American Society of Anesthesiologists on Children’s Surgical Care

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We read with interest the article “Optimal resources for children’s surgical care in the United States” from the Task Force on Children’s Surgical Care.1

The American Society of Anesthesiologists (ASA) strongly supports the efforts of the American College of Surgeons (ACS) to ensure that the highest quality surgical and anesthetic care is made available to the most vulnerable of our pediatric patients. As a national organization representing a diverse membership of more than 52,000 physician anesthesiologists, ASA recognizes the importance of specialty training and dedicated centers of excellence when providing care for high-risk patients. The ASA is the leading provider of education for the practicing anesthesiologist and sponsor of the leading scientific journal in the specialty, and as such, ASA embraces its responsibility to continually advance quality and patient safety. We work closely with the Society for Pediatric Anesthesia (SPA) and the American Academy of Pediatrics (AAP) Section on Anesthesiology and Pain Medicine, which share our support for the concept of optimized care for the very young, complex, or critically ill child undergoing a surgical procedure.

Although we support the aims of the project and applaud inclusion of the physician anesthesiologist as an essential component of any effort to improve the care of children, we have concerns regarding specific recommendations in the document. The shift of a significant portion of pediatric surgical care from nonspecialty hospitals can be anticipated from implementation of these guidelines. Given that nonspecialty hospitals provide the vast majority of pediatric care, movement of these procedures to ACS-designated specialty hospitals may have a number of negative consequences, including reduced access to care in areas where specialized pediatric facilities and expertise do not exist. Directing children to a specialty center for routine care will unnecessarily burden parents who may be required to travel long distances. Even in urban areas, the inevitable shift in care from nonspecialty hospitals has the potential to overwhelm the capacity of pediatric specialty hospitals, causing resources needed for complex patients to be used by those undergoing more routine procedures. Obviously, such an effect is not in keeping with the stated purpose and goals of the document.

Anesthesia care of otherwise healthy children less than 1 year old undergoing common outpatient procedures such as routine ENT, urologic, and ophthalmologic procedures, and others, is routinely, safely, and appropriately performed in the community setting by physician anesthesiologists who have completed an approved anesthesiology residency and who are appropriately licensed and credentialed, although not subspecialty fellowship trained or boarded in pediatric anesthesiology. Pediatric care is a core competency in anesthesiology residency, as it is in most if not all surgical specialties. Individuals completing training in anesthesiology who choose not to seek fellowship training in pediatric anesthesiology are nonetheless well prepared for the routine care of otherwise healthy infants and older children with mild or moderate coexisting disease, when practicing in an appropriately equipped facility. Board recognition of pediatric anesthesiology is very recent, and most pediatric anesthesiologists currently practice in specialty centers where children with complex needs tend to be referred. However, it is important to reemphasize that most pediatric anesthesia care is currently provided in the community setting by properly trained, certified, and credentialed physician anesthesiologists without specific subspecialty training and certification in pediatric anesthesiology. Continued improvements in surgical and anesthetic care of infants and children are certain to require diligent planning, careful thought, and a significant period of time. Over time, additional information regarding age-related risk and the continued movement of pediatric anesthesiologists completing fellowship into private, community, and even rural practices may change the form, application, and effect of these recommendations.

Despite these concerns, the ASA, in partnership with the SPA and the AAP Section on Anesthesiology and Pain Medicine, stands ready to work with the ACS and other relevant groups to improve the surgical and anesthetic care of children in all settings.

REFERENCE


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