Financial Disclosures

In accordance with the ACCME’s Accreditation Criteria, the American College of Surgeons must ensure that anyone in a position to control the content of this enduring material has disclosed all relevant financial relationships with any commercial interest. Therefore, it is mandatory that both the program planning committee and speakers complete disclosure forms. Members of the planning committee were required to disclose all financial relationships and speakers were required to disclose any financial relationship as it pertains to the content of the presentations. The ACCME defines a ‘commercial interest’ as “any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients”. It does not consider providers of clinical service directly to patients to be commercial interests. The ACCME considers “relevant” financial relationships as financial transactions (in any amount) that may create a conflict of interest and occur within the 12 months preceding the time that the individual is being asked to assume a role controlling content of the educational activity. The ACCME also requires that ACS manage any reported conflict and eliminate the potential for bias during the session. The planning committee members and speakers were contacted and the conflicts listed below have been managed to our satisfaction. However, if you perceive a bias, please advise us of the circumstances on the evaluation form. The requirement for disclosure is not intended to imply any impropriety of such relationships, but simply to identify such relationships through full disclosure, and to allow the learners to form its own judgments regarding the presentation. Oakstone Publishing, LLC has assessed conflict of interest with its faculty, authors, editors, and any individuals who were in a position to control the content of this CME activity. Any identified relevant conflicts of interest were resolved for fair balance and scientific objectivity of studies utilized in this activity.


The following faculty report no relevant financial interests: Dr Mary E Fallat.
Do Not Perform Surgery When Tired

Case: You have been up all night dealing with multiple patients and suddenly remember you have 3 large cases the next day. You clearly feel tired. What is the right thing to do?

Recommendations: As I have gotten older, I have tried to avoid this situation. When I know I will be on call or post call, I do not schedule big cases. Once in a while, though, something will come up and I have to take a call for a partner or one of my own patients might need assistance. So if I am operating for long hours or all night and faced with a situation you present. The right thing to do is to notify your patients, tell them you have been up all night and that it is really not in their best interest or your best interest to have a surgeon who is really tired performing a difficult procedure. Then hope they will agree with that philosophically and be willing to reschedule. Obviously, there could be a situation where they will be angry. I take care of children who have parents who work and may have taken off a day or many days if it is a complicated procedure. I would say most of the time — if you are nice about it and you explain the incidence of complications and risks goes up when someone is fatigued — most people would understand and be willing to reschedule.

Routine Surgeries: One of my mentors, Dr Polk, always used to say that 95% of pediatric surgery is routine and 5% is complicated. If someone has come a long distance for a fairly routine surgery and one of the partners is available and willing to do it, we would go ahead with the surgery. The family must understand they have not met this surgeon before. When they meet the surgeon, they must feel comfortable with the arrangement.

Complex Surgeries: If it is a complicated or complex operation, I think most of us would speak with the patient and recommend they reschedule rather than have somebody not familiar with your child do this complicated procedure, even if they have come a long distance or have already had a bowel prep. Although it is inconvenient, waiting is probably in the best interest and safest thing for your child.

How to Handle Complications

Operative mistakes do occur. A mistake does not imply you have done something wrong Part of this depends on how well the family and the patient understood the risks and complications of the procedure before they signed the consent form. Fortunately, the risks of common duct injury are less doing it laparoscopically now than when that procedure first became popular, and the risk actually is equal to that of doing an open cholecystectomy. Having said that, I think most patients recognize there is always a risk in doing surgery, and those risks can include a common duct injury. If it happens, it is unfortunate. Once in a while, it does still happen. It may or may not have been a “mistake”. I think using the word complication is probably a better word choice, and actually referring the patient to somewhere that particular complication can be better handled by someone who is more competent and comfortable handling that because they have done those cases more frequently is the right thing to do and has actually shown to decrease the risks of lawsuits.

Apology Laws Apply in Most States

Case: I happen to be the surgeon involved when the “mistake” was made. I go out to the family and explain what we are going to do and then apologize for what happened. Is that protective?

Recommendation: More than half of the states have an apology law, which means that if you apologize to someone for what has happened, it is technically not admissible in court should you get sued. We do not have an apology law in Kentucky. Personally, I feel the right thing to do is to express sorrow for what happened, although I am not protected by that. If there was a chance it could happen, that makes it a little bit easier. If it was an unexpected complication then, obviously, you have to work through it.
Go to the patient, and explain what happened. Things may be more complicated for both you and the patient, but going to them and being honest is usually received much more favorably than trying to hide it and have it come out later that you knew it happened. In fact, you not only knew it happened, it was your responsibility and you did not tell the patient. I think that looks on you with a much poorer light.

Facing Complications

At our institution, we have a morbidity and mortality count; we call it a quality improvement conference. Like historically most surgical services do, we discuss every complication and death that occur on our service, even if the complication is fairly small. We discuss all patients who have been readmitted within 30 days. We discuss all returns to the Operating Room within 30 days. Not only do we discuss them, we also discuss what events contributed to the complication. We categorize them — whether it is patient disease, a system problem, surgeon related, or a technical complication. This is not to be punitive but because we live in an educational environment where it is important to discuss things that happen and try to determine how we might do things better. Once in a while we discover a trend that might enable us to improve things for other patients by changing something we do in practice or something that our service does, and then we actually inform the system and make a change that makes things better overall.

Critical Review of Errors Are Opportunities for Growth

Most things that you have couched as mistakes are not going to remain hidden. Most hospitals have checks and balances and ways for what we call fall out to be reviewed by the medical director. There are certain monitors that somebody will be sitting in an office looking for. If they see that in a chart, it will fall out for review. Some of these errors are things that must be reviewed more thoroughly — such as a sentinel event, sometimes referred to as never events — but sometimes they are things such as wrong-site surgery in which somebody operates on the incorrect side. You are not only going to have to review that, you are going to have to dissect that because there are many checks and balances to prevent that from happening. Everybody involved in that particular case is going to gather to review all of the documentation for that case, all of the steps and processes that went into taking care of the patient to see where the misstep was or if, again, it was a system problem. What led to that patient actually having the procedure done on the wrong side? So, there are things now in hospitals, in medicine in general, that enable us to do a critical review in an effort to try to improve the system overall. Wrong-side surgery obviously is a much more profound problem than having somebody come back with an intraoperative abscess after a ruptured appendicitis, which is something you expect in about 15–20% of people. You have to consider what is expected, what is not expected, and if it is leaning towards something that you would never expect, then that becomes something that has to be reviewed critically.

Use of Innovation Needs Patient Permission

Case: I am doing a procedure and have just thought about a new way to do it, and I have got a little device and want to see how it works.

Recommendation: I think it depends on how much the practice varies from your standard practice. If it is a device that is going to do the same thing you have done with a different device but maybe in a little more novel way and you are not changing the operation mechanically in a significant way, then it is okay to do it. If is something that is going to change what you do in a more dramatic way, then it is probably something that should be discussed with the patient first, especially if you are aware you are
going to be trying it or doing it. In pediatric surgery, we see so many one-offs — unusual cases that might need a novel approach — that the lines can sometimes be a little bit blurred between what would be a traditional approach and what would be a nontraditional approach, but if you are doing something to enhance the well-being of an individual patient and that has a reasonable expectation of success, then I would view that as something that is certainly okay but should be discussed with the patient.

**Innovation Becomes Research:** If there are procedures more radically innovative and that go beyond the norm — you have invented a new device and you are going to test it, you are going to do something where you really do not know what the complications might be, or there might be unforeseen outcomes — then that should probably be viewed as research and go through an IRB for that matter because you are doing something outside of standard practice. You do not really know what the safety and effectiveness is going to be beforehand, so it is important to engage the patient and make sure he or she understands the risks and benefits of why you are doing it.

**Duty-Hour Restrictions Not Prohibitive to Training**

Duty hours were put in place basically to allow residents to have enough rest during their normal workweek and work month such that they would function more effectively, efficiently, and safely. They have been in effect for several years. If you look at 5 years of general surgery training, we have cut almost a year’s worth of training out of that 5-year timeframe because of these duty-hour restrictions. That has added to the decrease in operative time from a number of other things in training including that trauma is much more nonoperative. We do not do many negative laps anymore. The medical treatment of peptic ulcer disease has led to a dramatic decrease in the need for gastrectomies. We have had a decrease in open surgery because laparoscopic appendectomy, laparoscopic cholecystectomy, and advanced laparoscopy is often done by fellows or postgraduate trainees who are doing that as a fellowship. So, Overall, the operative experience has decreased for our residents. Now there is a resurgence in thinking about a different paradigm for general surgery training. A recent article in the *New England Journal of Medicine* examined almost 120 general surgery residency programs and compared duty-hour flexibility with traditional duty hours and found there was no difference in deaths or overall complications with these 2 different paradigms in almost 150,000 patients. The conclusion of this study was that less-restrictive duty-hour policies were probably okay.

**Duty-Hour Limitations Stifle Continuity of Care**

I think the ability to have more continuity of care is better for the patient. With duty restrictions, we have handoffs that are sometimes untimely. We have residents in the middle of doing a trauma evaluation who must do a handoff in the middle of taking care of an individual patient. To be honest, because on the pediatric surgery service we have had some 12-hour shifts, it seems like their handoffs are much more refined than somebody just leaving in the middle of patient care. There is a little bit of flexible time built in so that we can have better handoffs. Problems arise when you have poor handoffs, and the patient is left there in the lurch. There are things that may have needed to be done or said or followed up on, and the new resident does not know that and these fall through the cracks more often. This noncontinuous care has contributed to more medical errors and maybe less formalities and protocols because there is not the follow-through that you used to give if you stayed there and helped to continue to take care of your patient.

**Attendings’ Role:** The attendings must provide the continuous care and are working harder than ever. If we are really committed to patient care, then we pick up the slack.
Assisted Suicide Requests Should Be Managed by Palliative Care

**Case:** You are in a state that allows assisted suicide. A patient comes to you and requests help in his suicide. What should your response be?

**Recommendations:** I think it is important for people to be able to die with dignity. People seek assisted suicide for a specific reason — they feel they are getting poor symptom control, they are losing their dignity, or they no longer have a capacity to control body secretions, so they are experiencing depression. For whatever reason, they have decided they would no longer like to be living. There are palliative care experts who have the ability to help with symptom control and can make most individuals feel better about their end of life and their quality of life within that end of life so that the assisted suicide is not the way they choose to end their life. But if not and someone does, I think I would have a hard time being the person to help them unless I was also a palliative care expert living in a state where it is legal and had exhausted all resources of making that patient feel better about their end-of-life care. It is nice if a patient can die at home with their family while receiving hospice care and having their friends visit them to say goodbye. There are a lot of people who feel regretful they did not get to say goodbye to someone who was dying. We also have opportunities in pediatrics. We have a nice paper written about celebration of life in the ICU for someone who is dying and cannot get home.

To have their family and friends rally around them and come in and celebrate their life before they die in a critical care unit is a special event. Remembering people and celebrating who they were and the way they were is also really helpful for the family in a situation where they are losing a loved one, whether it is someone who had a life-limiting problem or someone who is at the end of life and had a great life. While situations vary, any way you look at it, you are going to have a grieving family. It is nice to be able to say goodbye in a special way.

DNR: Should You Resuscitate?

**Case:** You arrive on the scene of somebody who has just arrested and happen to know the patient very well. She does not have a DNR order, but you know she does not wish to have CPR. Is it a mandate we have to at least try CPR on every patient without a DNR?

**Recommendations:** If the understanding is the patient is not committed to a DNR, I think you would try to resuscitate that patient. If the physician and the patient have agreed, at least tacitly, that this patient does not want to be resuscitated, the physician could say he knows the patient and knows she does not want CPR even if that is not written. Return of spontaneous circulation means you have revived them but not necessarily to their baseline. When you have conversations with patients, it is good to discuss that point also. If someone has a life-limiting condition and arrests and already has significant health issues, even if it is a witnessed arrest, the chances of them being successfully resuscitated to their baseline may be a little bit less than if it is an otherwise healthy person. A patient should know that before deciding on a DNR.

DNRs Can Be Put on Hold

At our institution, we have a policy in place that requires reconsideration of the DNR and a full discussion of the options. The options could include rescinding the DNR, which means it is stopped for a period of time and you would like to understand between anesthesia and surgery when it will be reinstated after the surgery — whether that might be in the recovery room or the next day. If there is a patient who has terminal cancer or is a neonate with multiple congenital abnormalities and you were putting in a feeding tube so the child could go home and be in hospice care instead of being in the hospital, then I think there are some choices. If the family has made a conscious decision that when the
time comes for the child to die, it is okay, then I think you could continue the DNR. And if something happens in the operating room, as long as you have the surgeon and anesthesiologist who understand the family’s wishes — let us say that the child has some type of significant congenital heart disease and a trisomy 21 or trisomy 18 — and there is a cardiac arrest, because you are already controlling ventilation so there is not going to be a respiratory arrest, the family could say we do not want you to do CPR, we do not want you to shock the heart. The parents can say that if anything happens except a cardiac arrest, you can fix it, but if the child’s heart stops we understand the baby is going to die at some point, and we accept that and we do not want you to do CPR. We do not want you to do a defibrillation. I think if you are a compassionate physician and empathetic and understand what the family’s wishes are, you could honor that in the operating room as long as you understand what the family’s goals are for their patient. There is another caveat, which is that if you know the patient really well, they might say, “I just want you to do the right thing. You know, if you think it is something that is correctable and I will wake up like I am now, then I am happy for you to do what you think is appropriate, but if I am not going to be the way I was then I would rather die.” This is a situation where the physician and the patient have such a good relationship the patient is willing to put himself in the physician’s hands and let them make the decision. There are special circumstances, but really that is the right thing to do if somebody has a DNR. Obviously, it depends on what it is that you are going to do in the operating room — whether you are going to do a major procedure or just put a line in or a fairly minor operation.

Living Wills: Still Honor Patient Wishes

Case: Living wills are becoming much more common in our adult practice. You have a patient who comes in with a living will. He has a lower GI bleed but is awake and alert. He is breathing but continues to bleed. When you say that it is time for surgery, he denies it. What do you do? Recommendations: It sounds like he has the capacity to understand the treatment you would like to render, and he is probably competent to make a decision. So, if he says he does not want to proceed, you are not going to do it, because that is his wish and he is not going to sign a consent. Case Continued: His son arrives, who happens to be the power of attorney and says you have got to do surgery. What do you do then? Recommendations: The POA does not have decision capabilities if the patient is not incapacitated. So if the patient is awake and alert and can engage in a discussion with you, can communicate his choice, and ask appropriate questions, then he is competent to make his own decision. It does not matter what his power of attorney thinks. He is still a patient with the ability or the self-determination to accept or refuse treatment. Case Continued: The patient’s mental status is becoming decreased and the son says, “Well, I am POA and I say you want to go to surgery,” Where do you end up on that side? Which side of the fence do you end up on that discussion? Recommendations: The patient was able to convey his wishes to you before he became comatose, and I think you still need to go with what the patient told you because you are taking care of the patient. You are not taking care of the power of attorney. The papers, the living will, are for someone who comes in unconscious and unable to communicate his or her wants. You did not have a discussion with him before he came in, so you are relying on the power of attorney to make a decision because that is how the living will guides you. But in this case you have an awake and alert patient who came in and was perfectly capable of making his own decision before he became comatose, so I think you honor the patient’s decision.
Common Terms in Biomedical Ethics Defined

You preserve patient’s autonomy. This patient was able to make his own decision. You did good by the patient because you listened to what he had to say. You did no harm to him because you did not operate on him. He did not want to be operated on, and I think you provided justice to the patient by preserving the doctor-patient relationship and treating him as an equal as you would have wanted to be treated. **Definitions:** Medical paternalism means you are leaving the decision in the hands of your health care provider because you think they can make the best choice for you. An example is when the patient says, “Do what you think is best.” Surrogate autonomy is when the person who is speaking for the patient and making the decision does so with little input from you as the doctor, and you agree with what the surrogate decides. Beneficence basically means to do good. You have the welfare of the patient at hand. If you are talking about it in terms of research, you are putting the research participant, the welfare of the research participant ahead of any goal of the clinical trial. So you have the welfare of the patient at hand, but it is to do good for the patient basically. Informed choice means the decision is voluntary and based on choice. It is based on the values and goals of the patient presuming they can understand the information, they can ask appropriate questions, they can communicate their decision, they have the ability to reason and deliberate and understand the risks and benefits, so they are making an informed choice or decision about proceeding. This is one of the terms that is implied, I think, when we as physicians are asked to give alternatives of care to a patient for whom we are caring. Shared decision making seems to be creeping into everything we do. I think that is a good term for what we might do with an adolescent also, but basically you are involving the patient, their family, and you or any other team of health care providers in the decision-making process. For example, if you have a patient care conference and you invite all of the physicians, nurses, social worker, and chaplain as well as the extended family and, if appropriate, the patient to discuss all of the aspects of the care — the goals of care, the decisions that need to be made — and then you come to a cooperative or shared decision about what the plan is going to be. It may not be exactly the plan the physician wants. It may bend more towards what the family wants, but you have a thorough discussion of the options of care and then decide together what the plan of care will be.

Medical Interpreters Should Be Trained Professionals

**Case:** You have a patient who cannot understand English and a physician who does not speak the patient’s native language. However, a family member or another health care worker speaks the language of the patient as well as English. Can they interpret what needs to be done to make the shared decision making with the patient?

**Recommendations:** You really should not, and the reason is because those people have not been trained to be a medical interpreter. Although a nurse, medical student, or doctor who is fluent in that language might be better than a family member, they still have not been trained. It is at least perceived to be better to use an interpreter trained to translate. Part of this is because of what can be lost in translation. You want somebody who is able to take your words and transpose them into the intentional meaning of what you are going to do as well as the question and answers that the family has. Someone with limited use of that language is probably not going to be able to translate effectively, and even a nurse may not completely understand how to translate to help the family really understand what you are going to do, the risks and benefits, or to be able to receive information from the patient and ask appropriate questions of you. The best thing to do is to get on the interpreter phone or get the person in your hospital who is an interpreter for their language. A lot of hospitals actually have someone on site who can come to the bedside. If you are in a smaller hospital that obviously does not have a lot of resources, there are interpreters you can employ remotely so you can actually get the treatment plan across. Most of these are accessed by phone. There are also businesses now set up for this purpose. We have interpreter
phones in our hospital, and we can ask for just about every language dialect. It may take a little while to get somebody on the phone, but typically we have had no problems finding somebody to be able to translate.

Is Health Care a Right?

The United States is a little bit unique. Most other nations have some type of health care they provide for their public, and it is felt to be a right of living in that country. It is, at times, rationed, meaning there is a minimum of health care provided for the public. In most advanced nations, Westernized nations, there is also the option to purchase additional health care coverage if a person chooses. In the United States, we do not officially recognize a right to health care apart from the right to assistance in an Emergency Department, which is why so many people go to an Emergency Department or an immediate care center — that is where many of them get their health care, and they know they cannot be turned away. They are at least going to get someone to look at them. There is this concept of a decent minimum of health care that has been proposed where if you are functioning as a citizen within your country, you would get at least the amount of health care that would respect your dignity and your comfort. Everybody is entitled to that, and it is personalized. In the United States, there is almost this sense of entitlement. So, there are countries where 80-year-old people with renal failure might not be offered dialysis or a person with coronary artery disease needs stents or open heart surgery; they would be put on a waiting list. If they did not make it to the point where they could have their surgeries, that is just what happens. There are only so many slots, so prioritization does not occur quite as often as it does in the United States where someone could show up and say, “Well, I want to have my procedure done next Thursday because it is my day off,” and sometimes we bend over backwards to do that. The concept of a just health care system is that everybody gets the minimum. People get what they need within the constraints of the resources. If you are able to afford additional health care and it is felt to be appropriate for you, then you could have insurance you pay for. Everybody gets the decent minimum.

The Cycle for Those with Limited Health Care

We do not have unlimited resources. Oregon has become our poster child when it comes to rationing health care. It has been going on now for over a decade. I think health care there is potentially more fair. The majority of the country is at one extreme, but even with the Affordable Health Care Act, there are still a lot of people who do not have insurance nor do they have the means to get health care. We have a society that does not really recognize health care as a right. As a result, we have a lot of people with medical problems like obesity and drug addiction, things that they cannot get attention for because they cannot afford. Instead they fall into habits. Cheap food is easy to come by. People become obese and have the comorbidities that go along with obesity. We do not have a way to give them the preventative health care they need, so they go to the Emergency Department when they have an acute problem. Then, they have nowhere to go for follow-up to remediate those health problems or the money to buy medicines. They are in this vicious cycle where they just get sicker and sicker, and we are supporting them at the end of the day because we support the health care system for those who cannot pay for it.

HIPAA in a High-Tech World

While most of the nation is aware of the Affordable Health Care Act, there are other acts that have impacted the practice of medicine. One addresses HIPPA and the use of social media, protecting patient privacy in the engaged world. In our practice, we do not use Twitter or Facebook, but I know there are physicians who do use some of those platforms as a way of building their practice and communicating
with patients. If you are going to do that, you need to be very careful about making your personal site and your professional site distinct. Social media is something that is gaining in popularity, particularly with younger people. In fact, recent estimates of social media usage by doctors have risen from 41% in 2010 to 90% in 2011, and it is here to stay. The question is how to do it in a manner that allows patients to get access to good information without compromising the confidentiality they need.

**Email:** I do communicate with some of my patients by email. We have a University of Louisville physician’s site that is encrypted so that information is protected. I communicate with patients by email because I feel it is a good communication method, partly because I travel a lot. I have some complex patients and, even if I am away, I am the better person to understand what might keep them out of the Emergency Department. I also can help them access the system if they need to go to the Emergency Department. I actually invite my patients to email me if they have issues or problems because I feel I am the best person to help them, but it does mean I have to be vigilant about checking email also. If you are going to do it, you have to do it in a way that preserves the confidentiality of the patients. You might talk to your medical liability provider and see if there is some type of shared paperwork you could have with your patient so that the 2 of you understand how you are going to communicate and what is going to be allowed. For example, our permission slip asks specific questions such as the following:

Do you want us to leave information on your voicemail if you do not answer? Is it okay to call you at work or just at home? Should we use your cell phone? Should we use your home phone? Again, you know, where is the message appropriate? Or do you just want to get your message delivered personally?

And, I think those are things that help protect you as well as the patients, so they understand you are not going to be leaving a message on their voicemail that somebody else might pick up who they really do not want to hear the information.

**WIFI:** When you use an open WIFI system at a coffee shop to view an x-ray, that piece of personal medical information is then visible to the public rather than just the physician. Since this is so convenient, we sometimes are not as vigilant as we should be.

**Maintenance of Certification and Physician Competence**

Maintenance of certification and physician competence are not necessarily the same thing. Whether they are similar depends on if certification is directed toward what the physician is actually doing in his or her practice. The best parts of maintenance of competency are really committing oneself to lifelong learning and practice improvement. If you are a physician in practice and taking care of patients, you must be committed to your own lifelong education. Things are changing so quickly, and there is so much in the literature now that discerning what is helpful and what is not helpful is a process in its own right. Doing continuing education credits in what you actually practice is very important. Some pediatric surgeons and I do SESAP, which I think is helpful. I recently got notice it was time to retake my general surgery recertification examination. I do not really practice general surgery anymore, so I had to go back and relearn breast cancer, anal cancer, and rectal cancer and do a lot in vascular disease — things I do not normally do. I find it to be helpful sometimes to ask medical students questions to keep up.

**Looking Forward:** There are probably a lot of people who feel this is a waste of time. It is not maintaining the competency I need to be a pediatric surgeon. I think the American Board of Surgery and maybe internal medicine are already changing the way they do things, but there is a move afloat to make maintenance of competency or maintenance of certification more directed toward what a physician will actually be doing so that it is focused on their area of interest and practice. I think it will be an evolution. It will take a little while to figure out how to do that appropriately, but I think it could be a better system than it is right now. So, while I think maintenance of certification is important, I do not think we have the perfect system right now that really focuses on what people do when they go into practice.

For pediatric boards, I am under the same system of the American Board of Surgery General Surgery Boards as general surgeons and have to keep my maintenance of certification up every 3 years and at the
10-year mark take the high-stakes exam. Two years ago I retook the pediatric surgery recertification exam, and this year I took the general surgery recertification exam. Then I have to do so many hours of CME each year, some of which have to be self-assessment and some can be going to a meeting. Then I have to maintain my license to practice medicine and be credentialed at a hospital and be in good standing, so there are several components that go into maintenance of competency. I think that the lifelong learning part of it is going to change a little bit in terms of being more directed towards a person’s occupation.

**Steps to Implementing New Technology in Surgery**

The Children’s Hospital is one of 5 hospitals, so we have this system to implement new technology. We also have a medical executive committee. So, if a new technology comes along, there is a committee that researches how it has been done and how people get credentialed to do it. The committee develops competence and how to maintain competence.

**Developing Competence:** Competence might be the number of cases you have to do by being mentored first and then the number of cases you have to do annually to maintain your expertise in being able to do it. Also, what kind of training have you had? Were you trained during your fellowship or your residency and can you document that? How many cases did you do during your fellowship? What kind of continuing education have you received in that technique that will enable you to continue to do it outside of your technical skills? We develop credentialing forms. If it is a special procedure — like using the robot or doing some type of invasive cardiology technique — there will be a special form to fill out. In addition, they will have to provide documentation of their cases and their continuing education credits. For us, the system will churn out a report card for each physician and will show many things — how many admissions they had to the hospital, how many complications, how many reviews, anything that fell out for review, unexpected deaths. All of that is reviewed to see if there was anything related to that type of procedure. So, we have a pretty well-refined system that not only enables people to bring new technology in but allows them to be credentialed for it. I feel we have a pretty good system here.

**Steps to Implementing New Procedure in Surgery**

**Case:** An individual goes away to learn a new procedure or technology and comes back and says, “I want to do these cases.” There is no mentor. There is nobody else who has done it. What do you do with that situation?

**Recommendations:** You start by calling the place that where the person was “trained” to do the procedure. It depends on what the procedure is and how complicated it is. If it was something you really wanted to have at your institution and you are willing to invest in the equipment and the program that might go along with it, you would send that person, potentially at the institution’s expense, to go and be mentored somewhere. There they would actually get privileges and do the procedure under mentorship. Again, it depends on how involved it is, but fundamentally I think if it is a complex procedure, you need more than just a 2-day training course. As new technology comes, we struggle with how to train our residents and how to train someone in a new technology. I am finding new technology is scrutinized by institutions now more than ever before, so if we do not have a good mechanism to do this, we need to figure it out. Just saying, “I am going to do this,” and starting it raises more eyebrows than ever before. There are more people who understand it is not the right way to do things nor is it good for patient care.