

**Minutes
Board of Medicine
Surgical Care Committee
Marriott Airport Hotel
Tampa International Airport
Tampa, FL 33607
December 4, 2008**

The meeting was called to order at 5:20 P.M.

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

Attendees:

Robert Cline, M.D., Acting Chair
Fred Bearison, M.D.
Trina Espinola, M.D.(Arrived at 5:20 P.M.)
Onelia Lage, M.D.
Steven Rosenberg, M.D.

Larry McPherson, Executive Director
Ed Tellechea, Sr. Asst. Attorney General
Nancy Murphy, Paralegal
Donna McNulty, Asst. Attorney General
Ephraim Livingston, Esq. Prosecution Services
Gwyn Willis, Board Staff

Suzette Bragg Peterson, American Court Reporting

Guest Speakers:

Lance F. Grenevicki, M.D., Florida Patient Safety Corporation
Robert K. McCann, D.O. Chair Board of Osteopathic Medicine
Gary Dolin, M.D., Florida Society of Ophthalmologists

Tab #1 Open Discussion on Wrong Site Surgery

Dr. Cline opened with his reasons for requesting an open discussion on wrong site surgery. He stated that the time it takes to review a case (one year or more) leaves no opportunity to do root cause analysis to aid in preventing future wrong site surgery. He is seeking a more timely process of reviewing wrong site surgery cases and a different approach to disciplining physicians who perform wrong site surgery. He also reminded the Committee that the number of cases heard by the Board has remained about the same for the past few years.

Dr. Lance F. Grenevicki, Florida Patient Safety Corporation, stated that the FPSC was enacted by the legislature in 2004 and is made up of various representatives from organizations that offer patient care. They have strategies to look at patient safety issues and believe in a non-punitive approach to patient safety. Dr. Grenevicki informed the Committee that, recently, the FPSC has been approved at the Federal level as the first patient safety corporation that operates on a national level. The goals related to this new designation are in process. They plan to develop a near miss database for self

reporting near misses, provide education to students and offer continuing medical education to providers in the state. Each year, FPSC co-sponsors a patient safety forum with seminars on patient safety.

Dr. Cline asked if the FPSC had any data on wrong site surgery and if the Florida hospitals were required to report.

Dr. Grenevicki stated that they had no accurate data and their focus was on near-misses and a non-punitive approach. He also stated that hospitals were not required to report to FPSC and that any reports submitted or collected were confidential.

Dr. Cline asked Robert K. McCann, D.O., Chair, Florida Board of Osteopathic Medicine to speak.

Dr. McCann stated that the Osteopathic Board emphasized the team approach and are concerned with late reporting. The Osteopathic Board is also concerned with the time it takes to complete an investigation. He stated that the problem his Board faces, with the surgical team, is determining who is responsible for the team. A major concern is that the surgeon is not personally taking the informed consent and that there is no one person on the team who will take responsibility when a problem occurs. They feel that the lack of communication among the surgical team is problematic. He further stated that someone has to take the ultimate responsibility and added that because the Osteopathic Board must protect the public, they hold the physician responsible for the team. He explained that part of the discipline for Osteopathic physicians is to require that physicians do lectures on wrong site surgery and time outs to students and medical societies to educate and inform the other physicians about the seriousness of wrong site surgery.

Dr. Cline stated that the Committee had surveyed other states about the type of discipline used for wrong site surgery. Of those that responded, most do not have a separate rule about wrong site surgery and do not discipline the physicians unless it is a standard of care violation. Massachusetts and Pennsylvania have separate organizations that investigate wrong site surgery to determine the root cause and preventative measures. He also stated that Florida is unique in the way we discipline for wrong site surgery and expressed that he did not know if this is the best process.

Mr. McPherson asked if the Osteopathic Board saw very many wrong site surgery cases.

Dr. McCann stated that in the recent past, the Board was seeing more wrong site cases. He also stated that Florida is unique because we have a specific statute for discipline in wrong site surgery.

Dr. Cline asked Dr. Gary Dolin from the Florida Society of Ophthalmologists to speak. He commended the Society for the efforts that they are taking both statewide and nationally to educate their members on how to prevent wrong site surgery.

Dr. Dolin stated that the Society was surprised that the ophthalmologists were the leaders and that most cases were implantation of the wrong intraocular lens. He stated that the Society takes this very seriously and at every meeting, considerable time is taken to discuss wrong site surgery and how to reduce the incidence. He added that at

their meetings at the national level more than one course is offered on wrong site surgery and at the state level, several courses are offered on wrong site surgery.

Dr. Rosenberg asked how the percentage of ophthalmology wrong site surgeries compared with the percentages of the other specialties. Dr. Dolin did not have any data on the percentages.

Mr. McPherson asked about the status of a model procedure for lens implants proposed earlier by the Society. He added that as an example may be of use to the other specialty organization to reduce the wrong site surgery. Dr. Dolin stated that he did not have that information but would make an effort to obtain the information.

Dr. Lage asked for more details on the courses offered on wrong site surgery and what kind of evaluation. Dr. Dolin stated that the majority of the courses are offered by the malpractice carriers and that most of the courses were one hour lectures but since they offer several courses each year, the collective courses cover all phases of patient safety.

Dr. Cline asked Ephraim Livingston, Esq., Prosecution Services Unit how long it takes to process a case from the initial report to Board to review. Mr. Livingston stated that the time frame is approximately 10 to 12 months. He explained that wrong site surgeries performed in hospitals are reported via a "Code 15" report to the Agency for Health Care Administration. These reports are forwarded to the Consumer Services Unit where the case follows the same process as all other complaints or cases filed with the Department of Health.

Dr. Cline asked for information on whether the nurses are disciplined when they are involved in a wrong site surgery. Mr. Livingston stated that he would contact his counterpart with the Board of Nursing for that information.

Mr. McPherson suggested that Mr. Livingston contact Don Osterhouse in Tallahassee for the data on how many nurses have been disciplined, hopefully obtain the data in time to be included in the report.

Dr. Espinola asked if hospitals are fined in anyway because the hospitals are involved in the wrong site surgery.

Ms. Willis stated that she would try to get the information about any discipline given to hospitals and ambulatory surgery centers to be presented at the next meeting.

Ephraim Livingston suggested that a continuing medical education course be developed to become part of the disciplinary action. Mr. Tellechea suggested that the FMA or specialty societies develop the CME for the physicians. Dr. McCann stated that there is a segment on the "pause or time out" used in the Prevention of Medical Errors course and that he would share it with the Committee.

Dr. Cline stated that he wonders about the accuracy of the reporting.

Mr. Tellechea stated that the Legislature enacted a wrong site surgery statute to discipline physicians who perform site surgery. Dr. Rosenberg stated that maybe the Board needs to go back to the Legislature to revisit the statute and suggest changes to the wording.

Dr. Espinola stated that there is a difference between a small incision and removal of the wrong limb and the discipline should be adjusted to the incident.

Dr. McCann stated that the informed consent is a key to the solution. Physicians should follow what is on the informed consent. The pause or time out is the stop gap to preventing wrong site surgery.

Dr. Cline asked about the discipline for the first offense of a retained sponge. Mr. Livingston said that a letter of guidance is issued.

Dr. Bearison asked for clarification about the issuance of letters of guidance. Mr. Livingston stated that the Department of Health can issue only one letter of guidance. Mr. Tellechea stated that if an administrative complaint of this type is presented to Probable Cause Panel for a retained object, you can assume that a letter of guidance was issued for a prior incident.

Dr. Grenevicki stated that the FPSC is very interested in the discussion on wrong site surgery and near misses. He suggested that the members log on to the Web site for more information about the Patient Safety Corporation and the data that is produced.

Dr. Cline stated that this tab would be revisited at the next meeting.

Action Taken:

Dr. Cline requested this information be revisited at the next meeting.

Dr. Dolin would submit the pause or time out model being developed by the Society to the Medical Board.

Dr. McCann will share his PowerPoint on the pause or time out with the committee.

Ms. Willis stated that she would try to get the information about any discipline given to hospitals and ambulatory surgery centers.

Tab #2 Statistical Study on Wrong Site Study

Dr. Grenevicki asked about the total number of surgical procedures vs. the total number of wrong site surgeries. Ms. Willis stated that the last time the total number of procedures was requested, the total was over 7 million procedures in one year. The percentage of wrong site surgeries was 0.000005%, a very low number.

Mr. McPherson thought that the information showed significant data in the categories of severity and the type facilities (hospitals and ambulatory surgery centers) where most of the wrong site surgeries occurred.

Action taken: None

Tab #3 Statistics

Dr. Cline expressed concern about the adverse incident reports being made public and the outcome of each adverse incident. Ms. Willis stated that the statute and rule requires that an adverse incident report be completed for any condition or incident that requires transfer to a hospital for a higher level of care.

Action taken: None

No new business.

The meeting adjourned at 6:18 P.M.