

Position Statement

Reimbursement of the First Assistant at Surgery in Orthopaedics

This Position Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

The rising cost of health care has prompted government and private insurers to seek ways to contain those rising costs. Given the wide variation in the use of physician first assistants at surgery, policy makers are questioning whether physician first assistants are always necessary.

The members of the American Academy of Orthopaedic Surgeons (AAOS) are concerned with quality orthopaedic care, and also concerned about how rising costs of insurance may affect the delivery of care. The purpose of this position statement is to assist orthopaedists in working with third party payers to reduce expenditures for physician first assistants while protecting the health and safety of the patient.

Role of the First Assistant

According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital.

"The first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)."

How does the operating surgeon determine if an assistant is necessary and, if so, what level of training is required? The surgeon's first responsibility is to assure good patient care. The quality of an outcome of an orthopaedic procedure is dependent on several factors; among them are the characteristics of the operation itself, the condition of the patient, and the characteristics of the operating environment.

Characteristics of the Patient

While the risk and complexity of the procedure are major considerations, other criteria include the following:

1. Urgency of the patient's condition. An example would be the need to internally fix a limb with vascular compromise.
2. Patient's age and general medical condition including morbid obesity.
3. Cardiac, pulmonary, metabolic or hematologic factors that may cause complications with increased operative time or blood loss.
4. Operative complexity.

Characteristics of the Operation

In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include:

1. anticipated blood loss
2. anticipated anesthesia time
3. anticipated incidence of intraoperative complications
4. procedures requiring considerable judgmental or technical skills
5. anticipated fatigue factors affecting the surgeon and other members of the operating team
6. procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams can be cost effective.

Characteristics of the Operating Environment

The use of a physician first assistant varies geographically across the country, but also varies even among local institutions, in such settings as university hospitals, military facilities, community hospitals, and self-contained HMOs. Variability is also due to the availability of other assistants, such as resident staff in teaching hospitals or high quality non-physician technical assistants. There also may be equipment aids to surgery, such as positioning devices, retractors, and power tools, that may serve to minimize the need for skilled assistance. It should be noted, though, that while these devices are helpful (and, at times, essential), they frequently require skilled assistance to operate or monitor.

Conclusion

While consensus seems to exist on the variables to be considered in determining the need for a trained first assistant, little consistency exists as to the most appropriate type of assistant. Some orthopaedists routinely use technical assistants in cases for which other orthopaedists prefer a second orthopaedist. While lists of procedures might seem useful, it should be recognized that such lists can never be all-inclusive. The ultimate decision as to the need for a surgical assistant must remain with the operating surgeon. To do otherwise would jeopardize the quality of care.

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Position Statement 1120

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