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Do You Really Know Who Is Performing Your Operation: The Concurrent Surgery Controversy

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DO YOU REALLY KNOW WHO IS PERFORMING YOUR OPERATION: THE CONCURRENT SURGERY CONTROVERSY

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ABSTRACT

Concurrent surgery is presently one of the most controversial subjects in medical/legal circles. The practice involves the coordination of multiple operations by a surgeon so that preparation of one patient starts while the surgery on another finishes in a different operative suite. This form of double-booking has been around for more than 100 years and most surgeons know of or have been involved in the practice during their professional careers. An article by the *Boston Globe* in 2015, however, brought this little known custom to the public's attention with far reaching consequences. The adverse publicity triggered a Senate Finance Committee investigation and the American College of Surgeons issued a *Statement of Principles* offering guidance on overlapping surgeries. The end result is that a number of hospitals have issued new guidelines for their surgeons to follow and recommendations have been made to change the informed consent document to clearly note that physicians, other than the primary surgeon, may be involved in the operation. The publicity has also generated a number of lawsuits against doctors for concurrent surgery either in a malpractice or lack

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of informed consent context and whistleblower lawsuits for Medicare fraud. It is also anticipated that knowledgeable attorneys will investigate whether a doctor was double-booked whenever a surgical patient suffers an adverse consequence.

A number of articles have been published about concurrent surgeries in medical journals and newspapers. However, the topic has not been the focus of a law review article that addresses the issue from a legal perspective. This Article will provide that comprehensive analysis. The Article will discuss the controversy, the remedial measures that have resulted from the public's reaction to the practice, ethical considerations, and a summary of the court cases that have arisen.

I. INTRODUCTION

Tony Ming was diagnosed with a cervical compression of his spinal cord causing pain and paresthesia in the upper extremities.[2] This Forty-one year old man underwent a cervical corpectomy to remove two degenerated vertebrae.[3] However, the procedure went terribly wrong and he was left paralyzed, a risk that he knew going into the operation.[4] The patient sued his surgeon and learned that during the eleven hour operation, his doctor was absent for seven of the hours tending to another person.[5] The plaintiff testified that his decision to proceed with the complicated operation would have been different if he had known the surgeon would not have been present for the entire procedure.[6] Mr. Ming ultimately lost the case since the jury determined that the double-booked surgeries were not the proximate cause of his injury.[7] His tragic story, however, became the impetus for a *Boston Globe* exposé that raised concerns about the safety and transparency of concurrent surgeries.[8] The end result was the pitting of top medical personnel against each other,[9] state and federal investigations, hospitals reexamining their policies, the informed consent document undergoing scrutiny, and double–booking

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[2] William D. Kickham, *Massachusetts Hospitals Allowing "Simultaneous Surgeries": Wise Practice, or Foolish? Part Two of Two*, Boston Accident Lawyer Blog, Jan. 29, 2016, https://www.bostonaccidentlawyerblog.com/2016/01/massachusetts-hospitals-allowing-simultaneous-surgeries-wise-practice-foolish-part-two-two.html.

[3] Jenn Abelson, et al., *Clash in the Name of Care*, THE BOSTON GLOBE, https://apps.bostonglobe.com/spotlight/clash-in-the-name-of-care/story/ (last visited Sept. 25, 2018).

[4] Juan Guan, et al., *Overlapping Surgery: A Review of the Controversy, the Evidence, and Future Directions*, Neurosurgery, Vol. 64, Issue CN_suppl_1, 1 Sept. 2017, pages 110–13, https://doi.org/10.1093/neuros/nyx200.

[5] Tony Mira, *Concurrent Cases Can Be a Problem Not Just for Anesthesiologists*, ANESTHESIA INSIDER BLOG (Mar. 21, 2016), http://www.anesthesiallc.com/publications/blog/entry/concurrent-cases-can-be-a-problem-not-just-for-anesthesiologists. *The Boston Globe* reported that the surgeon performed five operations that day including the double-booked surgeries, logged 21 hours for his time and billing $73,000. Jenn Abelson et al., *In the Name of Care*, THE BOSTON GLOBE, https://apps.bostonglobe.com/spotlight/clash-in-the-name-of-care/story/ (last visited Sept. 25, 2018).

[6] Andrew M. Weller, *Concurrent Surgery and Informed Consent*, HONORS THESES (2017).

[7] Guan et al., *supra* note 4. *See also*, Meng v. Wood, 2017 WL 1247549 (Mass. Super. Jan. 30, 2017).

[8] Guan et al., *supra* note 4.

[9] Abelson et al., *supra* note 3.

becoming the focus of lawsuits.[10] This Article will discuss the controversy, the remedial measures that have resulted from the public's adverse reaction to the practice, and a summary of the court cases that have arisen.

II. THE CONTROVERSY

Concurrent surgery involves the coordination of multiple operations by a surgeon or team of physicians so that preparation of a patient starts in one room while the surgery to another person finishes in a different operative suite.[11] A number of other terms have been coined to describe this practice such as simultaneous surgery, overlapping operations, and double-bookings.[12] At one time, these terms where used interchangeably but they have now come to mean different things.[13] The American College of Surgeons has created the following distinction:

> **Concurrent Operations**
>
> Concurrent or simultaneous operations occur when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time.[14]
>
> **Overlapping Operations**
>
> "Overlapping surgeries" involve the coordination of various procedures for a single surgeon or teams of surgeons throughout the day, so that preparation and procedure for one patient begins in a one room as the care of another patient finishes in another room.[15]

Concurrent and overlapping surgeries frequently occur, especially at teaching institutions, but were seldom discussed until the exposé by the *Boston Globe*.[16] Nevertheless, most surgeons know of or have been involved

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[10] *Id.*

[11] *What is Concurrent/ Overlapping Surgery*, MASSACHUSETTS GENERAL HOSPITAL, http://www.massgeneral.org/News/assets/pdf/surgery_fact_sheet.pdf.

[12] This practice is most common among neurosurgeons, cardiac surgeons and orthopedic physicians. Sandra Boodman, *Is Your Surgeon Double-Booked*, THE WASHINGTON POST, July 10, 2017, https://www.washingtonpost.com/national/health-science/is-your-surgeon-double-booked/2017/07/10/64a753f0-3a7d-11e7-9e48-c4f199710b69_story.html?utm_term=.047da5c739cf.

[13] Caitlin Podbielski, *Is There A Key to "Critical and Key": Exploring Concurrent Surgery Billing and Ethics*, NEUROSURGEON, Vol. 26, Nov. 3, 2017, http://aansneurosurgeon.org/departments/medicolegal-tbd/.

[14] *The Operation – Intraoperative Responsibility of the Primary Surgeon, Statement of Principles*, AMERICAN COLLEGE OF SURGEONS, SECTION D, Apr. 12, 2016, https://www.facs.org/about-acs/statements/stonprin#iid.

[15] Nicholas Colyvas et. al, *Concurrent/Overlapping Surgeries*, CALIFORNIA ORTHOPAEDIC ASSOCIATION, http://coa.org/docs/WhitePapers/COASummaryConcurrentSurgeries.pdf (last visited Nov. 20, 2017).

[16] Tony Mira, *Concurrent Cases Can Be a Problem Not Just for Anesthesiologists*, (Mar. 29, 2016), https://www.linkedin.com/pulse/concurrent-cases-can-problem-just-anesthesiologists-tony-mira.

in the practice during their professional careers.[17] Advocates point to the efficiency of the custom by maximizing the limited availability of operating rooms while exposing the best surgeons to the maximum number of patients.[18] It also increases the much needed operative experience of residents and interns.[19] In instances of surgery that require unique skills, it prevents patient delays in obtaining the needed treatment. It is also mandatory in emergency situations involving multiple victims. For instance, that was the case with the Boston Marathon bombings, when many people required immediate surgery.[20]

Some aspects of operations are routine and perfectly suitable to delegation to a junior member of the staff. The opening and closing of an incision, harvesting blood vessels for a graft and freeing adhesions are examples.[21] As noted by Richard H. Rothman, M.D., a pioneer in the field of orthopedic surgery, "It is unrealistic to expect a surgeon to perform every non-critical aspect of an operation."[22] He then made the analogy of a senior partner in a law firm handling an appellate court appeal.

> The partner has the overall responsibility of developing the strategy on appeal and crafting the final brief. However, junior members of the staff will assist in performing the research and writing the initial drafts. Surgery is very similar. The chief surgeon remains responsible for the success and performance of the surgery, but others may assist in performing the non-critical parts of the operation such as the opening and closing of the incision.[23]

Jeffrey C. Liu, M.D., a head and neck surgeon notes: "Surgery is inherently inefficient. A surgeon may spend only about 30% of the time actually doing an operation. Given that surgeons are high cost, it seems a poor utilization of time. Concurrent surgery allows two elements - anesthesia time and turnover between cases."[24] While he favors simultaneous surgeries in general, Dr. Liu took issue when complex surgeries are booked concurrently. He noted, "I

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[17] Alexander Langerman, *Concurrent Surgery and Informed Consent*, JAMA SURGERY, July 2016, Vol. 151, No. 7 at 601, https://jamanetwork.com/journals/jamasurgery/article-abstract/2504500.

[18] Podbielski, *supra* note 13.

[19] *Id.*

[20] *What is Concurrent/Overlapping Surgery?*, MASSACHUSETTS GENERAL HOSPITAL, (Dec. 1, 2017), http://www.massgeneral.org/overlapping-surgery/about.aspx.

[21] Michelle Mello, et. al., *Managing the Risks of Concurrent Surgeries*, JAMA SURGERY, Apr. 19, 2016, Vol. 315, No. 15, https://jamanetwork.com/journals/jama/article-abstract/2505160.

[22] Dr. Rothman is the founder of the Rothman Institute, one of the country's largest academic orthopedic practices in the country, and serves as Professor of Orthopedic Surgery at Thomas Jefferson University Medical School. He is also the Vice Chairman of the Board of Trustees at Thomas Jefferson University. The quote is based upon a conversation with Dr. Rothman on November 25, 2017.

[23] *Id.*

[24] Dr. Liu is an Associate Professor of Otolaryngology - Head and Neck Surgery at the Lewis Katz School of Medicine at Temple University and an Associate Professor of Head & Neck Surgery at Fox Chase Cancer Center. This note is based upon an email exchange with the author on November 27, 2017.

believe the issue becomes one of concentration especially when a procedure requires three or more hours and overlaps with another procedure of similar complexity."[25]

Critics assert that simultaneous operations compromise patient safety since the surgeon may be unable to quickly respond to an emergency or a complication, and anesthetized patients may have to wait for a prolonged period until the surgeon arrives.[26] Patient advocates further argue that the motivation for concurrent surgery is financial, "enriching surgeons at the expense of patient care."[27] As one physician noted, "They in a sense have traded in their New England Journals of Medicine for the Wall Street Journal."[28] Another doctor describes the practice as a form of bait and switch. "The only reason it has continued is that patients are asleep."[29] The practice is also unsettling to patients who may wonder, "If my surgeon is out of the room, who is operating on me?"[30] This question raises the specter of the unethical practice from several decades ago of "ghost surgery," the act of secretly substituting one surgeon for another.[31] Michael F. Barrett, Esquire, an attorney who specializes in medical malpractice claims notes:

> A surgeon needs to be focused and attentive during surgery. A distraction can result in a break in attention to the detriment of a patient. After all, no two patient's anatomies are the same. A surgeon needs appropriate time to identify structures and acclimate him/herself to the particular patient's anatomy. An 'assembly line' approach to surgery may involve greater risk to the patient than traditional surgery.[32]

The validity of the informed consent document has also come under attack with a focus on whether the patient has been fully informed of the involvement of those participating in the procedure.[33]

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[25] *Id.*

[26] Kickham, *supra* note 2.

[27] UNITED STATES SENATE, CONCURRENT AND OVERLAPPING SURGERIES: ADDITIONAL MEASURES WARRANTED (2016), (2016), https://www.finance.senate.gov/imo/media/doc/Concurrent%20Surgeries%20Report%20Final.pdf [United States Senate]. The Boston Globe story revealed that the chair of the Department of Orthopedic Surgery at Massachusetts General Hospital had instituted an incentive system that awarded doctors bonus based upon their profitability. Jenn Abelson, et al., *Clash In the Name of Care*, A BOSTON GLOBE SPOTLIGHT TEAM REPORT, https://apps.bostonglobe.com/spotlight/clash-in-the-name-of-care/story (last visited on Mar. 24, 2018). Amy G. Dala, *Neurosurgeon Sets World Record with 27 Concurrent Surgeries*, GOMERBLOG, http://gomerblog.com/2016/12/neurosurgeon-sets-world-record-with-27-concurrent-surgeries/ (last visited Nov. 27, 2017).

[28] Abelson, et al., *Clash In the Name of Care*, A BOSTON GLOBE SPOTLIGHT TEAM REPORT, https://apps.bostonglobe.com/spotlight/clash-in-the-name-of-care/story.

[29] Boodman, *supra* note 12.

[30] Langerman, *supra* note 17.

[31] *Id.*

[32] Mr. Barrett is a senior partner at Saltz Mongeluzzi Barrett & Bendesky, P.C. and a top rated attorney in Pennsylvania. His comments are based upon an email exchange with the author on December 1, 2017.

[33] *Id.*

Regardless of one's position, several considerations must be balanced: guaranteeing the safety of the patient, providing future surgeons with the necessary training and experience, and supplying patients with the appropriate information in order to make an informed consent.[34]

III. RESEARCH STUDIES

An obvious starting point to determine the efficacy and safety of concurrent surgeries is to examine the studies dealing with the safety of the practice. It is very easy to prohibit double-bookings if the risks to the patient are increased. Surprisingly, very little research exits on the safety profile of concurrent surgeries.[35] To start with, more than twenty-six million operations were conducted in a hospital setting in 2014, but there is very little data about the extent of concurrent surgeries.[36] A Senate Finance Committee study, however, determined that overlapping surgeries occur 1% to 33% of the time with variations among hospitals.[37]

The research as a whole suggests that there is little difference in patient outcomes.[38] The first published study examined neurosurgical cases and found little difference in the number of complications between concurrent and non-simultaneous surgeries.[39] Patient outcomes were dependent upon the person's characteristics and kind of procedure performed.[40] Several hospitals looked into the issue at the request of a Senate Finance Committee investigation and found little disparity in the complication rates. Researcheres at the Mayo Clinic examined the data from thousands of operations and concluded that concurrent surgery "is as safe and provides the same outcomes for patients as non-overlapping surgeries.[41]

A recent study in *JAMA Surgery* conducted by scientists at Emory University retrospectively examined over two thousand neurosurgical cases to ascertain if overlapping surgery was associated with a higher morbidity and worsening patient outcomes.[42] They concluded that overlapping surgery in complex neurosurgical cases can be safely undertaken without increasing the risk to patient safety as long as the necessary precautions and patient selection

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[34] David Hoyt, *Looking Forward*, BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS, June 2016, http://bulletin.facs.org/2016/06/looking-forward-june-2016/#.WrZkLyOZN-U.

[35] Guan et al., *supra* note 4, at 6.

[36] United States Senate, *supra* note 27.

[37] *Id.*

[38] Guan et al., *supra* note 4

[39] *Id.*

[40] *Id.* at 6.

[41] Sharon Theimer, *Study Of Thousands Of Operations Finds Overlapping Surgeries Are Safe For Mayo Clinic Patients*, MAYO CLINIC (December 1, 2016), https://newsnetwork.mayoclinic.org/discussion/study-of-thousands-of-operations-finds-overlapping-surgeries-are-safe-for-mayo-clinic-patients/.

[42] Brian Howard, et al., *Association of Overlapping Surgery with Patient Outcomes in a Large Series of Neurosurgical Cases*, JAMA SURGERY, Nov. 8, 2017, https://jamanetwork.com/journals/jamasurgery/article-abstract/2661297?redirect=true.

processes are followed.[43] In fact, a paper presented at the American Surgical Association's Annual Meeting in April 2017, which analyzed data compiled by the National Surgical Quality Improvement Program, found that simultaneous surgeries do not present any increased risks to patients.[44] Interestingly, the presenters also found that concurrent surgeries tended to be elective operations at large academic hospitals.[45] They arise more frequently in emergency admissions and the procedures had a longer average surgery time.[46] A malpractice carrier was even asked to ascertain how frequently concurrent surgeries were mentioned in malpractice claims, and their review of 7,330 cases found no data to suggest that simultaneous surgery was a factor.[47] These statistics are in conformity with the opinion of many surgeons who have performed concurrent operations.[48]

Not everyone is satisfied with these studies asserting that the research has important limitations. Critics maintain that some of the studies had superior risk adjustments than others, the statistics are limited to a handful of institutions,[49] and no one knows what a larger sampling of hospitals would reveal. Most of the reported studies also involved academic medical centers and only one occurred in an ambulatory care setting. The studies were also deficient because none detailed the primary surgeon's time in the operating room, the time that it took to complete the procedure and who performed the critical parts of the operation.[50] Further, the appropriateness of concurrent surgeries cannot be limited to patient outcomes. Issues that remain include patient harm not readily apparent in these research papers as well as informed consent, moral obligations, and patient trust.[51]

IV. MORALITY

Moral or ethical conduct is a set of values established to channel a person's choices and actions. [52] In a medical context, it pertains to those standards that correlate ideals to the practice of clinical medicine and permit

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[43] *Id.*

[44] Richard Mark Kirkner, *Big Data Study Looks At Safety Of Concurrent Surgical Procedures*, ACS SURGERY NEWS, May 8, 2017, http://www.mdedge.com/acssurgerynews/article/137707/general-surgery/big-data-study-looks-safety-concurrent-surgical.

[45] *Id.*

[46] James Richard Bean, *The Decline and Fall of Concurrent Surgery*, WORLD NEUROSURGERY, 777, May 5, 2017, http://www.worldneurosurgery.org/article/S1878-8750(17)30162-6/pdf.

[47] *Are Concurrent Surgeries a Good Tool to Save Time and Money? Experts Express Caution*, Executive Summary, RELIAS, Feb. 1, 2016, https://www.ahcmedia.com/articles/137073-are-concurrent-surgeries-a-good-tool-to-save-time-and-money-experts-express-caution (last visited Mar. 21, 2018).

[48] St. James Therapy Ctr., Ltd. v. Gomez Enters., No. CI 2012-1288, 2012 Ohio Misc. LEXIS 18139 (Ct. Com. Pl. Aug. 23, 2012).

[49] Michelle Mello & Edward Livingston, *The Evolving Story of Overlapping Surgery*, JAMA SURGERY, July 18, 2017, https://jamanetwork.com/journals/jama/fullarticle/2636711.

[50] *Id.*

[51] Bean, *supra* note 46, at 777.

[52] *Morality*, http://aynrandlexicon.com/lexicon/morality.html (last visited Nov. 22, 2017).

those, no matter what background, to be offered quality and principled care.[53] These ideals include the respect for autonomy, non-malfeasance, or not harming others, benevolence, which stands for the principle of assisting the welfare of another, and justice, thereby permitting healthcare providers and patients to work towards a treatment plan absent of conflict.[54] These universal ideals apply to every patient and healthcare provider.[55]

Concurrent surgery satisfies the ideals of morality especially in the context of non-malfeasance and benevolence. After all, the physician's overriding responsibility is to advance the welfare of the patient. Simultaneous surgeries may carry some risk, but when examined in the context of the overall patient population, positive outcomes are identified.[56] The research also shows that patient outcomes do not differ between concurrent and non-simultaneous surgeries.[57] However, there are definite patient benefits, such as allowing the top surgeons to treat more people and advancing the training of junior physicians.[58] It also reduces the waiting time for a skilled surgeon to provide the necessary surgical care thereby saving lives.[59]

Concurrent surgery is supported by the utilitarian theory of ethics which focuses on the outcome of the conduct in both the long and short term.[60] Advantages and harms are balanced against one another to ascertain which action creates the greatest good for the largest number of individuals.[61] The benefits of simultaneous surgery are well documented and the risk of harm has been found to be no different than with non-overlapping surgeries.[62]

Since the primary surgeon remains personally responsible for the patient's well-being during the surgery, the real issue is one of trust or transparency between the doctor and patient.[63] The typical patient does not understand how operating rooms work or the real meaning of concurrent surgery. Patients tend to be naïve and do not consider simultaneous surgery

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[53] *Medical Ethics*, WIKIPEDIA, https://en.wikipedia.org/wiki/Medical_ethics (Last visited Nov. 22, 2017).

[54] *Id.*

[55] Weller, *supra* note 6, at 9. *See generally*, Robert J. Dempsey, *Counterpoint: Concurrent? Overlapping? Simultaneous Surgery? A Question of Informed Consent*, 26 AANS NEUROSURGEON (Nov. 1, 2017), http://aansneurosurgeon.org/features/counterpoint-concurrent-overlapping-simultaneous-surgery-question-informed-consent/.

[56] Weller, *supra* note 6, at 13.

[57] *Id.* at 19.

[58] *Id.*

[59] *Id.*

[60] TERRY HALBERT AND ELAINE INGULLI, LAW AND ETHICS IN THE BUSINESS ENVIRONMENT 74 (South-Western Cengage Learning, 7th ed. 2012).

[61] *Id.*

[62] Theimer, *supra* note 41.

[63] *American College of Surgeons Statements on Principles*, AMERICAN COLLEGE OF SURGEONS, § (II)(D) (Revised Apr. 12, 2016). http://bulletin.facs.org/2016/09/american-college-surgeons-statements-principles/#II_Relation_of_the_Surgeon_to_the_Patient.

to be a common practice despite its frequent utilization in teaching hospitals.[64] Therefore, the public feels deceived when they hear of a poor outcome involving concurrent surgery and believes that the physician has abused the doctor-patient relationship. The remedial solution is easy. Hospitals need to develop polices requiring surgeons to inform a patient sufficiently in advance of a procedure that the possibility of overlapping surgery exists; modify the informed consent document to clearly indicate that the physician may be absent during the non-critical parts of the procedure; and create educational materials which provide a more detailed explanation of the issue so that patients can accept or reject the planned concurrent surgery.[65]

V. INFORMED CONSENT

Informed consent is part of the foundation of American jurisprudence[66] and stands for "the right to bodily integrity."[67] The principle is based upon shared decision-making,[68] and was created to help offset the disparity of power in the doctor-patient relationship. "[R]equiring physicians to provide more information to their patients . . . help[s] to redress the power imbalance problems created by the inequality of knowledge."[69]

Informed consent has the greatest application to surgeons, and the American College of Surgeons indicates that the principle is more than just a legal mandate.[70] It is standard protocol for ethical conduct and has the capacity to enhance the patient's care and treatment outcomes.[71] Therefore, physicians must inform each patient about the plan for treatment and material risks of the procedure.[72] This includes, at a minimum, a discussion about:

> 1. The nature of the illness and the natural consequences of no treatment.
>
> 2. The nature of the proposed operation, including the estimated risks of mortality and morbidity.
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> 3. The more common known complications, which should be described and discussed. The patient should understand the risks as well as the benefits of the proposed operation. The discussion should include a description of what to expect during the hospitalization and post-hospital

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[64] Weller, *supra* note 6, at 37–38.
[65] United States Senate, *supra* note 27, at 12.
[66] Johnson v. Kokemoor, 545 N.W.2d 495, 500 (Wis. 1996).
[67] Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AMA J. of Ethics 563, 563 (2012), http://virtualmentor.ama-assn.org/2012/07/pdf/hlaw1-1207.pdf.
[68] MARK A. HALL, HEALTH CARE LAW AND ETHICS (8th ed. 2013).
[69] Samuel D. Hodge, Jr., et al., *Must Physicians Disclose an Alcohol or Substance Abuse Problem When Requesting a Patient Sign an Informed Consent Document*, 91 N. D. L. Rev. 309, 317 (2015).
[70] *Id.*
[71] *Id.*
[72] *Id.*

convalescence.

4. Alternative forms of treatment, including non-operative techniques.

5. A discussion of the different types of qualified medical providers who will participate in their operation and their respective roles.[73]

Generally, informed consent requires physicians to tell their patients about the material factors, risks, benefits, and alternatives procedures and to obtain their consent before proceeding with treatment.[74] As stated in *Matthies v. Mastromonaco*, the surgeon is required to disclose that information which allows a reasonable person "to consider and weigh knowledgeably the options available and the risk attendant to each."[75]

Does informed consent require a physician to disclose whether he/she will be involved in a concurrent operation, and would the patient withhold consent if that fact is known? The average person does not understand the intricacies and meaning of concurrent surgery and few consider it to be a common practice.[76] However, a survey published in the *Journal of the American Medical Association* ascertained that only 18% of patients would consent to a procedure where the resident acts as the surgeon thereby showing that it is an important consideration.[77] In view of the publicity generated by the *Boston Globe* articles and subsequent maelstrom, a reasonable person would want to know, not only information about the procedure, but also how it will be performed, and whether the doctor will be present during the entire procedure.[78] These conclusions are supported by the numerous comments generated by the *Boston Globe* exposé which demonstrated the public's displeasure with concurrent surgeries.[79]

The exposé further noted that patients are frequently not told that their operations may be done concurrently with another procedure so the newspaper questioned the informed consent process in general.[80] Another

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[73] *Id.* at 318.

[74] *Id.* at 318.

[75] 160 N.J. 26, 33, 733 A.2d 456, 460 (1999)

[76] Weller, *supra* note 6, at 37.

[77] Dempsey, *supra* note 55; In J. Edgington et al., *Preferably Not My Surgery: A Survey of Patient and Family Members Comfort with Concurrent and Overlapping Surgeries*, J. BONE JOINT SURG. AM., The authors of the article surveyed patients and their families at an urban medical center about their understanding of concurrent surgeries and they found that those undergoing surgical procedures were neutral or uncomfortable with operations that overlapped. It was the conclusion of the authors that it is important for the surgeon to explain the advantages and disadvantages of concurrent surgeries. A second survey found that only a small number of people are even aware of overlapping surgeries and the majority of those questioned did not like the practice but would consider it appropriate in specific circumstances. However, they believed that it needed to be discussed during the informed consent process.

[78] Langerman, *supra* note 17.

[79] Weller, *supra* note 6, at 37.

[80] David Hoy & Peter Angelos, *Concurrent Surgery, What is Appropriate?* ADVANCES IN SURGERY, 51, 114 (2017).

author opined that physicians in general provide inadequate information necessary for the patient to make an informed decision and that discussion is further complicated when the surgeon is absent during part of the procedure.[81] After all, a patient has the right to know if the surgeon is devoting his/her entire efforts to the operation.[82]

A Senate Finance Committee examined the concurrent surgery policies at a number of hospitals to ascertain what direction they provided to their surgeons concerning informed consent discussions. Forty-one percent of the policies reviewed mandated the surgeon tell the patient that the surgery is listed as an overlapping one.[83] An equal number of institutions only direct that their patients be told that the surgery "might" overlap with another operation. The policies of the remaining hospitals lacked sufficient clarity to identify a specific informed consent procedure on the topic.[84]

The Committee also reviewed the consent forms from fourteen hospitals to ascertain what type of information was being disclosed to the patient. They ascertained that only three consent forms specifically mentioned that the surgery was scheduled to overlap with a different procedure. Another form indicated that the patient would be notified if the doctor is scheduled for surgery in two operating rooms at the same time.[85] The remaining documents contained language that the Committee believed was too vague to inform the patient about overlapping procedures. For instance, four forms merely indicated that the doctor may be involved in overlapping surgery, and six others noted that "other healthcare providers may perform portions of the patient's surgery" without mentioning that the surgeon would not be in the operative suite during those times.[86] Massachusetts General Hospital, the subject of the *Boston Globe* article, modified its informed consent form by doubling its length and highlighting that the medical care may be rendered by a team of physicians. More specifically, the hospital's form now states "my doctor or an attending designated will be present for the critical parts of the procedure."[87]

The Committee did provide an informed consent document that it believed properly informed the patient of the possibility of concurrent surgery:

> My surgeon has informed me that my surgery is scheduled to overlap with another procedure she/he is

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[81] James Rickert, *A Patient-Centered Solution to Simultaneous Surgery*, Health Affairs, June 14, 2016, https://www.healthaffairs.org/do/10.1377/hblog20160614.055355/full/.

[82] Weller, *supra* note 6, at 3.

[83] United States Senate, *supra* note 27, at 10.

[84] *Id.*

[85] *Id.* at 11.

[86] *Id.*

[87] Abelson, *supra* note 3, at 25.

> scheduled to perform. I understand that this means my surgeon will be present in the operating room during the critical parts of my surgery but may not be present for my entire surgery. My surgeon has also informed me that she/he will supervise a surgical team which may include another attending surgeon, a surgery fellow and surgery residents and that some members of the surgical team will perform parts of my surgery. I understand that my surgeon or another qualified surgeon will be immediately available should the need arise during my surgery. My surgeon has answered all my questions about overlapping surgery and I give my consent.[88]

Because of the extensive publicity involving concurrent and overlapping surgeries, it is anticipated that claimant attorneys will focus on the informed consent document when there is a poor surgical outcome. Counsel will also review the medical records to see if the surgeon was involved in concurrent surgeries or left the patient unattended.[89] As one malpractice attorney noted in describing how he would pursue discovery in a concurrent surgery case:

> I would initially request the surgeon's notes and logs for not only the day of the operation but for the six-month period prior to the date in question. I would be looking closely at the amount of time the surgeon spends with each patient to determine if it conforms to standards. Additional requests would include inquiries into the identification and existence of potentially common complications experienced by the surgeon's patients as well as a request for the consent forms for these patients as the issue of patient consent and physician disclosure is a consideration.[90]

VI. REMEDIAL MEASURES

1. Private Organizations

The adverse publicity generated by concurrent surgeries has forced medical institutions to implement policies and for professional organizations to issue statements on the practice.[91] Massachusetts was the first jurisdiction to respond. The governor issued an executive order directing the state's regulatory agencies and boards to analyze their policies on patient safety.[92]

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[88] United States Senate, *supra* note 27, at 11.
[89] *See supra* note 32.
[90] Weller, *supra* note 6, at 38.
[91] *Id.*
[92] *Id.* at 39.

On January 7, 2016, the Massachusetts Board of Registration in Medicine became the first board to mandate that surgeons record every time they enter or exit a surgical suite and to identify the replacement physician.[93] Proposed legislation was also introduced on January 19, 2017, requiring patients to be provided with written notice about concurrent surgery along with a detailed accounting of the role of the primary surgeon's participation in the procedure at least fourteen days before the operation.[94]

Massachusetts General Hospital, the subject of the *Boston Globe* article, conducted an internal review of their concurrent surgery policy and created a website explaining their position. They also modified their informed consent form to state:

> I understand that Massachusetts General Hospital (MGH) is a teaching hospital. This means that resident doctors, doctors in a medical fellowship (fellows) and students in medical, nursing and related health care professions receive training here, and may take part in my procedure/surgery. A team of medical professionals will work together to perform my procedure/surgery. My doctor or an attending designee will be present for all the critical parts of the procedure/surgery although other medical professionals may perform some aspects of the procedure as my doctor or the attending designee deems appropriate.[95]

Other medical facilities have also re-examined their position on simultaneous surgery. For instance, Brigham and Women's Hospital banned concurrent surgeries with the same physician that run more than one hour unless an emergency arises in which case the primary surgeon is mandated to have another doctor immediately available.[96] The Swedish Medical Center approved a policy in August 2017 which provides that the primary surgeon will be present for the "substantial majority of the surgical procedure phase to ensure presence during the key and critical portions of the procedure."[97] That attendance will be documented in the post-operative note and operative log. However, circumstances may occasionally require the primary surgeon to leave the suite during the procedure but that doctor must be immediately

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[93] Marcia Frellick, *Overlapping Surgeries Push Massachusetts Board to Alter Rules*, MEDSCAPE MED. NEWS (Jan. 15, 2016), https://www.medscape.com/viewarticle/857382.

[94] *An Act Relative to Informed Consent for Concurrent Surgical Procedures*, Mass. H.R. 3514 (2017).

[95] *Massachusetts General Hospital Patient Consent to Procedure*, http://www.massgeneral.org/news/assets/pdf/MGHConsentForm.pdf (last visited Nov. 25, 2017).

[96] *Concurrent Surgeries: What's the Line between Safe and Reckless?*, ADVISORY BOARD (Oct. 29, 2015), https://www.advisory.com/daily-briefing/2015/10/29/concurrent-surgeries.

[97] *Overlapping Staffing of Two Operating/Procedural Rooms*, SWED. HEALTH SERV. (Aug. 2017), *available at* https://www.documentcloud.org/documents/3914422-Swedish-Health-Overlapping-Surgery-Policy.html.

available to return or to have a qualified alterative surgeon available.[98]

2. Medical Associations

On April 12, 2016, the American College of Surgeons[99] crafted a revised *Statement of Principles* dealing with double-bookings.[100] The *Statement of Principles* clarifies the organization's stance on the issue, better identifies acceptable procedures, and recognizes the best ways of moving forward.[101] Their statement was based upon an evidence-based and consensus driven process.[102] It provides that the primary surgeon is responsible for the patient during the procedure and should remain in the operative room or be immediately available for the entire operation. If the surgeon cannot be present for any portion of the time, another physician should be "immediately available" who shall be under the primary surgeon's personal supervision.[103] Parts of the procedure may be delegated to qualified practitioners, such as residents, interns, and surgical assistants, but that person shall remain under the primary surgeon's direct supervision. The surgeon, however, must always be an active participant during the critical parts of the procedure.[104]

These amended principles are not legal mandates but follow the Medicare billing regulations.[105] Critics maintain, however, that these guidelines merely maintain the status quo and give surgeons too much discretion in ascertaining what constitutes the key and critical parts of the procedure.[106] As Senator Chuck Grassley noted: "It's not clear how these guidelines would change the status quo reported by the *Boston Globe*."[107] Equally as important, the American College of Surgeons failed to define what it meant by the key and critical parts of the operation, thereby allowing it to remain a subjective determination.[108]

Several other medical organizations have weighed in on the issue. For instance, the various associations for neurologists and neurosurgeons

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[98] *Id.*

[99] American College of Surgeons, FACEBOOK (Nov. 26, 2017), https://www.facebook.com/pg/AmCollSurgeons/about/?ref=page_internal. The American College of Surgeons is a scientific and educational association of surgeons created 1913 to improve the quality of care for surgical patients.

[100] Bean, *supra* note 46, at 776–78.

[101] David Hoyt & Peter Angelos, *Concurrent Surgery, What is Appropriate*, ADVANCES IN SURGERY, 51, 113–24 (2017).

[102] *Id.* at 115.

[103] American College of Surgeons, *Statements on Principles* (Apr. 12, 2016), https://www.facs.org/about-acs/statements/stonprin.

[104] *Id.*

[105] *ACS Issues a 'Wake-Up Call' On Double-Booked Surgeries*, ADVISORY BOARD (Apr. 15, 2016), https://www.advisory.com/daily-briefing/2016/04/15/double-booked-surgeries.

[106] *Id.*

[107] *Id.*

[108] Mello, *supra* note 21. These terms are defined as "those stages when essential technical expertise and surgical judgment are necessary to achieve an optimal patient outcome. The critical or key parts of the operation are determined by the primary attending surgeon." AMERICAN COLLEGE OF SURGEONS, *supra* note 14.

adopted most of the American College of Surgeons' *Statement of Principles* as its own.[109] The American Medical Association's House of Delegates adopted Resolution 706 instructing the AMA to work in concert "with specialty societies on issues related to concurrent/overlapping surgeries."[110] The California Orthopedic Association recommends that their organization work with hospitals to create appropriate policies and physicians involved in overlapping operations should plainly document that "they were present during the 'critical portion of the operation.'"[111] A search for a position statement about concurrent surgery by the American Association of Orthopedic Surgeons, however, was unsuccessful. This is disappointing considering the number of overlapping surgeries performed by this specialty group.[112] The only item that could be located was a story in *Orthopedics Today* which stated: "The American Academy of Orthopedic Surgeons strongly endorses the [American College of Surgeons'] consulting statement."[113]

3. Government

The *Boston Globe* story prompted the Senate Finance Committee, in its capacity as the overseer of the Medicare and Medicaid programs, to investigate overlapping surgeries.[114] The Committee was alarmed by the potential risk to patients, doctor transgressions, and inappropriate billing practices identified in the article.[115] Their investigation was launched by the sending of a letter to twenty teaching institutions asking about the practice at their hospitals. [116] The staff also examined the written materials issued by the Centers for Medicare and Medicaid Services (CMS) and the position statement by the American College of Surgeons.[117] The end result was a twenty page report that provides a summary of the issues and concerns.[118]

That report noted that CMS requires, as a condition for receiving payment, that healthcare providers follow the Medicare Conditions of

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[109] American Association of Neurological Surgeons et al., *Position Statement on Intraoperative Responsibility of the Primary Neurosurgeon,* (July 20, 2016), http://www.aans.org/pdf/Legislative/Neurosurgery%20Position%20Statement%20on%20Overlapping%20Surgery%20FINAL.pdf.

[110] AMA House of Delegates Update: June 13, 2017.

[111] *Concurrent/Overlapping Surgeries*, CAL. ORTHOPEDIC ASS'N 1, 7 (Feb. 2017), http://coa.org/docs/WhitePapers/COASummaryConcurrentSurgeries.pdf.

[112] This is based upon a search that the author conducted on both the internet and home page of the organization on November 26, 2017.

[113] *Concurrent Surgery: Defining and Implementing a Safe Practice,* ORTHOPEDICS TODAY (June 2016), https://www.healio.com/orthopedics/business-of-orthopedics/news/print/orthopedics-today/%7B2550f2a9-f03a-4d1c-b9f3-0dc7d7c36d02%7D/concurrent-surgery-defining-and-implementing-a-safe-practice.

[114] United States Senate, *supra* note 27.

[115] *Id.* at 1.

[116] *Id.*

[117] *Id.* at 2.

[118] *Id.*

Participation (COPs).[119] That regulation provides:

> (a) If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.
>
> (1) In the case of surgical, high-risk, or other complex procedures, the teaching physician *must be present during all critical portions of the procedure* and immediately available to furnish services during the entire service or procedure.
>
> (i) In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field.
>
> (ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.[120]

This provision is notable for several reasons. It mandates that physicians be present during all "critical parts" of the procedure but fails to mention concurrent surgeries and it only applies to physicians working in a teaching capacity. There are no prohibitions that would prohibit a doctor from billing for simultaneous operations in a non-teaching setting.[121] An examination of the CMS Manual and Joint Committee for Hospital Accreditation also fails to discuss overlapping surgeries.[122] However, the *Medicare Claims Processing Manual* does address the circumstances under which teaching hospitals can bill when surgeons are involved in double bookings.[123] Section 100.1.2 – Surgical Procedures provides:

> In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure…When a teaching physician is not present during non-critical or non-key portions of the

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[119] *See* 42 C.F.R. §415.172 (LexisNexis 2018).

[120] *Id.*

[121] Policy and Advocacy Brief, *Advocacy Snapshot*, AMERICAN UROLOGICAL ASS'N, (Dec. 15, 2016, 8:38 AM) https://community.auanet.org/blogs/policy-brief/2016/12/15/advocacy-snapshot-week-of-december-12-2016.

[122] United States Senate, *supra* note 27 at 2–3.

[123] CMS Manual System, Pub. 100-04 Medicare Claims Processing, §100.1.2 – Surgical Procedures (Sept. 14, 2011), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.

> procedure and is participating in another surgical procedure, he/she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise (emphasis added).[124]

What constitutes a critical or key part of the operation is again left to the subjective discretion of the surgeon but the opening and closing of an incision are not part of this determination.[125]

These billing mandates are applicable only for treatment provided to Medicare patients in teaching hospitals which account for over 20% of the institutions that receive Medicare funds. In other words, they are not applicable to non-teaching operations in teaching institutions, non-teaching hospitals, or to procedures conducted on patients not subject to Medicare.[126]

The Senate Finance Committee's Report noted that the few studies on the safety of concurrent surgery failed to document any safety risks, but that absence is not the equivalent of saying that no such risks exist.[127] The need to guarantee patient safety cannot be ignored. Therefore, the Committee's staff encouraged healthcare providers, who receive Medicare and Medicaid benefits to steps, including the development of a policy on overlapping surgeries, to identify what constitutes a critical part of the operation, to develop procedures that guarantee patients understand the meaning of overlapping surgery, and to develop a process that enforces any policy that exits or may be established.[128]

While this Committee Report provides an important analysis of the issues, no steps were taken to make sure that the recommendations were implemented. Neither Congress nor any governmental agency has enacted any rule pertaining to or prohibiting concurrent surgeries.[129] Nevertheless, the adverse publicity has caused medical institutions[130] to reexamine or to create remedial measures dealing with the issue.[131]

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[124] *Id.*

[125] United States Senate, *supra* note 27, at 4.

[126] *Id.* at 4.

[127] *Id.* at 17.

[128] *Id.*

[129] Alana Sullivan & Sara Kay Wheeler, *Overlapping Surgery Developments, HCCA 21st Annual Compliance Institute* (Mar. 26-29, 2017), https://www.hcca-info.org/Portals/0/PDFs/Resources/Conference_Handouts/Compliance_Institute/2017/311print2.pdf.

[130] The New England Baptist Hospital took the unusual step to publicly state that their facility did not perform concurrent surgeries. *No Concurrent Surgeries at NEBH*, New England Baptist Hospital, https://www.nebh.org/becoming-a-patient/no-concurrent-surgeries-at-nebh/ (last visited Nov. 29, 2017).

[131] *See, e.g.*, Kathleen Shostek, *Concurrent (Overlapping) Surgery: Addressing the Risks*, Healthcare Risk Management Review (Sep. 29, 2016), https://www.hrmronline.com/contributed-article/concurrent-overlapping-surgery-addressing-the-risks. An interesting study in 2017 examined the effect of the more stringent rules on overlapping surgery at a hospital that prohibited attending surgeons from beginning a new case until all critical parts of the first operation were completed. The results showed that the new restrictions were not linked to any reduction in overall or serious complications. However, the participation rates of residents were significantly diminished and the wait time for operations appreciable expanded. J.

VII. COURT CASES

The uproar over concurrent surgeries has failed to generate many cases on the practice. Perhaps this lack of litigation is merely a reflection of the short time that has elapsed since the *Boston Globe* published its 2015 story. In any event, the lawsuits that exist have arisen in either a medical malpractice or lack of informed consent context, or *qui tam* actions by individuals alleging Medicare billing abuses by doctors and hospitals. The following is a summary of those cases.

Watkins v. Cleveland Clinic Foundation dealt with whether the plaintiff consented to having a sinus operation performed by a resident instead of her surgeon.[132] The facts reveal that Birdie Watkins was a sixty-year old woman who underwent surgery for a deviated septum. The plaintiff was told that the procedure would be performed by Dr. Eliachar with the assistance of medical residents.[133] The surgeon, however, was scheduled to perform four other operations in two different operating rooms at the same time. Dr. Eliachar ended up performing no part of the procedure which was done by a surgical resident. Unfortunately, a proper airway was not maintained and the plaintiff was left in a persistent vegetative state.[134] A lawsuit was filed on the grounds of fraud and battery, and the jury returned with an award of almost $10 million. An appeal by the defendants was denied, and the court noted that when the surgeon asserted that he would perform the operation, he knew that he was scheduled to perform simultaneous surgeries and failed to disclose that he had no intention of conducting the septoplasty. As the primary surgeon, he had the obligation to monitor the patient throughout the operation including the administration of the anesthesia. Dr. Eliachar also had the obligation to control the actions of the resident and to supervise those actions.[135] The defendants were found liable for a technical battery because proper consent was not given for someone other than the surgeon to perform the operation.[136]

Mathew Hipps sued the Virginia Medical Center over surgical complications that forced him to undergo extensive reconstruction of his penis.[137] The facts show that Mr. Hipps was told that he had an abdominal

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Guan, et al., *Impact of a More Restrictive Overlapping Policy: An Analysis of Pre-and Post Implementation Complication Rates, Resident involvement, and Surgical Wait Times at a High Volume Neurosurgical Department*, J. Neurosurgery (Nov. 3, 2017), http://thejns.org/doi/abs/10.3171/2017.5.JNS17183?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&.

[132] Watkins v. Cleveland Clinic Found.,130 Ohio App. 3d 262, 269 (8th Dist. 1998).

[133] *Id.* at 1057.

[134] *Id.*

[135] *Id.*

[136] *Id.*

[137] Andy Szal, *Consent Form Controversy, Penis Reconstructive Surgery Prompts $8.5 Million Jury Verdict*, ADVANTAGE BUS. MEDIA (Apr. 12, 2017), https://www.surgicalproductsmag.com/news/2017/04/consent-form-controversy-penis-reconstructive-surgery-prompts-85-million-jury-verdict.

tumor that required surgery.[138] The informed consent document noted that Dr. Kobashi, the chair of the department of urology, would insert the stent into the ureter, a tube that transfers urine from the kidney to the bladder.[139] In reality, the procedure was performed by a urology fellow whose name the plaintiff claims was added to the consent form after it was signed.[140] The operation damaged the urethra causing the plaintiff's bladder to back up with urine. This complication mandated additional surgery to rebuild this anatomic part by "splaying open his penis and grafting tissue onto it."[141] A subsequent investigation revealed that Dr. Kobashi never appeared in the operating room so the surgery was performed by a urology fellow in her absence.[142] The jury was instructed that the informed consent form allows others to assist the primary surgeon, but it does not allow the doctor "to assign an unnamed physician to perform the procedure."[143] The jury returned with an $8.5 million dollar verdict.[144] Counsel for the plaintiff commented, following the decision, that the jury's award could prompt additional lawsuits as the result of the growing controversy over surgeons performing concurrent surgeries.[145]

Holsapple v. Upstate University Hospital involves a claim by a neurosurgeon that lost his employment with the defendant because he repeatedly complained about the risks involved with concurrent surgery.[146] Dr. Holsapple claimed that the hospital was more interested in its bottom line than patient safety by letting other doctors assist the primary surgeon with complex back surgeries who were unqualified to do the procedures.[147] The chair of the neurosurgery department purportedly told the plaintiff that he was "tired of [his] complaints" and removed him from the position as the hospital's residence coordinator.[148] The plaintiff ultimately resigned claiming that the work environment became so intolerable that he could no longer work as a neurosurgeon.[149] The court found in favor of the plaintiff and awarded $88,637 in lost wages and benefits.[150]

Two administrative complaints were filed against Dror Paley, M.D.,

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[138] *Id.*
[139] *Id.*
[140] *Id.*
[141] *Id.*
[142] Bob Young & Mike Baker, *Jury: Virginia Mason should pay couple $8.5M in disfigured –penis case*, The Seattle Times, (Apr. 7, 2017), https://www.seattletimes.com/seattle-news/health/jury-virginia-mason-should-pay-couple-in-disfigured-penis-case/.
[143] Szal, *supra* note 137.
[144] Hipps v. Virginia Masion Medical Center, 2017 WL 1955488 (Wash. Super. Ct. 2017).
[145] Szal, *supra* note 137.
[146] John O'Brien, *Upstate Hospital retaliated against whistleblower in 'bad soap opera,' judge rule*, ADVANCE MEDIA N.Y. (June 7, 2017), http://www.syracuse.com/health/index.ssf/2017/05/upstate_hospital_forced_doc_out_after_he_complained_about_double_surgeries_judge.html (last visited Mar. 21, 2018).
[147] *Id.*
[148] *Id.*
[149] *Id.*
[150] *Id.*

a West Palm Beach surgeon, for improperly supervising a surgical team that operating on the wrong portion of a child's leg while the physician was handling other procedures.[151] The second complaint involved the doctor's failure to properly supervise the insertion of a device in the wrong ankle of a child.[152] The doctor, who specialized in limb-lengthening operations, defended against the sanctions by asserting that he was not responsible for the improper actions of the physician assistant, and that he was only involved in one other procedure at the time.[153] The Florida Department of Health and the State Board of Medicine both admitted that they did not have rules that prohibited a surgeon from performing concurrent operations.[154] About one year later, the Florida Board of Medicine's Probable Cause Panel determined that the case should be dropped thereby admitting that the complaints were groundless.[155]

Several lawsuits have been filed asserting whistleblower claims over billing practices related to overlapping surgeries. In *Goldberg v. Rush University Medical Center*, the plaintiffs maintained that the defendants fraudulently charged Medicare and Medicaid for concurrent and overlapping surgeries in violation of the Medicaid rules and regulations.[156] Rush is a teaching hospital that provides care to Medicare and Medicaid patients. Reimbursement laws mandate that teaching physicians must be present during the "key and critical" parts of an operation, and to be "immediately available" for the entire procedure. When involved in overlapping surgeries, the primary surgeon must also "personally document in the medical records when he/she was physically present during the…critical portions of both procedures," and if not immediately available, the surgeon must arrange to have a qualified practitioner present.[157] The plaintiffs assert that for a number of years the defendants submitted bills to the government that violated these rules and regulations. For instance, they claim that bills were submitted in cases where the surgeon never entered the operative suite, and six complex operations were simultaneously performed by the same person in different rooms.[158] It was also alleged that the residents routinely falsified the records by noting that the surgeons were present for the critical parts of the operations when they were absent.[159] The court determined that it is unlawful to knowingly

[151] Joanne Finnegan, *Florida Surgeon Faces State Complaint Over Case Involving Concurrent Surgery*, FIERCEHEALTHCARE (Mar. 21, 2016), https://www.fiercehealthcare.com/practices/florida-surgeon-faces-state-complaint-over-case-involving-concurrent-surgery.

[152] Megan O'Matz, *Limb-Lengthening Doctor Faces State Complaint*, SUN SENTINEL (Mar. 18, 2016), http://www.sun-sentinel.com/local/palm-beach/fl-doctor-dror-paley-20160318-story.html.

[153] Finnegan, *supra* note 151.

[154] *Id.*

[155] Diane C. Lade, *State Medical Board Drops Wrong Site Complaints Against South Florida Surgeon*, SUN SENTINEL (Mar. 3, 2017), http://www.sun-sentinel.com/health/fl-doctor-paley-wrong-limb-complaint-dismissed-20170227-story.html.

[156] 929 F. Supp. 2d 807, 811 (N.D. Ill. 2013).

[157] *Id.* at 812.

[158] *Id.* at 812.

[159] *Id.* at 820.

present to the government a false claim for payment, and individuals can file *qui tam* actions on behalf of the United States.[160] The defendants moved to dismiss the lawsuit and claimed that the plaintiffs' failure to allege the duration of the operations did not offer enough information to infer that the operations overlapped. The court denied the motion and stated that the claimed practices appeared to violate the Medicare rules and regulations. The alleged fraud involved submitting Medicare claims for overlapping surgeries in which the teaching surgeon was not immediately available and did not arrange for another qualified doctor to be present.[161] The end result was that Rush University Medical Center paid $1.5 million to settle this lawsuit.[162]

On July 27, 2016, the Department of Justice entered into a $2.5 million settlement with the University of Pittsburg Medical Center (UPMC).[163] The government alleged that a number of neurosurgeons at the Medical Center submitted false claims "for assisting with or supervising surgical procedures performed by other surgeons, residents, fellows, or physician assistants, when those neurosurgeons did not participate in the relevant surgeries to the degree required."[164] Despite the settlement with the government, a *qui tam* action filed by the whistleblowers was allowed to proceed. These individuals, who previous worked at UPMC, claimed that the hospital had installed a compensation plan to encourage neurosurgeons to inflate their revenues while compromising patient care.[165] It was further noted that the UPMC neurosurgeons billed for surgery performed by junior members of the hospital staff which freed up the physicians to perform concurrent surgeries.[166] The court granted the defendants' motion to dismiss but allowed the plaintiffs "one last, best chance," to file an amended complaint with the admonition that the court "would not tolerate using the pretrial tool of discovery to justify the allegations."[167]

In *Waldmann v. Fulp*, the plaintiffs alleged that the defendants submitted hundreds of false billing claims to the government for surgical and other medical procedures.[168] The complaint alleged that Dr. Ray Fulp submitted bills showing that he performed the surgery, when they were in fact

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[160] *Id.* at 816.

[161] *Id.* at 820.

[162] *Rush University Medical Center to Pay Over $1.5 Million to Settle False Claims Act Allegations*, Whistleblower News, GETNICK & GETNICK (Mar. 24, 2016), https://getnicklaw.com/2014/03/rush-university-medical-center-to-pay-over-1-5-million-to-settle-false-claims-act-allegations/.

[163] Sullivan & Kay Wheeler, *supra* note 129.

[164] *False Claims Act Violation by UPMC Resolved for $2.5 Million*, U.S. DEP'T OF JUST. (July 27, 2016), https://www.justice.gov/usao-wdpa/pr/false-claims-act-violation-upmc-resolved-25-million.

[165] Kris B. Mamula, *Judge Dismisses Lawsuit Against UMPC Over Doctors' Bonuses*, PITTSBURGH POST-GAZETTE (June 22, 2017), http://www.post-gazette.com/business/healthcare-business/2017/06/22/UPMC-whistleblower-lawsuit-favorable-ruling-neurosurgeons-bonus-compensation/stories/201706220126.

[166] *Id.*

[167] *Id.*

[168] 259 F. Supp. 3d 579, 628 (S.D. Tex. 2016).

performed by others who did not possess a medical license. For instance, it was alleged that the operating room technicians administered epidural injections, and removed and inserted pins in total knee and hip replacements. They further maintained that they witnessed Dr. Fulp start surgeries, and then leave to work on cases in different operating rooms while the technicians worked on the patients.[169] The defendants moved for a summary judgment claiming that their conduct was not a false claim as a matter of law. The court denied the motion and noted that such a claim may be "factually false" when it is represented that the billed services were performed by one person when in fact they were performed by an unlicensed provider.[170] The forms submitted to the government certified that the patient care was rendered by Dr. Fulp or by an employee under his direction. The plaintiffs maintained that this representation was false. The surgeon did not "personally furnish" the services, nor were the technicians under his "personal direction" when the critical parts of the procedures were performed.[171] The court noted that the definition of personal direction mandates the presence of the primary surgeon during the providing of the services. Direct supervision further requires that the surgeon remain immediately available to respond to every emergency until the patient is removed from the operative suite.[172] At a minimum, this requires the actual presence of the doctor directing the delegated acts during the providing of the billed-for-services. In this case, the plaintiffs presented evidence that showed Dr. Fulp billed the government for services for one surgery when he was in a different operating room at the same time. Because he was in a separate room, the surgeon could not have personally directed the individuals performing the services.[173]

Things took an ugly turn in June 2017 when a former anesthesiologist at Massachusetts General Hospital sued that facility in federal court maintaining that at least five orthopedic surgeons put their patients' lives in jeopardy by conducting concurrent surgeries and by committing Medicare fraud by not being in the operating room for the critical portions of the operations.[174] The hospital denied any wrongdoing and asserted that they followed all applicable laws and regulations. The premise of the lawsuit is that the doctors kept their patients under anesthesia too long so that they could work on other cases at the same time. This lawsuit is currently pending.[175]

The Medical College of Wisconsin, Inc. paid $840,000 under the False Claims Act to resolve a lawsuit based upon illegal Medicare billings by

[169] *Id.* at *11.
[170] *Id.* at *15.
[171] *Id.* at *22.
[172] *Id.* at *16.
[173] *Id.*
[174] Joanne Finnegan, *Whistleblower Doctor Files Lawsuit Over Concurrent Surgery at Massachusetts General Hospital*, FIERCEHEALTHCARE (June 8, 2017), https://www.fiercehealthcare.com/practices/whistle-blower-doc-files-lawsuit-over-concurrent-surgeries-at-massachusetts-general.
[175] *Id.*

neurosurgeons at its facility who participated in concurrent surgeries that were primarily performed by unsupervised residents.[176] The Medicare regulations note that the government will pay for a teaching physician's services only if that senior surgeon is present for the "key parts" of the operation, immediately available during the length of the procedure, or has arranged for another surgeon to be accessible. In this case, the hospital did not satisfy these requirements.[177]

United States v. Erickson involved the administration of anesthesia in the context of overlapping procedures.[178] An ophthalmologist and his medical center were convicted of Medicare Fraud. The facts show that the surgical center hired certified registered nurse anesthetists (CRNA) to administer anesthesia to patients undergoing surgery and to monitor their progress. An investigation revealed that the defendants billed for as many as twenty-seven hours in a ten-hour work day for overlapping services.[179] The Center would bill for the services of the CRNA "in continuous anesthesia blocks, with the anesthesia time for one patient beginning immediately after the anesthesia time for another patient had ended.[180] This practice inflated the anesthesia billing periods when the nurse anesthetists was not present to monitor the patient. The regulation provides that the units of billing time involving the continuous actual presence of the healthcare provider starts when the anesthetist begins to prepare the patient for anesthesia, and ends when the nurse is no longer in personal attendance, which means when the patient may be safely transferred to post-operative care.[181] The defendants claimed that the phrases "continuous actual presence" is unconstitutionally vague because it does not define how close the nurse must be to the patient. The court disagreed and noted that the regulation mandates the CRNA to be present with the patient until that person is placed under the care of another.[182]

VIII. CONCLUSION

Concurrent surgery has been practiced in operating rooms for many years with little fanfare. That dramatically changed with the *Boston Globe* exposé that brought the custom to the attention of the public with a great deal of negative publicity. Nevertheless, research studies show that there is no real

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[176] *Medical College of Wisconsin, Inc. Pays $840,000 to Settle Alleged False Claims for Neurosurgeries*, U.S. DEP'T OF JUST. (Jan. 9, 2015), https://www.justice.gov/usao-edwi/pr/medical-college-wisconsin-inc-pays-840000-settle-alleged-false-claims-neurosurgeries.

[177] *Id.*

[178] 75 F.3d 470 (9th Cir. Ct. App. 1996).

[179] *Id.* at 475.

[180] *Id.*

[181] *Id.* at 476.

[182] *Id.*; *See also,* Ambulatory Anesthesia of New Jersey, P.A. v. Leavitt, 2007 WL 655599 (D. N.J. 2007); Furlong v. Shalala, 238 F.3d 227 (2d Cir. 2001) (involving a dispute with the Department of Health and Human Services for concurrent invasive monitoring of patients by anesthesiologist during major surgery). The question was whether the services provided were medical or surgical procedures for purposes of payment, where more than $2 million was at issue. *Id.*

difference in patient outcomes between concurrent and non-simultaneous surgeries. Most surgeons still support the practice because of its ability to offer skilled care to more people and to provide junior physicians with much needed training. Critics are unmoved and believe concurrent surgeries should be banned. Whether the government will put a stop to the practice remains to be seen. However, the cat has been let out of the bag, and lawsuits centering on the issue of concurrent surgery are being filed.