statuses.
19

20 Dr. Nuss stated the Committee needs facility information on this data as well.
21

22 Dr. Espinola asked if there had been any follow up by AHCA since they last met with the
23 Committee via conference call.
24

25 Mr. McPherson stated that although the Board and AHCA have met on this issue there has
26 been no new measure that has been agreed upon by the 2 agencies.
27

28 Dr. Patrowicz asked for specialty area data as well since in the past the Committee was
29 successful in partnering with the specialty society
30

31 Action taken: Board staff will review how disciplinary actions of others involved in wrong site
32 and foreign body cases might be classified in the data base other than as a "related case" to the
33 456 foreign body or wrong site statuses
34

35 **Tab 2 – Rule 64B8-9.009 – Standard of Care for Office Surgery**

36 The Board received a request from D. Ty Jackson, Esquire requesting clarification of the rule
37 reference to the "Standards of the American Society of Anesthesiologists for Basic Anesthetic
38 Monitoring" instead of the "Guidelines for Office-Based Anesthesia".
39

40 After discussion, it was determined that both standards should be included in the rule.
41

42 Mr. Tellechea advised he would make the necessary date reference changes and then confer
43 with the Chair regarding the additional standards. He advised he would present revised rule
44 language at the next meeting.
45

46 Action taken: Board counsel will revise the language and confer with the Chair regarding the
47 additional standards to be included in the rule
48

49 **New Business:**

50 There being no further business, the meeting adjourned at 5:58 p.m.