How to Be an Efficient Laparoscopic Team (Didactic)

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Professional Education Information

Target Audience
This educational activity is developed to meet the needs of residents, fellows and new minimally invasive specialists in the field of gynecology.

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How to Be an Efficient Laparoscopic Team (Didactic)

Elisabeth Janschek, Chair
Vicki Barnett, Co-Chair

Faculty: Mark W. Dassel, Joerg Keckstein, Astrid Urabel, Wendy K. Winer

This interactive course provides skills and knowledge on how to implement teamwork in the laparoscopic setting and improve so the quality of surgery. Even skilled gynecologic surgeons often underestimate the role of teamwork to optimize their own performance in laparoscopy. Teamwork includes preoperative management and intraoperative organization of various tasks of the surgeon, nurse and technician. Basic and advanced techniques will be discussed to allow surgeons to tackle simple and complex endoscopic procedures. An emphasis will be made on the integration of the nurse’s work, the organization of the technical equipment, and necessary interdisciplinary cooperation for efficient laparoscopic work.

**Learning Objectives:** At the conclusion of this course, the clinician will be able to: 1) Appreciate the role of teamwork in the setting of advanced laparoscopy; 2) organize the team in the operating room according to the surgical complexity of the case; 3) implement guidelines for nurses and technicians to facilitate the surgeon’s work; 4) develop surgical strategies according to simple teamwork rules; and 5) perform safer and efficient surgical procedures.

**Course Outline**

8:00 Welcome, Introductions and Course Overview  
E. Janschek

8:05 Teamwork from the Surgeon’s Point of View  
E. Janschek

8:30 Nurse’s and Technician’s Role within the Team  
A. Urabel

8:55 Credentialing for MIS: Laparoscopy, Robotics, Other  
V. Barnett

9:20 Questions & Answers  
All Faculty

9:35 Break

9:50 Education of Surgical Concepts and Skills  
M.W. Dassel

10:05 Improve Interdisciplinary Surgery! How Interdisciplinary Surgery Can Be Organized: Demonstration with Cases of Severe Deep Infiltrating Endometriosis  
J. Keckstein

10:30 Perioperative Management: The Work of the Team Starts Long Before the Surgical Procedure and Ends Much Later  
E. Janschek

10:50 The Perfect Operating Room – A Future Vision?! How Can We Improve Organization and Equipment in the Meantime?  
A. Urabel/V. Barnett

11:10 Marketing Your Team and Social Media  
W.K. Winer

11:30 Questions & Answers  
All Faculty

12:00 Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop and have no conflict of interest to disclose (in alphabetical order by last name).
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Consultant: Conceptus Incorporated
Kimberly A. Kho*
Frank D. Loffer, Executive Vice President/Medical Director, AAGL*
Linda Michels, Executive Director, AAGL*
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The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
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Mark W. Dassel*
Elizabeth C. Janschek*
Joerg Keckstein
Other: Patent Holder: Karl Storz
Astrid Urabel*
Wendy K. Winer*

Asterisk (*) denotes no financial relationships to disclose.
Teamwork from the surgeon’s point of view

Dr. Elisabeth Janschek, OÄ
Department of Gynecology and Obstetrics, LKH Villach, Austria

Disclosure

I have no financial relationships to disclose.

objective

- At the end of this lecture, the participant will be able to
  - optimize synergy between operating hands
  - define and
  - standardize the interactions within the team
  - transfer patient’s information

Laparoscopic Surgery

- A laparoscopic surgery is the result of complex multidisciplinary interactions among highly specialized professionals.
- The Extended Team is constituted:
  - Surgeon(s)
  - Instrumenting nurse
  - Circulating technician
  - Anesthetist
- Specific planned tasks are performed with sophisticated equipment.
- The surgical team has to respond to unexpected clinical events and the respective patient’s conditions.

Keckstein’s Laparoscopic School in Villach (Austria)

- Villach’s Surgical Team:
  - Surgeon
  - 1st Assistant
  - 2nd Assistant
  - Instrumenting Nurse, circulating nurse (technician)
  - Anesthetist
- All play a proactive role and enable
  - Synergy of operating (hands) instruments
  - Anticipation of needed instruments, sewing material
  - Flawless regulation of devices
- Gynecological live surgery Team:
  - Surgeon
  - 1st Assistant
  - Instrumenting Nurse

Surgeon

- The Surgeon is the leader of the team, but team-performance is fundamental to safe and efficient work.
- Surgeon:
  - provides direction
  - gives instructions
  - and explanations to the team members
- Needed changes in strategy are discussed together and the surgeon decides how to proceed.
- Everyone is aware of what is happening!
Time out

- Silence in the OR-Theatre → Concentration!
- Communication:
  - patient’s identity
  - briefs team on procedure/site/laterality
  - together with anesthetist patient’s requirements
  - single shot antibiotic
  - surgical risks
  - special instruments/devices
  - implants
- Documentation: performed by circulating nurse

Synergy of hands

The 1st Assistant
- knows what will be the next surgical step.
- is actively involved in surgical steps with one hand.
- is primarily responsible for bipolar hemostasis.
- contributes very much to good sight by following the surgeon’s steps with the camera and his instrument.

Camera

- eye of the whole team!
- role:
  - center point of interest
  - have a steady hand
  - make slow movements
  - beware of correct orientation of planes
  - readjust focus
- HD-camera ensures quality of the picture
  - 30° optic allows good view in angulated sites

Nurse

- is specialized in gynecological laparoscopic surgery (surgical standards for instrumenting nurses)
- ensures ideal environment for the surgery:
  - anticipates instruments during the procedure
  - prepares the adequate suturing material
  - coordinates the technician for flawless synchronization of equipment regulation.
- contributes to good sight:
  - warms up the optic preoperatively
  - regulates CO2 flow during the procedure
  - cleans the lenses
  - Thermoflat heats up CO2

Anesthetist

- Is familiar with gynecological laparoscopic surgery.
- Can cope with extreme Trendelenburg-positioning of the patient and special arm placement.
- Is informed by the surgeon
  - About progress of surgery
  - Complications
  - Blood loss
  - Application of vasoactive substances

Ergonomics

- Incisions (minimum of 4, position adapted to the patient’s anatomy and pathology)
- Comfortable posture of the whole team (extralarge step for surgeon & 1st assistance, 3 monitors, extreme Trendelenburg positioning of patient)
Operation strategies

- Avoid unnecessary changes of instruments
- Use instruments in versatile manner
- Change instrument and/or strategy if progress is poor or lacking
- Standardize routine procedures: LASH, TLH, ADNectomy, URETEROLYSIS
- Safety of the patient is a matter of the whole team!

All are alert during surgery:
- to avoid complications
- to recognize technical defects

Non-technical Skills

- Team values:
  - common goal
  - mutual respect
  - leadership
- Communication:
  - shared picture of the situation
  - for effective completion of the tasks
- Teamwork:
  - skills for working in a team context
  - joint task completion
  - team member satisfaction
- Situation awareness!

End of surgery

- Documentation (pictures, videos, electronic chart)
- Debrief
  - oral to the anesthetist
  - written and oral to the gynecologist on duty
- Written postoperative orders
- Detailed description of surgical procedure

THANKS

TO THE WHOLE TEAM!!!
# Objective

- At the end of the lecture the participant will be able to:
  - Prepare and check the surgical equipment
  - Assist the surgeon in a proactive way
  - Contribute to the patient’s safety

# Preoperative Work

- Patients scheduled for surgery are reviewed for:
  - Special instrument requirements
  - Technical devices (maintenance and repair, single use complements)
  - Relevant medical information of the patient (positioning of the patient, latex-allergy)

# Nurse’s Team

- Surgery nurse
- Circulating nurse - technician

# Surgery Nurse

- High specialization in gynecological laparoscopic procedures
- Continuity of the stuff
- Standardization of all procedures and its associated instrumentation
- Instructions to the circulating nurse

---

**Disclosure**

- I have no financial relationships to disclose.
circulating nurse

- Assists the surgery nurse
- Is in charge of:
  - all technical devices during surgery
  - documentation (surgery, instruments, videos and photos, time out, technical devices, histological probes, frozen section)
  - supplying the surgery nurse with required suturing material, single use instruments

checking the equipment

- Laparoscopic set of devices
- CO2 Laser
- AIDA-system

laparoscopic set of devices

- HD-camera(s)
- Illumination system
- Insufflator
- Morcellator motor
- Power supply for high frequency surgery
- Documentation system

HD-monitors

- Connection to the respective camera
- Correct preselections
- Optimal positioning

CO2 Laser

- Turn on the CO2-laser
- Control the laser-arm
- Connect the coupler to the laser-arm and check the target beam

checking the instruments

- Endoscopic instruments
- sterility concerns
- integrity and functionality
- correct assemblance
**instal documentation**

- Open patient’s electronic time-out form of the patient documentation system

**preprocedural phase**

- Patient’s identification
- Patient’s chart:
  - Admission Work up form
  - Informed consent signed (surgery and anesthesia)
- Check with the patient
  - Known allergies
  - Implants, piercings lenses, prothesis removed
  - Procedure and site (nephrectomy)
  - Skin assessment

**positioning**

- Belongs to the nurse’s field of responsibility
- Circulation nurse positions the patient under the supervision of the surgical nurse
  - In specific cases: surgeon and nurse’s team place the patient together

**Positioning**

- Teamwork with anesthesia
- Special cushions
- Arm position
- Leg position

**scrubbing & draping**

- Surgery nurse scrubs abdomen
- Circulating nurse:
  - Scrubs vulva and vagina
  - Removes the wet clothes
  - Places the bladder catheter
- Both drape the patient

**Patient ready for surgery**
**Time out**

- Patient is ready for surgery
- Confirm all team members are ready for time out (OR doors are closed)

**During surgery**

**extreme trendelenburg**

- For difficult surgical procedures in the pelvis
- Better ergonomic standing of the surgical team
- Be aware of the duration of this position!

**during surgery**

- Correct insertion of instruments

**during surgery**

- Constant control of trocar’s position
- Regulate the insufflation modus according to the smoke development
nurse's assistance

- Documentation (employed instruments, gauzes, devices)
- Regulate the technical devices
- Nurse's assistance hands out all required instruments and sawing material

co2 laser

- Change the optic and trocar
- Elevate the surgical table
- Focus the laser and control the setting (modus, energy)
- Continuous suction/insufflation

during long procedures

- Control the position of the lower extremities
- Kinesthesia
- Restore supine position and reduce the intraabdominal CO2 pressure for approximatively 20min each 2 hours of surgery

end of surgery

- Confirmation of completeness of instruments
- Count of needles
- Count of surgical gauzes
- Inspection of the patient's skin
- Close documentation

Thank you for your attention!
Credentialing for MIS: Laparoscopy & Robotics

Vicki Barnett, RN, MSN, CNOR
Director, Surgical Services
Northside Hospital
Atlanta, Georgia

I have no financial relationships to disclose.

The participant will:
1. Describe the rationale for developing credentialing for MIS
2. Discuss proposed models for credentialing and privileging for robotic surgery
3. Use a participative approach to credentialing recommendations based on evidence

Advanced Center for MIS and Robotic Surgery

Robotic Training Center for MIS: Since 2009; Nearly 300 surgeons trained
The debate continues about evolving credentialing requirements for MIS surgeons.

- Responsibility of hospitals to ensure surgeons are being trained, credentialed and monitored.
  - Although proctoring is a modality by which competency can be evaluated, other training tools and guidelines are needed to ensure that the requisite knowledge and technical skills are acquired and maintained current.
  - Medico legal Risks
  - Costs compared to laparoscopy

- Adoption of aviation model
  - Operating a surgical computer system such as the daVinci surgeon console is analogous to flying an airplane.
  - Proctoring a specific number of cases may not measure proficiency.
  - Professional organizations are moving toward the requirements of demonstrating proficiency and maintaining currency.
  - Currency is the minimum number of activities required in a defined period to be necessary to maintain one’s skills.

Professional Organization Guidance

- ACOG: Secretary Steven W. Remmenga, MD
  - The society plans to release credentialing guidelines for vaginal, abdominal, and robotic sacrocolpopexy procedures. There is concern that robotic procedures are being performed with minimal to no training. (Feb 2013)
  - AAGL: (Statement from Dr Lenihan here - pending)

- Basic robot-assisted laparoscopy credentialing
  - Online training modules
  - Observation of live robotic-assisted laparoscopic cases
  - Bedside training by a qualified trainer for docking, bedside assisting and resolving bedside system issues
  - Hands-on training with the “robot” using simulation, if possible
  - Complete at least 2 successful proctored cases by an appropriate hospital-approved proctor
  - Training must be completed within 2 months of when the first proctored case is performed

- AUA (American Urologic Association) SOP’s for Urologic Robotic Surgery:
  - Credentialing is the responsibility of the individual institution
  - Minimum requirements
  - ACGME residency core curriculum: minimum of 20 cases
  - Prescribes process if no residency core curriculum
  - Board eligible or certified
  - Proctoring who has completed 50 procedures with 20 similar to the one being proctored
  - Review of surgical outcomes after the surgeon’s initial experience by an unbiased group of peers at the same institution
  - Maintenance of privileges with peer review monitoring
  - Institutional support: Requires commitment from the institution for resources including dedicated ORs, nursing team, robotic surgical coordinator, ongoing training.

Developing an Experience and Evidence Based Approach

Hospitals adopting robotic technology should:

1. Establish multidisciplinary peer review committees
2. Include all specialties and anesthesia representatives
3. Establish local guidelines based on their own needs
4. Develop criteria to determine who should be trained
5. Maintain consistency in training
6. Determine the minimum number of proctored cases
7. Develop proctor criteria and standards
8. Establish a timeline between training and initial cases
9. Determine robotic peer review processes
10. Establish minimum cases per year to maintain privilege
11. Implement competency based credentialing
12. Develop a process to review new surgeons applying for privileges who have trained and certified elsewhere

Industry: Intuitive Surgical Inc.

- Phase I
  - Developed clinical pathway for physician training
  - Does not replace hospital policy regarding credentialing
  - System overview
  - Live procedure observation
  - Procedure commitment immediately after training
  - Select a dedicated surgical team
Industry: Intuitive Surgical Inc.

- **Phase II**
  - On-line daVinci training: 1 hr system technical overview
  - System training on site: 4 hour system overview, OR set-up, docking, instruments, console, emergency procedures review
  - On-line procedure modules timed and evaluated: 4 hours
  - Off site training at Intuitive Lab
  - Proctoring: Number of cases determined by hospital
  - **Recommendation**: Procedure dry run; trend case times; video record cases 1-20 for review; post-case review.

6. Remmenga, S. Secretary’s report. District VI Advisory Council 2012 Annual Business Meeting. Feb; 201
9. Standard Operating Practices (SOP’s) for Urological Robotic Surgery
Education of Surgical Concepts and Skills
How to Be An Efficient Laparoscopic Team

Mark Dassel, M.D.
Assistant Professor
Department of Obstetrics and Gynecology
University of Utah

Disclosures
I have no financial relationships to disclose.

Course Objectives
- Identify important team surgical skills and concepts
- Identify operating room team member roles and traditional training biases
- Determine which surgical skills and concepts are commonly lacking and need to be addressed
- Develop a plan to rectify deficits in surgical team training

Important Surgical Skills and Concepts
- Technical
  - Surgical dexterity
  - Knowledge and clinical skills
- Non-technical
  - Communication
  - Situational awareness
  - Decision making
  - Teamwork
  - Leadership
  - Managing Stress and Fatigue

The Role Players(s)
- The surgeon
  - Trained to communicate succinctly in headlines,
  - Trained to be “the leader”
  - Trained in Evidence Based Medicine
  - Anesthesia (Anesthesiologists, CRNAs)
    - Trained to communicate succinctly, work the numbers, and focus “up top”
  - OR nurses (Circulators, Scrubs)
    - Trained to communicate holistically, in broad narratives SEXTON
    - Trained to be the “copy editor”
    - Most important skills - Communication, Teamwork, Situational awareness

Which skills and concepts are most important?
- Communication
  - Aviation industry identifies lack of communication as the most common cause of error
  - Lack of communication is a major source of surgical complications
  - Ranked high in importance for scrub nurses, anesthesiologists, physicians
Which skills and concepts are most important?

- Teamwork
  - Most commonly cited as associated with Adverse events (with communication)
  - Observational Teamwork Assessment for Surgery
  - 2nd most commonly cited in NOTTS

Who are the best team members?

- Leadership
  - Attributed often to the surgeon, though benefits in all surgical roles
  - 3rd most commonly cited in NOTTS

How do we best teach surgical skills and concepts?

- As a team
- As a role-player
- In perpetuity
- Develop a culture

Educate as a team

- Foster team unity
- Identify team goals
- Delineate role responsibilities
- Identify team pitfalls
- Grievance policies
- Team simulation and didactics

Educate role-players

- Delineate strategies to work under pressure
- Communication with difficult personalities
Educate Each other

• Each and every day.
• Pre-briefings
• Post-briefings

Pre-Briefings

• TIME OUTs
  – Patient, procedure, blood products, beta-blockers, antibiotics, allergies
• PATIENT HISTORY
• PROCEDURE SPECIFICS AND REQUIREMENTS

Post Briefings

• THE GOOD, BAD, AND THE UGLY
• INTERACTIVE FEEDBACK
• IMPROVEMENT SUGGESTIONS
• HIGH FIVES

Pitfalls

• One more hokey training
• Abandonment of the hierarchy
• Set it and forget it
• Frying pan approach
• Not Dancing with the devil

What is the quality of our evidence?

• The literature is expanding rapidly
• The tools are rudimentary
• Tough to design reproducible tests for complex human behavior
• Many validated tools being tested and put to use and some clear trends are present

Trends in the education of TEAM surgical skills and concepts

• Developing systems to nationalize education
• JCAHO initiatives
• Growing bodies of literature
• AHRQ move towards establishing teamwork
SOURCES

Improve interdisciplinary surgery!
How interdisciplinary surgery can be organized: demonstration of cases of severe deep infiltrating endometriosis

Prof. Dr. Joerg Keckstein
Dep.of Gyn. And Obs.
Landeskrankenhaus Villach, Austria
University Ulm, Germany

Objectives
• Demonstration of interdisciplinary diagnosis of deep infiltrating endometriosis
• Planning of surgical approach to DIE with extragenital lesions
• Setting of OR for DIE surgery
• Problem-orientated surgery with various specialists

DIE
• Disease of the whole pelvis, not only gynecologic disease
• Symptoms do not correlate with the stage of the disease
• Diagnosis of the complete disease difficult
• Operative diagnostic procedure may end in a difficult procedure

Die-Diagnosis
• History
• Clinical examination
• Ultrasound
• MRI
• X ray
• Endoscopy
• Laparoscopy

When do we need other specialists?
• For diagnostics:
  • Radiologist
  • Gastroenterologist
  • Urologist
  • Abdominal surgeons
Die - diagnostics

- The patient’s complaints are responsible for the diagnostic pathway
  - GP
  - Gyn
  - Abdominal surgeon
  - Urologist
  - Radiologist

Different pathways in DIE

Gynecologist

- History
- Clinical examination (gyn.)
- Transvaginal Ultrasound
- MRI
- Laparoscopy

Abdominal surgeon

- History (not gyn.)
- Clinical examination (not gyn.)
- CT
- MRI
- Endoscopy

Urologist

- History
- Abd. Ultrasound
- CT
- MRI
- Cystoscopy

Diagnostics of DIE

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<tr>
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<th>others</th>
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<td>Nerves, others</td>
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</table>
Surgery of DIE

- Who makes the diagnosis?
- Should surgery be done by:
  - One surgeon (gyn, abd. surg., urol.??)
  - Interdisciplinary surgical team?
- Who makes what?
- Who follows the patient?
- Who takes care of the complication?

Bowel endometriosis

- The surgical procedure has to be adapted to:
  - Patient’s complaints
  - Surgical skill
  - Experience of the team
  - Possibilities of postop. care

Videos

- Case reports of bowel endometriosis
  - History
  - Diagnostic
  - Surgery

Surgical treatment of DIE

- Gynecologist
  - Expert in endometriosis
  - Skilled surgeon with gynecologic organs
  - Urologist, abdominal surgeon
  - Experts in specific procedures for excision or repair of “their” organs
  - Reduced expertise in surgical treatment (reconstructive) of gynecological diseases and organs
  - Fertility surgery not trained

Bowel endometriosis

Our experience

- Situation in 1996
  - Few cases of bowel resection reported by gynecologists
  - Shaving is standard procedure
  - Reports of abdominal surgeons do not focus on the complete disease

Bowel endometriosis

Our experience

- 2013
  - Many reports on bowel resection in GYN journals
  - No guidelines available
  - Warning on overtreatment and complications
  - Lack of randomized trails
Preoperative Planning of surgery

- Bowel involvement
- Shaving
- Disc resection
- Segmental resection
- Multifocal lesions
- Stoma?!

Preop. Planning

- Informed consent
- Balance between pro and con
- Chance of curing
- Risks of complications
- Discussion of alternative operative and/or conservative therapeutic options

Bowel Endometriosis

- We learned and will learn our lessons in bowel surgery
- Communication with abdominal surgeons before, during and after surgery has to be improved
- New techniques of bowel surgery with stapling devices
- New datas on results after surgery

Ureter

- Diagnostics
  - Sonography of the kidney (gyn, uro, rad)
  - MRU(rad)
  - During operative treatment(gyn,uro)
- Treatment
  - Ureterolysis(gyn,uro)
  - End-to-end anastomosis(gyn, uro)
  - Ureterocystoneostomy (gyn,uro)
  - Nephrectomy(uro)

Videos - Ureter

- Case reports of ureter endometriosis
- Diagnostics
- Surgery
- Follow up

Videos - Bladder and others

- Case reports of endometriosis of the bladder and inguinale
- History
- Diagnostics
- Treatment
Surgical team
Setting in our OR

• Gynecologist
• Surgeon with two assistants, with 5 hands in action
• Nurse, technician
• Abdominal surgeon and Urologist in stand by

Surgical team
Setting in our OR

• OR I
• Two HD cameras (parallel possible)
• US, CT or MRI pictures visible on OR screen

Summary

• DIE is a challenge for gynecologist and other specialists in diagnostics and surgical treatment
• Interdisciplinary communication before, during and after surgery improve the surgical procedure and the outcome significantly
• Perfection of surgical skills, of technical support and as well of organisation of the team is the goal of centers of excellence
perioperative management: the work starts long before the surgical procedure and ends much later

Elisabeth Janschek, MD, OA
Department of Gynecology and Obstetrics LKH Villach

Disclosure

I have no financial relationships to disclose.

objective

- At the conclusion of this activity, the participant will be able to:

first contact

- History of the patient
- Actual symptoms
- Gynecological Examination
- Transvaginal ultrasound, Sonography of the kidneys
- Plan other imaging or procedure if required
  - MR
  - MR-Urography
  - Isotope Nephrogram
  - Insertion of a DJ
  - CT

Inspection-Speculum

- Examine:
  - Vulva
  - Cervix, vagina,

palpation

- bimanual Palpation
- Uterus
- Uterosacral ligaments
- Cul de sac
- Adnexes
- Lateral pelvic wall
- rectal examination
Sonography

- is integral part of the patient's assessment
- is performed by the gynecologist
- can detect extragenital endometriosis such as bladder, bowel and obstructive uropathy secondary to endometriosis

➡ interdisciplinary work can be planned in advance

#### Bladder involvement

#### Bowel involvement

#### Adenomyosis

#### Endometrioma

#### Hydronephrosis
other imaging

- MRI
  - fat saturated MRI (minimal size 4mm for detection)
  - MR Urography: Ureter-anatomy and topography
- ING in case of obstructive uropathy

define goals of surgery

- Removal of symptomatic lesions
- In the case of infertility:
  - try to restore functional anatomy
  - preserve or reconstruct Organs

precise preoperativ diagnosis

- allows you to
  - inform the patient about the required surgery
  - address specific risks of planned surgery
- can save organ function (kidney)
- reduces the incidence of inadequate or partial surgical treatment
- reduces the cost and suffering associated with inadequate treatment

Preoperative workup

- Informed consent is given to the patient
- Record pertinent non endometriosis-related medical history
- Schedule surgery with the adequate, if indicated, interdisciplinary team:
  - general surgeon for bowel resection
  - urologist for Bladder/ureter/kidney resection

day of admittance

- Reexamination of the patient
- Signing the informed consent for surgery
- Gynecological and anaesth. admittance management according to our guidelines
- Bowel preparation for bowel resection
- Preoperative patient presentation to Prof. Keckstein
- OR plan
### Postoperative Handover
- Recovery-room
- ICU
- Ward

### Daily Ward Care
- Control residual urine in all patients with DIE
- After Bowel surgery:
  - fast track according to our guidelines
  - removal of intraabdominal drain after bowel movement
- After Bladder surgery:
  - drainage of the bladder for approx. 10 days
  - retrograde cystography prior to removal of drain
- Ureteral surgery/Psoas Hitch: interdisciplinary care
  - DJ for approx. 3 weeks (or as ordered by urologist)
  - ultrasound control of kidney(s) after removal of DJ

### Daily Ward Care
- Patient is informed about her surgery (intraoperative videos)
- Patients with DIE have the opportunity to:
  - read about endometriosis (brochure)
  - receive psychological support
  - get a diet counseling (bowel resection)
  - enrol in an rehabilitation program

### Detection of Complications
- Postoperative bleeding
- Bladder dysfunction
- Infection
- Leakage of sutures (bowel, ureter, Bladder)
- Paralytic Ileus
- Injury of bowel, bladder, ureter

### Discharging Patient
- Final examination of the patient includes
  - gynecological examination with TVU and kidney ultrasound
  - detailed interview addressing questions of the patient
  - oral and written postoperative care plan
  - oral and written recommendations for further treatment

### Discharge Management
- Gynecological examination with ultrasound of the kidneys
- Review surgical procedure with the patient
- Address
  - questions of the patient
  - post-operative care
  - possible need for rehabilitation
  - advise patient for the future
The Perfect Operating Room – A Future Vision?!
How Can We Improve Organization and Equipment in the Meantime?

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I have no financial relationships to disclose.

The participant will:
1. Describe marketplace influences on the practice of medicine.
2. Discuss value disciplines influencing the business of medicine.
3. Describe the relevance of evidence based practice in the marriage of practice and technology.
4. Determine practical examples of improving operating room efficiency through process redesign.

A System Focused on Health and Well-Being

- Medicine is evolving to a system focused on health and well-being.
- This system will be rewarded more for keeping people healthy and out of the hospital and less for treating those that are hospitalized.
- A high percentage of hospital admissions may be considered a failure in our system’s ability to keep patients healthy.

Evidence-based Clinical Practice Guidelines

- Individualized, patient-centered care at the point of care
- Standardization of clinical documentation
- Enhanced patient safety
- Improved clinician satisfaction & staff retention
- Streamlined regulatory compliance
- Safe streamlined care based on current evidence

Value Disciplines

1. Customer intimacy (service/relationships)
2. Product leadership (innovation/R&D)
3. Operational excellence (efficiency/effectiveness)

The best organizations make a choice of one discipline and, with rare exception, can’t excel in two. Health care will need to be that rare exception in the future. One discipline won’t be enough for providers. And once the transformation to two is complete, the result for patients will be better medical care at lower prices.
Customer Intimacy
Service/Relationships

- An obsession with the core processes of solution development (helping the customer understand exactly what is needed), results management (ensuring the solution gets implemented properly), and relationship management
- A business structure that delegates decision-making to employees who are close to the customer
- Management systems that are geared towards creating results for carefully selected and nurtured clients
- A culture that embraces specific rather than general solutions and thrives on deep and lasting client relationships

Product leadership
(innovation/R&D)

- VR Surgery and Validity:
  - Face: Realistic look and feel
  - Content: Useful as a training tool
  - Construct: Ability to distinguish between Novice and Expert users
  - Concurrent: Compares to a similar or related construct (dry or tissue labs)
  - Predictive: Predicts actual performance in the OR

The Evolution of Practice and Technology

October 6, 2013 - October 10, 2013
American College of Surgeons 99th Clinical Congress (ACS)
Washington, DC

October 3, 2013 - October 5, 2013
Clinical Robotic Surgery Association 5th Worldwide Congress (CRSA)
Washington, DC

October 22, 2013 - October 26, 2013
31st World Congress of Endourology & SWL (WCE)
New Orleans, LA

November 7, 2013 - November 10, 2013
Society of Robotic Surgery (SRS)
Lake Buena Vista, FL

November 10, 2013 - November 14, 2013
42nd AAGL Global Congress on Minimally Invasive Gynecology
Gaylord National Resort, Washington, DC

Improving Operating Room Efficiency

- Process Redesign
  - redesigning the process that occurs between operations would lead to a decrease in nonoperative time (NOT = room turnover time plus anesthesia induction and emergence time).
- Integration of resource management activities
  - Improved profits
  - Performance management improvement
  - Maximized resource utilization
  - Streamlined workflow
  - Supply cost reductions
  - Enhanced care delivery

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11. info@MimicSimulation.com
the perfect operating room—a future vision?! How can we improve organization and equipment in the meantime?

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Disclosure

I have no financial relationships to disclose.

organization

- Checklist coordinator
- Standardized performances
- Operating room charta
- Joint Commission International

communication

- Skills for teamwork
  - efficient exchange of pertinent information between members
  - shared understanding of the situation
  - coordinated team activities

equipment

- Centralized control of the operating room
- Ergonomic and user-friendly design
- audio-visual communication
- 3-D camera

training

- Teletraining with OR 1
- Worldwide Congress participation
future vision

- Automated planning
- Core competencies
- Team satisfaction
- Reduction of setup and turnover times
- Availability of patient’s information during surgery
- Optimal room booking
- Optimal resource utilization
Marketing Your Team and Social Media

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Challenges of Marketing

1. Cost – budget
2. Current/traditional – education - what’s new/decreased morbidity/improved results – be a "resource"
3. Technology – social media - connect with people on a more personal level, allow patients to become more familiar with who you are – develop relationships – "between you and the patient".
4. Identify your audience - where are they?
5. Research – what’s worked in the past (you & others).
6. Identify your goals – increase patients/surgeries?
7. Transparencies – people are always being sold things - must be “down to earth” – not a sales pitch – today’s consumer is more aware than ever before about being taken advantage of.

Marketing Budget

• Determine “marketing budget”
• Determine who will manage the budget
• What are the goals – bring in more patients to the practice?
• Determine the breakdown of spending for marketing – internet, tv ads (very expensive), newspaper articles.....take advantage of things that are less expensive....focus on education....cost of having a designated person for the internet.....

Breakdown of Marketing

• TV and radio ads
• Social media – internet (domain name)....
• Presentations – locally and nationally (webinars, podcasts.....)
• Publications – magazines, newspapers etc.
• Interviews – news, internet, meetings.....
• Educational opportunities for the community....giving talks at local events
• Local and National organizations....Endometriosis Association, Rotary Clubs, Hospital sponsored events for the community....

Social Media – anything that promotes an exchange with people – there are different types of communication

• 1:many but still allows for 1:1 communication
• Can consume it but also can interact with - which makes it unique
• Social media or social networking – used interchangeably
• Facebook and/or twitter
• Youtube
• Blog – tumblr (a platform) for a type of blog
• Linkedin
• Flickr
• instagram

Disclosure

I have no financial relationships to disclose.
Popular Types of Social Media

- Twitter
- Facebook
- Website for your practice (exchange)
- Internet blog (communication) – Tumblr (a platform for a type of blog)
- Internet groups (exchange among people and possibly health care providers)
- Videos online - YouTube, Surgery U – may be a component of an exchange
- Associations – many have their own social media/blogs etc.
- Webinars – online presentation that may have an exchange format
- LinkedIn – professional exchange
- Flickr – exchange often involves photos
- Instagram – exchange with photos and may be linked to Facebook

How to begin - develop a domain name

- The name of your practice or group – website
- Many groups use that name for their social media (facebook, twitter etc) – can make continuity easier and less “invasive” to the health care provider (security)
- Must have a person who regularly responds especially for “social media” – regular exchanges.
- For instance if it’s endometriosis, maybe it’s a person that has or has had endometriosis that is employed for this purpose
- Could be the physician who responds.

The “Social Media Process” –
1. person looks at a website (information/education) – COEMIG designation
2. they communicate with us via social media (facebook/twitter…)
3. develop a relationship with the patient – build trust, give the patient a sense of who you are and what it would be like for them to be a patient in “your practice”

Your Team

- Have an informational website about your team – helps develop a level of comfort for patients….may not include an exchange.
- Focus on education – what your team does that benefits patients….opportunity for Q&A
- Website has educational articles – discusses new techniques….Q&A
- Blog on website for patients or other health care providers (discussion)….blog possibly
- Podcasts – educational – may include exchange format.

YouTube

- Surgery videos
- Videos of your team
- Videos of instrumentation and equipment
- Educational videos
- Show various procedures
- Patients interviews
- Team members speaking about what they do

Twitter or Facebook

- Having a dialogue/conversation with users/customers in a way that traditional marketing doesn’t allow – an exchange/a conversation….you engage your customers
- Ongoing updates – have someone who manages this – once you begin you need to continually update
- Q & A
- Comments from others who read this
- Be prepared to respond to negative comments
- Not all comments will be positive
- Weigh pros and cons to interactions with others
How to measure the success of your marketing

- Track how many hits you get on your website
- Track comments
- Have patients fill out questionnaires or how they heard about your practice
- Analyze where your patients come from
- Referral sources
- Ongoing research of marketing
- Is the goal being achieved – ways to improve

Inherent challenges in measuring the success of social media marketing

Must look at “short term” and “long term” – quality not just quantity
1. If you have 1,000 followers on twitter or facebook it doesn’t matter if they don’t become patients...
2. New patients – questionnaire – ask specifically if they follow you on facebook/twitter...
3. Medicine is unique – much of your audience includes people who seek you out...the challenge is to connect with people who are not actually looking for you.
4. We are specialized – what we are offering is not relevant to everyone
5. Make your presence a “resource” to engage people who need your services.
6. After someone has become a patient – how do you keep them coming back – make it a resource – something people will want to come back to and continue to engage with you.

Pros and Cons of Social Media

- Be aware that the pros can be many – way to interact and hopefully have a positive impact with large numbers of people and possibly facilitate in education, attracting new patients....
- Security – be careful not to put personal information – unfortunately some people have other ideas so you must be careful.
- Negative comments about a practice, surgery, hospital, physician – whether warranted or not, be aware and be ready to respond in an appropriate manner if you deem that to be appropriate.

Social Media

- First check what’s out there.
- Get ideas.
- Talk with some “experts.”
- Have input from someone who is “computer” savvy.
- Necessary to be up with the times.
- Don’t start until you or your designated team member/members are ready.
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166,”Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

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If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.