The Operative Note

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"No job is completed until the paper work is done." This cannot be more true than in healthcare—no surgical intervention can be considered completed until the operative note is done. The operative note is an essential part of the patient's medical care and records. It is part of the expected standard of care in all hospitals accredited by The Joint Commission or other international hospital accreditation organizations. Most hospitals delineate in their bylaws or policies and procedure manuals their expectations for prompt and accurate documentation of operative procedures. Many hospitals use a 24-h limit to have this note dictated. Not fulfilling such documentation represents a deviation from the standards of care.

The operative note is an integral part of the medical care provided to the patient and reflects the quality of care delivered. Its value may not be immediately apparent, particularly to the harried surgical resident. If the patient does well and does not require any further care for that problem, it may become a purely historical document. However, its value cannot be underestimated when a patient presents in the future needing additional related care at the same or another healthcare facility. Such need may arise when the original healthcare provider is no longer available and a different healthcare provider is going to assume care of that patient. Similarly if another operation becomes needed in the future, the pertinent details of what was performed during that operation cannot be undervalued.

Consider a patient with an aortic graft infection or aortoduodenal fistula. This patient will require an operation to correct the problem; and, like all reoperations in the same surgical field, the exact details of the original procedure become crucial. Thus, in the case cited, it is very important to know the location and configuration of the aortic anastomosis, whether it was performed using an end-to-end or end-to-side configuration. It is also crucial to know if the surgeon was able to place the aortic clamp in the usual infrarenal position or whether suprarenal clamping was necessary to allow for the construction of the proximal anastomosis. Such details are essential for the proper planning and selection of the most appropriate treatment option in the typically challenging reoperative situation. Trying to tackle this problem without knowing such details can further complicate the management of such patient resulting in a suboptimal outcome.

Similarly consider a patient with Crohn's disease requiring a second or third operation to manage yet another complication of the inflammatory bowel disease, where additional small bowel resection is anticipated. It is very important to know what was done or resected in the prior procedures and the length of the remaining small bowel to select the most appropriate surgical management.

Proper documentation is also necessary for ensuring payment for the procedure performed. The details will be necessary so that the appropriate CPT® (Current Procedural Terminology®) codes are submitted and charged. Such codes may vary depending on the extent of the procedure. For example, the coding for skin grafting will depend on the surface area covered. Similarly, reimbursement for stab phlebectomy of varicose veins will vary depending on whether the number of phlebectomy sites performed is greater or less than ten stabs.

For reimbursement purposes, the procedure must be indicated and must have been performed and clearly documented. "If it is not documented, it is not done." If it is not legible or understandable, then it can be viewed as not done. If the charts are audited for billing and the documentation does not reflect the billing submitted, the surgeon will be required to pay back what was not properly documented even if it was performed, along with whatever fines may be deemed necessary.

Proper documentation is also mandatory for risk management. Should an adverse event occur and the case is being reviewed for by a malpractice attorney, the operative note

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may be the surgeon's best ally or his worst foe depending on the documentation level. Adverse events can occur during an operation in the best of hands. Attempts at covering them or avoidance of describing them in the operative note and clarifying how they were managed can reflect negatively on the surgeon when the case is being reviewed. Consider a patient with hoarseness following a thyroidectomy or tongue deviation following a carotid endarterectomy. The operative note should indicate whether key structures were identified or spared such as the recurrent laryngeal nerve or the hypoglossal nerve.

The operative note follows a standard form and must include all of the essential information. It should be inclusive but not redundant or verbose. The following elements should be included in every operative note:

- The preoperative diagnosis
- The name of the procedure
- The postoperative diagnosis
- The indication for the procedure
- Clear description of the procedure
- Postoperative condition

(This will be discussed in the clear description of the procedure.) The *preoperative diagnosis* will reflect the medical condition for which the procedure is being performed. The *name of the procedure* will summarize what was done intraoperatively and is often used to guide coding and subsequent billing. The *postoperative diagnosis* will identify whether the operative findings were supportive or different from the preoperative diagnosis.

The *indication* section is a very essential part of the operative note as it will reflect the thinking process and frame of mind of the surgeon prior to the operation. It will clarify the justification for the operation that will be used if the case is being audited for billing issues or for malpractice litigation. It will also allow the surgeon to clarify the reasoning behind selecting one approach versus another. It should document that the case was discussed with the patient and that the procedure was explained to the patient along with its risks and benefits. It will further confirm that an informed consent was obtained and who were involved in the decision-making form the patient's side and family.

The *description of the procedure* is the crux of the operative note and should include several components. These components include the time-out, anesthesia type, monitoring lines, Foley catheters, position, prepping and draping, incision type, intraoperative findings, pertinent structures identified and protected, and the details of the procedure performed. The details of the procedure performed will include the anatomic location, specimen resected, viability of remnants, configuration of anastomoses, staples or hand sewn, any testing of anastomosis, placement of drains and tubes, and finally the closure technique.

The operative note should clearly indicate that a "time-out" was performed to confirm the patient identity, procedure, and correct site of surgery. It should clarify the position of the patient for the operation and clarify whether the positioning was performed according to the expected standards. The positioning will clarify how the arms were placed, whether cushion pads were used to support bony prominences and protect for any skin ulcerations or nerve compression or stretch in select positions.

The anesthesia used for the procedure should be clearly documented in the note along with the monitoring lines or catheters inserted. The method of prepping and draping is routinely included in the note. The next element is to clarify what type of incision and the location of the incision. The intraoperative findings are noted. It is very important to clarify and document the intraoperative findings in the operative note, especially if there were unexpected findings or if they caused a change in the procedure or the original planned intervention.

Always discuss and document whether important vulnerable structures were identified and protected, such as a recurrent laryngeal nerve during a thyroidectomy and a vagus or hypoglossal nerve during a carotid endarterectomy. The procedures performed should be clarified, and if any prosthesis was used, clear indications of the type and size of the prosthesis used should be documented, the conduct of any kind of dissection, the extent of the dissection, the steps until the completion of the procedure, and finally the closure of the incision. Finally it is also important to comment on the patient's condition upon the completion of the procedure. All these elements are very essential as they provide a clear documentation of the indication for what was performed and how it was conducted. Such documentation will allow other healthcare providers to care for this patient in the future if the patient care was transferred to another location or to another state or if the initial surgeon is no longer capable of providing care or if the patient wishes to switch to another healthcare provider. Such note will provide the necessary documents for billing and auditing purposes and for risk management.

It is a fine line between having a verbose and redundant operative note and a clear and to-the-point note that provides the needed information. Suppose you were to read the operative note two years after the surgery was performed. Would it provide sufficient level of detail that you could easily visualize what was done and why?

There are reports indicating that the use of templates may be helpful in some patients to avoid missing key important information in the management of these patients (DeOrio 2002). Having templates for dictations or to describe the operative notes allows the surgeon to use a systematic approach to the dictation that will not allow for missing any important information and could allow for better patient

care (Elit et al. 2006). How to prepare an appropriate operative note was rarely taught or instructed to the budding surgical residents starting their surgical training. Such need was identified and addressed by a book entitled *Operative Dictations in General and Vascular Surgery*, coedited by Carol Scott-Conner and Jamal J Hoballah (2011), which has served as a companion to Chassin's textbook. This has been a very useful educational resource to the surgical residents in training as a quick guide prior to performing a surgical procedure or in preparation for the certifying part of the American Board of Surgery examination.

Finally it is very valuable that a surgeon keeps copies of his/her operative notes. The electronic medical records facilitate the ability of the surgeon to maintain soft copies of all his/her operative notes in an organized and manageable manner.

In summary the operative note is a solid reflection of the care provided. It is the responsibility of the surgeon to ensure that the essential elements of a surgical procedure are promptly documented in an accessible operative note.

References

DeOrio J. Surgical templates for orthopedic operative reports. Orthopedics. 2002;25:639–42.

Elit L, Bondy S, Chen Z. The quality of the operative report for women with ovarian cancer in Ontario. J Obstet Gynaecol Can. 2006;28(10):892–7.

Hoballah JJ, Scott-Conner CEH, editors. Operative dictations in general and vascular surgery. 2nd ed. New York: Springer Science + Business Communication; 2011.