

Pediatric Perioperative Environment: Should Hospitals and Anesthesia Practitioners Have Performance-Based Credentialing. The California Experience: Wave of the Future?

Community Hospital Perspective

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Introduction.

I finished my anesthesiology residency in the early 1980's and, as a redirected former surgical resident with aspirations toward pediatric surgery, I chose to spend an additional year of education and research doing a pediatric anesthesia fellowship. At the time of this decision I met with my department chairman at UCSF and outlined for him the general plan for the year, which I had worked out with the help of the faculty advisor who had consented to take me on. Beginning with a totally blank slate, we had sketched out a year that was about 2/3 clinical and laboratory research and 1/3 just doing cases in the OR. I had even arranged to do this latter part at the Children's Hospital of Philadelphia, which was gracious enough to make that possible. My chairman said it sounded like a very good plan, gave me his blessing, and that was it, no other formalities required. It was indeed a great year and near the end of it I got a phone call from a classmate who had recently begun his private practice career in San Jose. The anesthesia group that had recruited him as a "cardiac anesthesiologist", was looking for a "pediatric anesthesiologist", as part of their effort to add expertise or at least some cache to their roster. That was nearly twenty years ago and I've been there ever since.

During these years, pediatric anesthesia has been evolving into an increasingly important and more widely appreciated subspecialty. Along the way we have witnessed the formation and growth of the Society for Pediatric Anesthesia, the formal accreditation of pediatric anesthesia fellowships programs by the ACGME, and the many other related landmark events discussed by Dr. Hackel. In California there are 8 pediatric hospitals, and many large pediatric services within private, public and academic hospitals, including 23 with pediatric ICUs, according to statistics. Much of the surgical and anesthetic care of infants and children takes place in these settings, but also in much smaller community hospitals where these patients are cared for on an infrequent and sporadic basis. When I first joined my private practice group of about 15 individual anesthesiologists, virtually all of them provided anesthetic care for all types of pediatric surgical patients. The hospital had a level three NICU and therefore some very small and sick neonates sometimes required our services. Some of my colleagues welcomed these cases as challenging opportunities, but the majority held them in fear and dread. After I joined the department and a few years later another anesthesiologist with pediatric anesthesia fellowship training came along, the two of us ended up being asked to do these cases when they arose. Of course the other members of the department had less and less exposure to these patients and if both of us were out of town or unavailable when one needed surgery, usually on an emergency basis, it created a very uncomfortable situation for everyone involved. Eventually as our group grew, and with significant impetus from our referring surgeons and neonatologists, we developed a sub-group of

7 or 8 “pediatric anesthesiologists”, one of whom is on call 24/7, all having demonstrated ongoing clinical competence in managing these cases. We now even have a separate pediatric surgical center (2 rooms) within this community hospital, which provides a special family and child focus, and perioperative nursing skills especially devoted to that facility. I tell this history only to illustrate a pattern of evolution, which is occurring to some extent at many community practice settings throughout California.

BAYPAC, CSA, and CCS

In the 1980s an informal group of Northern California pediatric anesthesiologists began to meet regularly for discussions of common interest over dinner. Under the leadership of Drs. Alvin Hackel of Stanford and George Gregory of UCSF, this group became formally organized as the Bay Area Pediatric Anesthesia Consortium (BAYPAC), and adopted a mission of physician education and patient advocacy. The membership is diverse, representing Stanford, UCSF, UC Davis, Oakland and Fresno Children’s Hospitals, as well as many community practices. Several members of BAYPAC are also active in the leadership of the California Society of Anesthesiologists (CSA) and considerable exchange of information occurs between these two organizations. In addition to BAYPAC members, pediatric anesthesiologists from throughout California are well represented among the CSA leadership and discussions regarding pediatric anesthesia are commonly part of the CSA’s usual agenda.

Several years ago, California Children’s Services (CCS), a division of the Department of Health Services of the State of California was given a mandate to update and rewrite criteria and qualifications for anesthesiologists caring for beneficiaries covered by their funding program. These patients are generally neonates and children with complex or chronic medical problems. CCS’s current criteria for anesthesiologists, which have been in effect for many years, do not adequately address continuing competency measures, and even equate “training in pediatrics” with pediatric anesthesiology. Upon becoming aware of this opportunity, Dr. Hackel suggested that both BAYPAC and CSA offer to assist CCS in rewriting this portion of their Manual of Procedures. It was understood that although these new regulations would apply only to patients covered under the CCS program (a small fraction of the total pediatric surgical cases in our State), they would have, in effect, the force of law, and would perhaps set a standard for other State funded programs and conceivably even influence private health plans. It was therefore looked upon as an opportunity for us as anesthesiologists, in helping to develop these new regulations, to incorporate the principles of local medical staff authority and responsibility described in the AAP Guidelines. In addition, it was hoped that we might persuade CCS officials that new regulations placed upon anesthesiologists caring for certain categories of pediatric surgical patients, should properly be accompanied by outcome studies to assess the effect of such competency requirements on patient care and safety. CCS was initially enthusiastic about this collaboration and a technical advisory committee (TAC) was formed which included representatives from both BAYPAC and CSA. Although the TAC met many times over several years and made significant progress toward the development of a comprehensive policy based on the principles set forth in the AAP Guidelines, we have not met for the past 2 years and this work has not been completed. Although there are a number of reasons for this hiatus, much of the blame seems to rest with distractions created by the budget miseries of our State and political issues in Sacramento.

Los Angeles Times Articles and the Kaiser Hospitals

On February 24, 2003, an article appeared in the *L.A. Times* questioning the causes behind problems occurring during the administration of anesthesia in a Southern California hospital, resulting in the near-death of a 2 month old and the death of second 19 month old patient, both scheduled for routine, elective surgeries. Charles Ornstein, the *Times* reporter who wrote the article, sought the opinions of nationally recognized pediatric anesthesiologists who, upon review of hospital records related to these events, were highly critical of the quality of care provided to these patients. The report emphasized that this hospital had a relatively low number of pediatric surgical cases, and cited references to published studies linking lack of adequate experience to untoward outcomes. Most stunning however, was the revelation of internal email pleadings made by the hospital's anesthesiologists to the administration, that cases involving very young or complex pediatric patients be referred to another hospital, or that a contractual arrangement be made with "pediatric anesthesiologists" to provide care in such cases. There was clearly the strong suggestion that this group of anesthesiologists were being coerced into attempting to provide patient care beyond what they felt capable of performing safely. Mr. Ornstein noted the growing recognition of pediatric anesthesiology as an important subspecialty and also brought up the work being done by our CCS task force to develop statewide standards for pediatric anesthesia services.

A second article appeared in the newspaper on March 6, 2003, which again brought up questions about the experience and training of anesthesiologists providing care for young children and infants. It was reported that the hospital in question had established a new policy which requires that anesthetic care to children under 2 years of age be given by an anesthesiologist with "in depth pediatric training", of which there were 3 at this hospital. One of these was the newly appointed chief of anesthesia, an experienced pediatric anesthesiologist recruited from Northern California. The hospital, which was the subject of these two articles, is part of the Kaiser system, the largest and truly the original health maintenance organization in California. The Kaiser system in California is really two systems, one in the north and one in the south and they operate relatively independently. Because of the impact of the public exposure caused by these *L.A. Times* articles, the anesthesia chiefs of both the Northern and Southern California Kaiser Hospitals have begun a process to develop a refined policy with regard to anesthesia services for pediatric patients. This policy will include performance based credentialing as well as regionalization of pediatric cases identified as requiring a higher level of care. It has also been stated that outcome data will be collected in an effort to evaluate the impact of these policy changes on patient care.

The California Society of Anesthesiologists Policy on Pediatric Anesthesia

The impact of the *L.A. Times* articles was also felt strongly by the leadership of the CSA, which had become very familiar with the issues of pediatric anesthesia care, through its work with CCS in attempting to update their policies in this area. The CSA President, Patricia Dailey, MD, wrote a letter to the editor of the *Times* endorsing and supporting measures to improve the anesthetic care of infants and children. In addition, she, along with others, embarked upon an effort to have our State component society take a stand and create a model policy on pediatric

anesthesia. Using the published documents from the AAP and ASA as a guide, the CSA developed the following policy statement, which was approved by the CSA House of Delegates on June 7, 2003. It has been published in the CSA Bulletin, and is currently available on the CSA website (www.csahq.org).

CSA Policy on Pediatric Anesthesia

At institutions that provide pediatric surgical services, the medical staff should determine what pediatric surgical services the institution is capable of providing and establish criteria for privileging the anesthesiologists and surgeons.

1. Plan of Care

The medical staff should develop and maintain a written policy defining the perioperative care of pediatric patients that may be appropriately provided in the facility. The policy should be based upon considerations of age, risk categories, proposed procedure, facility equipment, support resources (laboratory, radiology, respiratory care) and the availability of anesthesiologists, surgeons, and pediatricians as well as nursing staff who are experienced in the pre-, intra-, and postoperative care of pediatric surgical patients.

2. Criteria for Privileging

The medical staff of individual patient-care facilities should determine criteria for anesthetic care for pediatric patients. Anesthesia for pediatric patients may be provided and/or directly and immediately supervised by an anesthesiologist with clinical privileges as noted below.

A. Regular Clinical Privileges

Anesthesiologists providing and/or directly supervising clinical care for pediatric patients should be graduates of anesthesiology residency training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) or its equivalent, should be board-certified or board-eligible and should have documented continuous competence in the care of patients in specified categories in order to maintain those clinical privileges.

B. Special Clinical Privileges

In addition to the requirements noted above, it is suggested that anesthesiologists providing and/or directly supervising the anesthetic care of patients in the categories designated by the facility's department of anesthesiology as being at increased risk for anesthetic complications (thus requiring special clinical privileges) should be graduates of pediatric anesthesiology fellowship training programs accredited by ACGME (or its equivalent) or should be fully credentialed members of the department of anesthesiology who have demonstrated continuous competence in the care of such patients as determined by the department of anesthesiology.

C. Minimum Case Volume to Maintain Clinical Competence

Any minimum case volume required to maintain clinical competence in each patient care category should be determined by the facility's department of anesthesiology, subject to approval by the facility's medical staff and governing board.

Responsibility and Autonomy of Individual Medical Staffs

Although I have described some of the adaptations that have taken place in my own practice to establish performance based credentialing for pediatric anesthesia, our department has only just begun to consider writing a formal policy defining it. Through the efforts of many pediatric anesthesiologists working through our various professional societies, the concept of establishment of a written policy on pediatric surgical and anesthetic care is being promoted. The agencies that accredit most free-standing surgery centers appear to have welcomed this addition to their accreditation manuals. The ASA has included such a statement in its document entitled "The Organization of an Anesthesia Department". As the implications of these changes begin to take shape, each of us, as members of our departments and medical staffs, need to participate in the process of assessing the capabilities of the practice setting in which we work. We should take a proactive role in defining optimal care of our patients and resist the economic and political forces that may undermine our professional responsibilities.