CHAPTER 9

THE PREOPERATIVE PROCESS

Steven R. Carter, DPM

The preoperative process includes multiple steps that will be covered in some detail. The process begins with the initial diagnosis and treatment of the condition and continues until the surgery begins. The preoperative process usually involves multiple encounters but not always. There are some unusual instances where every step is completed during one encounter. The preoperative process may be performed by one or more doctors. In some instances the work-up and conservative treatment may be initiated by one doctor and completed by another, as in the example of an initial treating physician later referring the patient to another podiatrist for surgical consultation.

Unfortunately, less than optimal outcomes occasionally occur after surgery and subsequent litigation occurs. The preoperative process and supporting medical records are always thoroughly scrutinized for areas of weakness. Some of the opinions I offer in this article come from my experience serving as an expert witness in malpractice litigation. I will try to point out various areas that seem to frequently cause trouble.

CONSERVATIVE TREATMENT

It is generally recognized that there are a range of nonsurgical options for the various conditions that eventually necessitate surgery. For some conditions there may be very few, whereas for others there may be multiple. In addition to the different types of conservative treatment options available, the duration of time utilizing these options can vary greatly depending on the nature of the condition. The main point is that the amount of conservative treatment needs to be considered reasonable for the condition being treated in the context of the symptoms it is causing and the function that is being limited. Many podiatrists for example would consider 6 months of conservative treatment to be typical for a patient with plantar fasciitis prior to considering a recommendation for surgery. However, consider a patient with plantar fasciitis that at the 3-month point has been treated with multiple types of conservative treatment, which have all failed, and the patient continues to have severe pain. In this circumstance, a recommendation for surgery earlier than 6 months might well be reasonable. Each conservative treatment that is done (or recommended but refused) should be documented. It is unfortunate when sufficient conservative treatment was instituted but never memorialized in the medical record.

GENERAL RECOMMENDATIONS

1) If the duration of conservative treatment is shorter than what is generally accepted as typical, some statement needs to be made to justify a recommendation for surgery. As an example, it may be that the patient has not responded at all to conservative treatment, the patient is in severe pain and it is therefore judged unreasonable to require that patient to continue treatment that has little chance of working in deference to some temporal "milestone." 2) It may be that there is no conservative treatment that has a reasonable chance of success. If this is the case, then it should be explicitly stated in the record that no practical option exists. 3) Avoid shortcutting conservative treatment because of pressure from the patient. We sometimes hear statements such as: "I'm losing my insurance next month so I need to go ahead and get the surgery done," "It is the end of the year and my deductible has been met," or "I am not interested in conservative treatment."

RECOMMENDATION FOR SURGERY

At some point along the perioperative timeline a recommendation for surgery is going to be made. In contrast, having an "academic discussion" with a patient about surgery as a potential option for a condition is not the same thing as making an explicit recommendation that a patient actually have surgery in the context of the specific set of circumstances. When a recommendation for surgery is made it is presumed that excepting certain contingencies (e.g., the patient passes medical clearance) the doctor believes that surgery is a reasonable and justifiable choice for treatment of the condition.

Necessity for Surgery: The Big Picture

An important element when recommending a patient have surgery is the awareness that this is an intensely scrutinized event. Before making the recommendation we should thoughtfully consider the question "are the symptoms, condition, impairment of function, or whatever the complaints may be sufficiently problematic to justify surgical intervention?" A rarely painful arthritic first great toe joint that does not interfere with function would be difficult to justify a recommendation for surgery. That is not to say there is never an instance where it would not be. The point however, is from an outsider's standpoint, "does the big picture make sense"? It may be that a clear explanation

might well provide sufficient understanding to an unrelated party as to why surgery was recommended. If some element of the big picture does not make sense and a bad outcome and subsequent litigation occurs, it can be expected that an allegation of performing unnecessary surgery will be made.

Goals

It is important to communicate to the patient what the surgery is meant to accomplish, and how likely it is the goal will be achieved. Furthermore, it may be pertinent to discuss the degree of improvement that is expected to be accomplished by the recommended surgery. Consider a patient who is in such severe pain that it is causing her to miss work. In this instance, surgery could in principle be judged successful even if the degree of pain postoperatively never decreased lower than a moderate level. We might certainly hope that after sufficient recovery any surgery might result in nearly complete pain relief. If however, that does not occur, residual pain is not in and of itself evidence of a failed surgery. This concept points out the importance of the discussion with the patient before the surgery to understand her goals and expectations and to effectively communicate the likelihood of being able to achieve these. If the patient's expectations exceed what is typically seen after the specific type of surgery being recommended, then the surgeon should strongly consider refusing to operate on the patient.

Rehabilitation and Typical Postoperative Course

One element of the preoperative process that can cause trouble is the failure to adequately have and document a discussion where the patient is told and made to understand the length of time that is often necessary before they will be able to enjoy the benefit of the surgery that is to be performed (time to maximum medical benefit). We all know that bunion surgery can be associated with pain and stiffness for months after the osteotomy has healed and the patient is allowed to resume the use of regular shoes. This is not necessarily a complication, but rather a somewhat typical, expected postoperative unpleasantry. However, if the patient is not explicitly told to expect that this may occur, there can be problems if such an event occurs. Patients will frequently ask "how long is the recovery?" This question needs to be answered carefully. Often it is answered in the context of how long it takes to return to normal shoes, or to return to work etc. "You'll be back in regular shoes in 4 weeks" can be a misleading answer. It may be an incomplete answer because recovery often continues for months after a patient resumes the use of normal shoe wear. A more complete way to answer the question would be to state that recovery has "phases" and go on to explain what this means. There is little to gain and much to lose when a patient is not made to clearly understand the typical postoperative unpleasantries to be expected after surgery.

Time Out of Work

This is a particularly important preoperative topic discussion regarding the postoperative course. On occasion, employees are terminated if they do not return to work within a particular time frame. This can be financially devastating to a patient, therefore, when discussing time off of work (especially for occupations that are predominantly weightbearing) we need to speak in terms of what is the "typical" time off of work for a patient undergoing a certain type of surgery. Unfortunately, some patients' postoperative pain, swelling etc. may be greater than what is typical and therefore more time off than what is normally expected may be necessary. The patient needs to be made aware of this.

Patient Expresses Desire to Proceed with Surgery

A patient that eventually has surgery, has at some point in the preoperative period alerted the doctor by some method that she would like to proceed with surgical intervention. It could be a phone call from the patient or during a follow-up office visit encounter. If a phone call is the means by which the office is notified then some statement needs to be entered into the medical record documenting the call. Something like "Ms. Jones contacted the office and stated that she would like to proceed with the scheduling of surgery that was recommended." If a full discussion has not taken place about the goals, risks, expected course, etc. then an additional face-to-face encounter with the patient is recommended.

Preoperative Questionnaire

Prior to surgery, the standard elements of the podiatry history and physical will be updated. However, there are some issues specific to surgery that will need to be addressed preoperatively. The questions to the patient can be addressed in the office or an over the phone interview by a medical assistant. Some of the information collected might require an opinion by the primary care physician as a part of the medical clearance process (Figure 1). An example might be confirming the use of anti-coagulants. If so, then that will be an issue to be addressed with the primary care physician or cardiologist. Other questions relate to bleeding disorders, history of blood clots, use of rheumatoid arthritis medications, wound healing problems, and a history of substance issues.

It is important to be aware of and address these issues before surgery. It is unfortunate when a case has to be cancelled on the day of surgery because the patient was not told to discontinue use of her rheumatoid arthritis medication.

Name: ____________________________ Date: _________________________

1) Allergies: ____

2) Are you on any blood thinners? ______________ **Names:**____________________________________

Recommendations prior to surgery : ____

3) Do you have any bleeding disorders? (blood clots too easily or not well enough; also Sickle Cell disease) ____

4) Are you on any medications for rheumatoid arthritis (or similar condition)?
_________________ **Names:** ____

Recommendations prior to surgery : ____

5) Have you ever had a blood clot? ______________________ **If "yes" what were the circumstances and how was it treated ?** ____

Recommendations prior to surgery : ____

6) Do you have sickle cell anemia or sickle cell trait? _______________________________________

7)Have you ever had any substance abuse problems (drugs or alcohol?) __________________
____

8) Do you form thick scars (keloids) after surgery? ____

9) Have you had any complications from anesthesia or surgery in the past? _______________
If "yes" please explain the nature of the complication:
____
____

10)Have you had any wound healing problems in the past? ___________________________________
If "yes" please explain the nature of the complication:
____

11) Date of last x---rays: ____

Figure 1. Preoperative questionnaire.

Medical Clearance

Much can be said on this topic but a few points are in order. Whether or not a patient "should" be sent for medical clearance is sometimes clearly necessary and at other times it is not. In general, I believe it is better to get clearance, but the subject can be controversial. In any event, it is a topic beyond the scope of this article. However, if the doctor states in the medical record that the patient is to be sent for medical clearance prior to surgery, it is very important that she follows through on this. I can point to a specific practical example in a malpractice case on which I served as a defense expert. A late middle-aged female with a history of coronary artery disease, diabetes mellitus, and renal failure was scheduled for a bone biopsy of the distal phalanx of the hallux. The medical record stated that the patient was to be sent for preoperative medical clearance but the encounter never occurred. During the surgery the patient went into respiratory arrest and subsequent cardiac arrest. It was argued that the patient was over sedated and not properly monitored. The patient was anoxic for several minutes and suffered devastating brain damage. In the operating room she was resuscitated, but several days later was disconnected from life support. The plaintiff's counsel contended that the podiatrist was partly liable for failing to have obtained medical clearance.

Sometimes when a preoperative medical clearance consult is ordered, the returned documentation may be ambiguous or may not explicitly comment as to the patient's suitability for elective surgery. The document may merely be a simple history and physical, which is not the same as medical clearance. Therefore, I prefer to have the medical consult physician sign a form explicitly stating that patient is cleared. Also, any pertinent peri-operative recommendations can be added if necessary (Figure 2).

"Pre-T"

"Pre-T" is a term that we sometimes use to indicate physical therapy that is ordered before surgery. The purpose is to make certain (prior to surgery) that a patient is able to comply with restrictions such as non-weightbearing. If the patient is not physically able to maintain non-weightbearing status, then the surgery may have to be cancelled. Also the therapist can help address issues specific to the patient's living arrangement such as going up and down stairs.

Informed Consent

Informed consent is the process of disclosing sufficient information (including the goals, risks, rehabilitation period, chances of success, etc) to a patient so that the patient is in a position to make a voluntary choice to accept or refuse the recommended surgical procedure. A majority of the pertinent issues have often been addressed at earlier encounters and ideally were documented in the medical record. On the day the consent is signed these can be briefly reviewed with the patient. A few other items may need to be addressed if they have not already been covered with the patient.

Technical Aspects of the Procedure

The procedure should be explained to the patient using simple to understand terminology. Drawings can sometimes be helpful.

Risks

The final discussion of risks needs to review the types of adverse events that although are not "expected," do occasionally occur. These complications are the types of adverse outcomes that go along with the type of surgery the patient is to undergo. As an example, nonunion of a first metatarsal osteotomy is not expected or common, but should be discussed as a possible complication in the context of a patient planned to undergo an Austin bunionectomy. Using this same scenario as an example it is not required to explicitly discuss items that are highly "bell-curve improbable" like death and loss of limb, which are on all standard surgical consents. Other possible complications such as infection and wound healing problems should be mentioned.

Discussion of the items above needs to occur prior to the day of surgery and should be performed by the doctor as opposed to the medical assistant. Having a patient sign the consent the day of surgery is quite common and well accepted, but a discussion of the risks needs to have occurred prior to the day of surgery. Otherwise, a patient can complain that they signed the consent under duress, which is defined as "an unlawful pressure exerted upon a person to coerce that person to perform an act that he or she ordinarily would not perform."

If it is the doctor's common practice to have the patient sign the consent the day of surgery, it is important to make sure the patient has not been premedicated when the consent is signed. I have seen one instance where a patient claimed that he could not read what he signed the day of surgery because prior to being transported to the preoperative holding area his glasses were taken from him and stored with his belongings.

PREOPERATIVE CHECKLIST

A final point is an encouragement for the doctor to develop a preoperative checklist or other procedure that is close to fool-proof as possible, so as to minimize the chance of forgetting something important. In the accompanying lecture to this article I show a notebook (Figure 3) with multiple labeled sections. Each one is a reminder of all the potentially necessary items. (Not every item is needed on

John Doe, DPM

Date: ______________________________________

Patient Name: ________________________________

Dr. ________________________

This patient is scheduled for surgery on: ______________________________

Procedure: ____

Contemplated Anesthesia: ____

Length of Case: ____

Prior to Surgery the patient will need:

1. Pre-op H&P with Medical Clearance for surgery (within 30 days of surgery)
2. CBC w/ Diff
3. EKG (w/in 6 months if over 50)
4. UCG (if applicable)
5. Other labs/tests as needed for Pre-op Clearance

Peri-Operative Recommendations:

____

____

Patient is medically optimal and of acceptable peri-operative risk.

____

(PCP Signature)

Figure 2. Sample preoperative medical clearance form.

Figure 3. Preoperative notebook.

every case). If for instance the section for medical clearance is empty, and I am certain I ordered it, I am reminded to go and look for this document. The sections included in my notebook are preoperative questionnaire, surgical consent form, podiatry H&P, medical H&P, medical clearance form, EKG, UCG, Labs, vascular clearance, and preoperative orders. In my experience, this system produces fewer errors than looking through a stack of papers while trying to remember if all the pertinent documents are present.