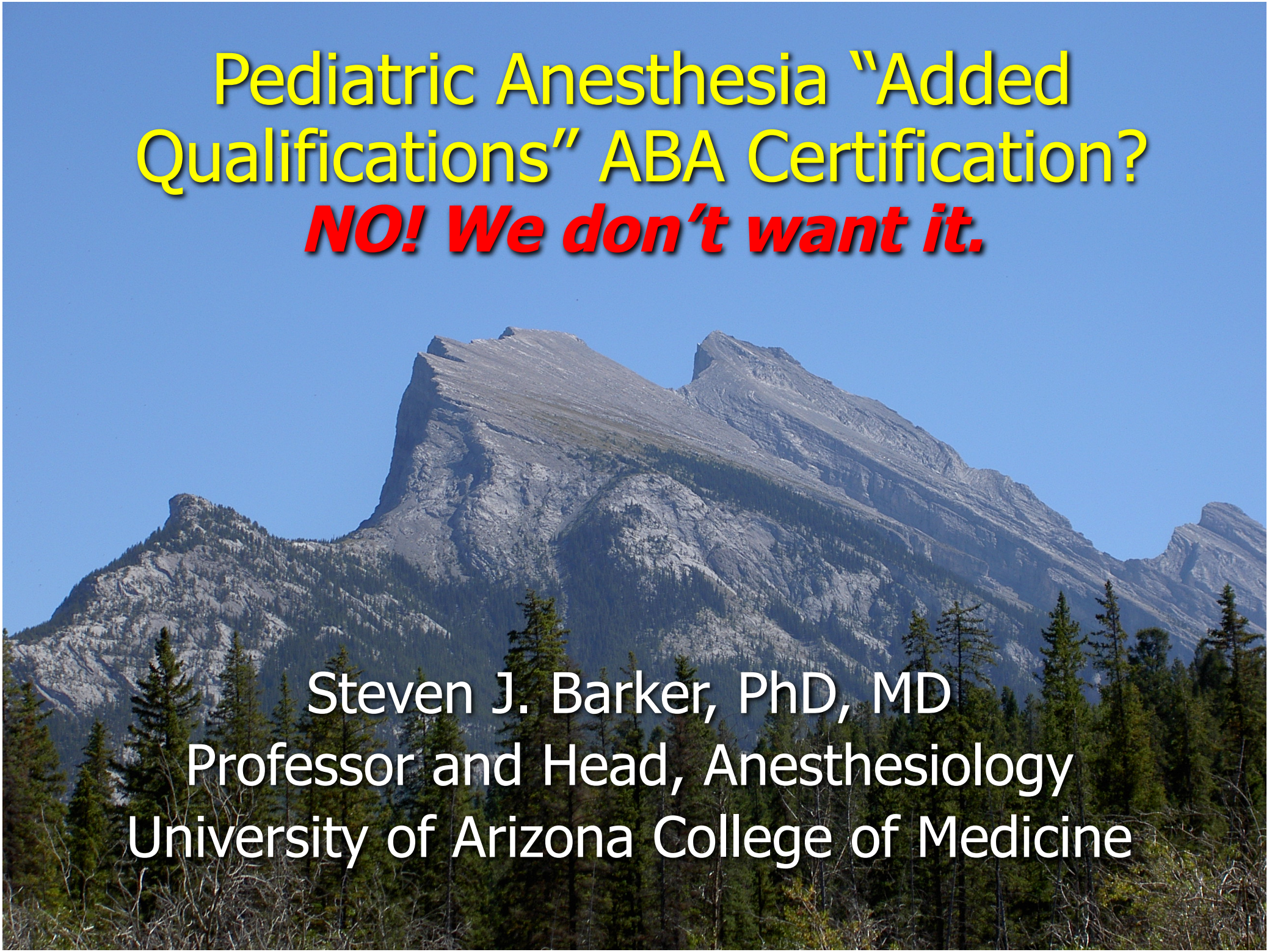
Pediatric Anesthesia "Added Qualifications" ABA Certification?
NO! We don't want it.
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Current Status:

- We have "boarded" (ABA Added Qualifications) subspecialties in Pain and Critical Care.
- *Important:* These subspecialties do not provide intra-operative anesthesia care.
- We have ACGME-accredited fellowships in Pediatric Anesthesia, with others coming soon.
- We have non-accredited fellowships in:

Current Fellowships:

Cardiac anesthesia*
Neuro-anesthesia
Obstetric anesthesia
Regional anesthesia
Ambulatory anesthesia
Vascular anesthesia
Geriatric anesthesia
Liver transplant anesthesia
Research
Others??

* Next to be accredited

Other Specialties that Need Fellowships *and Certification*?
(Reductio ad absurdum)

- Orthopedic Anesthesia: *Has been suggested!*
- Anesthesia for Head/Neck Surgery?
- Anesthesia for Gastrointestinal Surgery?
- Anesthesia for Ophthalmology?
- Anesthesia for Bariatric Surgery?
- Anesthesia for Difficult Surgeons?

CONSEQUENCES?

The four "THINGS"

Thing #1: *Who decides?*

- ~80% of pediatric anesthesia today is given by NON-fellowship trained anesthesiologists.
- Must we *require* peds boards for certain peds cases? Standard of care? *Of course we will!*
  - Which cases and **who decides?** (If you think we will, think again!)
    - Surgeons?
    - Patients (moms)? *This is already happening!*
    - Hospital administration?
    - Payers???? *You bet!*
  - Do we call in a "Pediatric Anesthesiologist" for an appendectomy on a 15 yr-old? 2 yr-old? 6 mo, septic?
  - Will payers *refuse to pay* if not done by Peds Anesth?

Pediatric Anesthesiologists: *Supply vs. Demand*

Year	# trained	ACGME slots
2006	108	150
2005	113	0
2004	104	0

- Even if every one of these does 600 peds cases/year, that equals 195,000 cases.
- *Plus,* every surgeon puts the kids first on the schedule multiple peds rooms.

Do they all need a Pediatric Anesthesiologist?

Thing #2:
Slippery Slope; Camel's Nose

- Same issues for cardiac anesthesia, *and:*
  - Does a "Cardiac Anesthesiologist" need to be called in for bring-backs?
  - Does cardiac person do <u>all</u> thoracic cases: thoracotomy, thoracoscopy, pacemaker?
- Imagine *all* these problems for:
  - Neuro, Liver, Obstetric, Geriatric, Vascular, Bariatric, Orthopedic, etc.

Consequences of this Trend:

- Remember our friends the General Surgeons:
  - *Spun off:* ortho, opthal, neuro, ENT, vascular, cardiac, plastics, urology.
  - "Department of Residual Surgery"?
  - Is this our future?
- We will have *LOTS* of call schedules!
  - We (U-AZ) already have call for: trauma/general/OB, cardiac, peds, pain, CCM, liver. *We have 27 faculty!*
  - How many other schedules will be added?

Consequences of Trend (2):

- Pay for all of these calls? *Of course.*
  - How do you value peds call versus heart call? *Chair plays referee.*
  - Where does the call $$ come from?
    - *Example*: Liver X-plant call at U of AZ.
- Which ones have to be In-House?
  - Who decides? *The chair?*
  - Acceptable response time from home?
- ***What is left for the rest of us?***
  - Anesthesia for cholecystectomy?

Thing #3:
Why did you select anesthesiology?

- Lifestyle? Money? *Are these the people we want?*
- **"Because I get to treat *ALL* patients with *ALL* diseases for *ALL* types of surgery!"**
  - ***That's what makes anesthesia challenging and fun.***
  - ***That is why we attract the "best and brightest" students today. Will we continue to do so?***

Thing #4:
CRNA's

- According to AANA, CRNA's are qualified and competent to perform:
  - ALL regional blocks, including neuraxial, peripheral, plexus blocks. *(AANA BOD, 1989)*
  - Insertion and interpretation of arterial, CVP, and pulmonary artery catheters, as well as TEE. *(AANA BOD, 1987, 2005)*
  - General anesthesia on **ALL** patients, including pediatric, geriatric, and everyone in between.
  - Chronic pain care.
  - In other words, ***they can do it all!***

Devil's Advocate:

I'm the hospital CEO, and it's budget time…

Anesthesiologists *OR* **CRNA's**

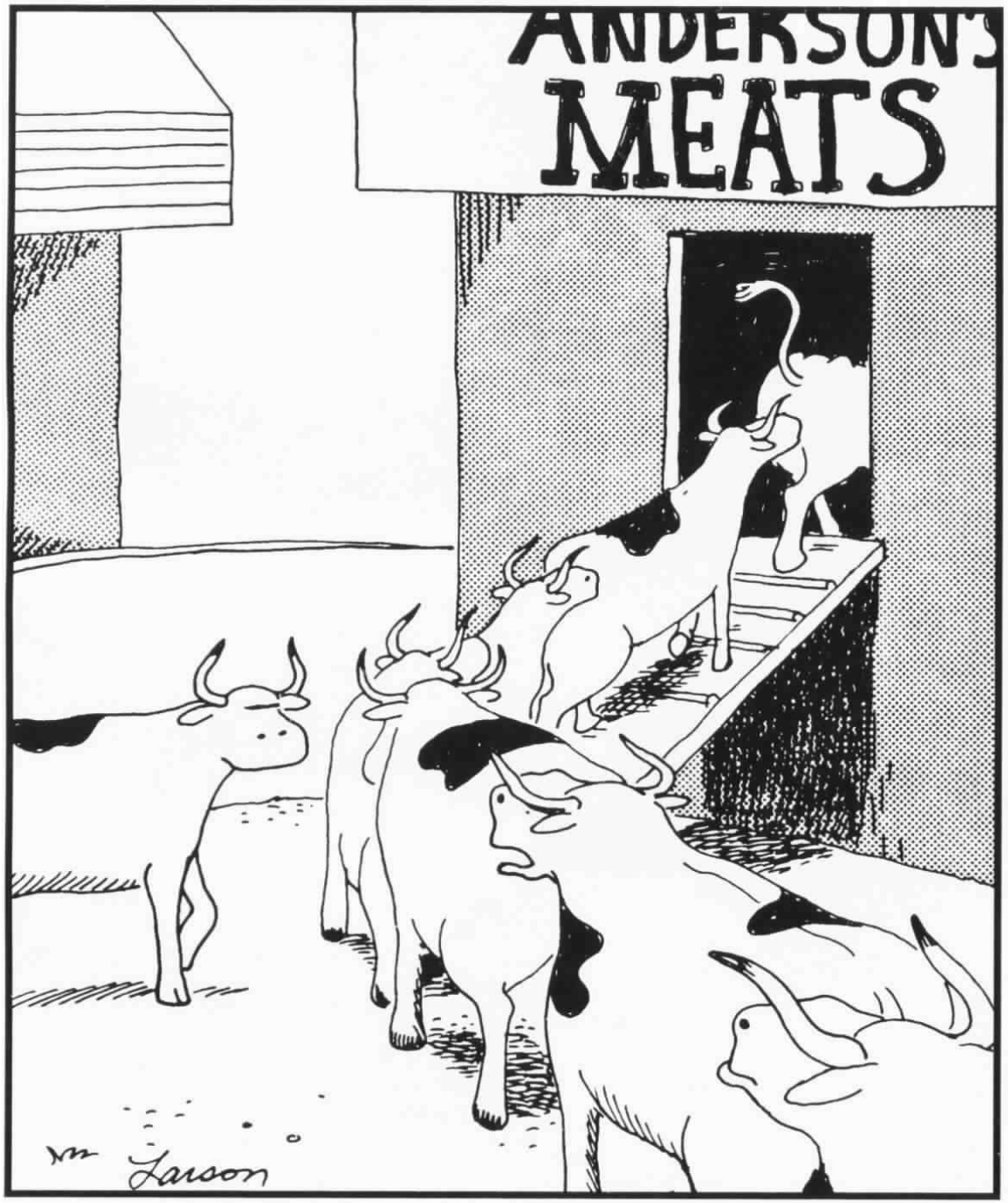
- Must have peds, cards, then OB, etc?
- Multiple call schedules – each one costs $$.
- Subspecialists cannot cross-cover.
- 'Generalists' can't do much of anything.

- They can do it all.
- Only one call schedule.
- Fewer FTE to cover whole hospital.
- Cheaper and just as good!

Let's see…. Which do I choose?

SUMMARY:

- As complexity of anesthesia knowledge increases, we are driven towards *"Balkanization"* – dividing our specialty into subspecialties that don't talk to each other. ***"Like a Surgeon!"***
- As we become more subdivided, our specialty has less appeal to the "best and brightest," *and* it is less fun.



"Hey! You! … No cutting in!"

Sometimes we should *not* follow trendy fashions, and *not* "go with the flow."

Be different!

RECOMMENDATIONS
from a curmudgeon

- **Use caution with the proliferation of subspecialties that will further divide anesthesiology.**
- ***NO*** **to "added qualifications" ABA certification of pediatrics or other subspecialties that practice *anesthesia care in the operating room*.**

THANK YOU!

- Roger Moore, Jeff Apfelbaum, Mark Lema. *(3 ASA Presidents)*
- Reference Committee on Admin Affairs – Dan Cole, Chair.
- And the Executive Council of the ASA.
- For standing strong for what is right: *ASA-HOD voted disapproval of Added-Qual Peds Boards on 10-22-08.*
- ***SAAA should stand with them!***


THE END
Stop