
CORRESPONDENCE

ANESTHESIA CARE PROVIDERS' BASED INTERDISCIPLINARY PERI-OPERATIVE CROSS-OVER POST-MARKET - SAFETY- SURVEILLANCE: IS IT FUTURISTIC PATIENT SAFETY IDEA? RUNNING TITLE: POST-HIRE PMSS FOR INTERVENTIONISTS

DEEPAK GUPTA *

Education and practice of medicine potentially provides an unexplored avenue for anesthesia care providers wherein currently practiced anesthesia care providers' initiated quality-assurance (QA) can grow out of the bounds of peri-anesthesia events. These QA processes should expand into anesthesia care providers' based interdisciplinary peri-operative cross-over post-market (post-hire) safety surveillance (PMSS) as similar to PMSS for devices¹ and drugs². Anesthesia care providers witness plethora of surgical interventions, multiple ways of performing same interventions and comparative peri-operative variability across surgical operators. Hence, their understanding of peri-operative outcomes with system- and operator-based risk factors can guide them to generate a local and indigenous rating system for operators that guide (a) the operators themselves, (b) their supervisory administrators, and (c) their paying patients to make appropriate decisions wherein consequently (a) the operators are given procedure-specific privileges based on their personal understanding of their limitations, (b) the administrators' decisions are guided by statistical analysis of local peri-operative outcomes and (c) the patients' shopping capabilities are enhanced by transparent local ratings of the operators' procedures-specific proficiency.

The cross-over will be the operators themselves preempting similar avenues for the administrators who may decide against blanket privileges³ for the anesthesia care providers who themselves by default are practitioners of procedural medicine. This PMSS will not mean an excuse for letting go personnel but healthcare-generated wealth will be re-distributed according to the health care providers' proficiency as adjudged by local patient outcomes. Redistribution according to dynamics of allowable and restricted procedure-related privileges will ensure each interventionist gets his/her share without losing his/her elite economic status in the society. The secondary benefit will be that the rising incomes of proficient proceduralists will inspire peer practitioners to either accept their limited access to perform procedures or improve their proficiency to target top end elite salaries⁴⁻⁵.

* MD.

Affiliation: Department of Anesthesiology, Wayne State University/Detroit Medical Center, Detroit, Michigan, United States.
Corresponding author: Dr. Deepak Gupta, Box. No. 162, 3990 John R. Detroit, MI 48201, United States. Tel: 1-313-745-7233, Fax: 1-313-993-3889. E-mail: dgupta@med.wayne.edu

The new PMSS will be asking simple questions to the anesthesia care providers that whether they would want the particular operative procedures performed upon them or their next of kin by operators being rated. Analogously, the operators would be asked whether they would want specific anesthesia procedures and specific practice of anesthesia provided to them or to their next of kin or to their patients by anesthesia care providers being rated. Though the documentation of interventionists' rating per procedure will be a three-pronged question "Definitely-Not Sure-Never" and the cumulative datasheets generated will reflect percentages per rated procedure for the interventionists, these comprehensive datasheets will be restricted for limited personal as well as in-house management. However, the selective datasheets that reflects only the proficiency "Definitely" data (and not the deficiency "Never" data) of rated interventionists will be shared with the future patients who will have electively decided to undergo the rated procedure at the rating health institution, and will need in-house informational support in terms of health institution's local rating systems of its interventionists.

Although in-house QA processes already exist, the perceptive positive reinforcements ("I prefer this interventionist for me and/or my next of kin" instead of "I do not prefer this interventionist for me and/or my next of kin") from these in-house processes will be able to percolate into the awareness of future patients who are coming for elective interventions. Moreover, compared to lay persons, the educated peers would be better guides for the prospective patients so that they can make informed decisions based on their choices as well as the urgencies of their clinical situations where-in deciding for/against the rated operating interventionist is an immense question for the patients.

When evaluating a care-giving system where focus is only on prevention of mortality, that system is apparently visualizing only the tip of iceberg. The iceberg of patient safety is constituted of unappreciated or under-reported morbidities that can be easily quantified by continual QA/PMSS processes with potential corrections/preventions by pre-emptive re-allocation and re-organization of the locally and objectively peer-rated interventionists' teams in question. Hence, the sole aim of this PMSS will be to ensure constant

vigilance and regular review about procedure-specific privileges based on patient outcomes secondary to mortality and morbidity as well as supporting medical staff's perceived outcomes secondary to near-hits-near-misses so that the operators (including anesthesia care providers) can themselves find their niche in any of the following: (a) blanket clinical privileges (b) restricted procedure-specific privileges (c) academics (d) research (e) administration-management⁶. This will ensure that the providers' remunerations do not cease but the proportions of avenues (clinical privilege based, experience and seniority based, local patient outcome based, academics based, research based, and managerial based avenues) generating these reimbursements are safer for the patients, the administrators as well as the operators wherein clinical interventions involving the major risks for patient safety are only performed by the interventionists proficient in those areas as adjudged by the continual QA/PMSS processes whereas not-so-safe proceduralists can primarily focus on other avenues as well as interventions that involve only minor risks for patient safety.

The local ratings system cannot be anonymous to avoid the appeasing traits of the inter-dependent peers as well as to ensure that the PMSS raters stand by their ratings performed daily with each patient encounter/procedure performed by the rated operators. Another avenue as a direct result of this PMSS process is that there will be a need for creating transient phase of provisional restrictions to blanket privileges. The interventionists will be allocated to the transient phase when they will be learning new techniques or adjusting their old techniques to timely improve their worsening outcomes/ratings. Similarly, the permanent restrictions to blanket privileges will not mean that these restrictions cannot be overturned depending on the vigor of the rated interventionist who is ready to learn and improvise. This arrangement will always be dynamic because PMSS process will not be meant for vindications but to honestly aim at preemptively acting in response to personal failures that, if overlooked, can affect the patient safety outcomes.

Every process (including PMSS) will always have a paradox of an eventual slippery slope. However, the intentions are clean and honest so that base salaries and base stature of interventionists will not change; and only

the transcendental salaries will be at constant dynamic adjustment pathways according to the interventionists' prowess and proficiency for the procedures as well as their results and patient outcomes. The rating systems will ensure that the salary adjustments are transparent without any malign. In summary, analogous to PMSS for drugs and devices, the novice application will

ensure post-hire PMSS for operators/interventionists by interdisciplinary peers who will apply lay persons' understanding, interpretations and sensibilities but will possess more than just lay persons' experience in regards to medical knowledge, clinical skills, communication skills, decision-making capacity and professionalism when rating an interventionist.

References

1. FDA.gov <http://www.fda.gov/MedicalDevices/Safety/CDRHP/ostmarketSurveillance/default.htm> Accessed on March 26, 2014.
2. FDA.gov <http://www.fda.gov/drugs/guidancecomplianceregulatoryinformation/surveillance/ucm204091.htm> Accessed on March 26, 2014.
3. BARASH PG, CULLEN BF, STOELTING RK, CAHALAN MK, STOCK MC, ORTEGA R (Eds): Handbook of clinical anesthesia 7th edition, Ch. 2, Wolters Kluwer Health/Lippincott Williams & Wilkins, Philadelphia 2013.
4. Medscape.com <http://www.medscape.com/features/slideshow/compensation/2013/anesthesiology> Accessed on March 26, 2014.
5. MACINTYRE P, STEVENS B, COLLINS S, HEWER I: Cost of education and earning potential for non-physician anesthesia providers. *AANA J*; 82:25-31, 2014.
6. REICH DL, GALATI M, KROL M, BODIAN CA, KAHN RA: A mission-based productivity compensation model for an academic anesthesiology department. *Anesth Analg*; 2008, 107:1981-8.