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# I do not believe (have faith) in this: Can I say NO?: Future of Post-Hire Post-Market-Safety-Surveillance (PMSS) for Physicians

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# I do not believe (have faith) in this: Can I say NO?: Future of Post-Hire Post-Market-Safety-Surveillance (PMSS) for Physicians

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## My opinion

When the author had conceptualized post-hire Post-Market-Safety-Surveillance (PMSS) [1] for physicians in general and operating room personnel in particular wherein their co-workers and supporting staff may futuristically rate the individuals in question regarding how likely the rating personnel may consider the rated personnel medico-surgically managing their own selves or their next of kin, it was not considered what if the personnel do not have faith in this PROCESS of "co-workers' and supporting staff's rating and choose to refuse it. The primary reasons to refuse rating their team members/leaders could be variable.

The first question is, "I do not believe (have faith) in this PROCEDURE: Can I say NO?" It is a genuine concern wherein the raters can refuse rating a procedure that they will NOT consider for themselves or their next of kin. However, the ethical question arises whether they can assist a procedure that they will not even consider for themselves or their next of kin. The answer would be that it is the patient's choice that matters. That is correct but the proceduralists too may choose to transfer out a patient if their choices do not match. However, the matching of choices has yet not percolated to the supporting medical staff including anesthesia care providers wherein the question for supporting medical staff still remains, "I do not believe (have faith) in this PROCEDURE: Can I say NO?" A controversial example of surgical procedure can be robotic-assisted diagnostic-only laparoscopy wherein some third-party payers (medical insurance providers) may put forth their feet down and say NO. A correspondingly controversial example of anesthetic procedure can be epidural analgesia being disfavored by some surgical teams because their past experiences with peri-operative epidural analgesia among their patients may prompt them to say NO.

The second question is, "I do not believe (have faith) in this PROCEDURE for this PATIENT: Can I say NO?" This is the common peri-operative question and one of the goals for comprehensive preoperative assessments by both operative and anesthetic teams.

Patient-specific factors can make usually safe procedures potentially unsafe for specific patients and herein lies the decision-making burden on the teams to decide for/against a procedure in good faith taking into account the medical dilemma as well as the ethical dilemma. However, it is also valid to consider what the follow up consequences will be if either one or both teams say NO and decide against the performance of procedure. There can be three scenarios that can evolve: (a) the patients are managed with alternative medical/surgical options while they stay under the care of the same teams; or (b) the contradicting teams show resolve and partner with alternative collaborative teams to perform the procedures if the procedure rooms' scheduling processes allow these changes; or (c) the unsatisfied and un-resilient patients can choose to leave the care of the teams and find alternative operative and anesthetic teams on their own who can accommodate their wishes for the procedures despite patient-specific safety concerns raised by the original teams. An example of surgical procedure can be robotic-assisted laparoscopic procedure in steep Trendelenburg position in patients whose cardio-respiratory hemodynamics are intolerant to steep Trendelenburg position. An example of anesthetic procedure can be epidural analgesia in patients wherein there may be no clear-cut insertion guidelines if "these patients are being preoperatively medicated with newly-introduced innovative anti-coagulants and anti-platelet agents.

The third and final question is, "I do not believe (have faith) in this PROCEDURE for this PATIENT by this PROCEDURALIST: Can I say NO?" This one is the most controversial avenue because it is NOT available to all in a balanced way with equal opportunities for unpretentious say. Operative teams may have been choosing their supporting staff including anesthetic teams (overtly or covertly), (a) to maintain cordial procedure-room atmospheres for assumingly safer-work environments by ensuring easy-to-work-with supporting personnel, and (b) for their patients' safety wherein their patient outcomes may warrant them to personally know their anesthetic teams' and supporting staff teams' proficiencies and efficiencies in regards to assisting their procedures. Although futuristic idea of post-hire PMSS may open

up avenues for supporting staff members to follow their own personal convictions regarding assisting procedures, it is still a long way far ahead because the supporting staff members including the non-proceduralist anesthetic team members may be replaceable with more ease due to availability of alternatives/substitutes/replacements when required to assist a procedure as compared to their proceduralist-team counterparts who lead the execution of those procedures.

In summary, the informed choice by the consenting patient can be expanded and boosted by aware and educated dynamic inputs from the teams that include proceduralist members, supporting medical staff members as well as anesthesia care providers (either in the role of proceduralists themselves or just as supporting medical staff members). Probably depending on a choice for/against the PROCESS of co-workers and supporting staff rating their proceduralist team members per futuristic idea of post-hire PMSS<sup>1</sup>, it will be sometime before we can get firm answers for the evadable question "I do not believe (have faith) in this PROCEDURE/PATIENT/PROCEDURALIST/PROCES S: Can I say NO?"

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