

# The CSA House of Delegates Adopts a Policy Statement on Pediatric Anesthesia

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The CSA Policy Statement on Pediatric Anesthesia, adopted by the House of Delegates at the June 2003 annual meeting, represents the latest iteration in the evolution of this specialized area of our discipline. The origins of this Statement can be traced back at least a decade to the realization that many community-based anesthesiologists were, with increasing frequency, questioning the validity and ethical standard of pressures being applied to them to undertake the care of infants and children which seemed inappropriate in their practice setting. These pressures were often politically or economically motivated and came from the facility's administrators, third party payers, referring surgeons, or a combination of these. Calls for advice, received by pediatric anesthesiologists at academic institutions and children's hospitals, from these community anesthesiologists prompted initial discussions of how these problems could be addressed.

A "working group" comprised of leaders within the national pediatric anesthesia community was spearheaded by Dr. Alvin Hackel of Stanford and Dr. George Gregory of UCSF to informally discuss this issue and confront the question of how and where should infants and children receive optimal surgical and anesthetic care. The deliberations of this group eventually led to the publication several years ago, by the Section on Anesthesia of the American Academy of Pediatrics, of "Guidelines for the Pediatric Perioperative Environment" in the journal *Pediatrics* (Vol. 103, No. 2, February 1999, p. 512-515). These "Guidelines" encouraged the more recent publication by the ASA of the brochure "Pediatric Anesthesia Practice Recommendations" produced by a task force of the ASA Committee on Pediatric Anesthesia. <http://www.asahq.org/clinical/PediatricAnesthesia.pdf>

Last spring, a series of articles published by the *L.A. Times* questioned the causes behind apparently anesthesia-related death and morbidity of children undergoing procedures at a Southern California hospital. These articles gave fresh impetus to discussions among officers and directors of the CSA regarding the practice of pediatric anesthesia, relating to our ongoing interactions with California Children's Services. The following Policy statement is based

## **Policy Statement on Pediatric Anesthesia–Cont’d**

on the two previous publications cited above and emphasizes the importance of local medical staff autonomy, and its duty and responsibility to establish and maintain appropriate policy and credentialing standards regarding the perioperative care of infants and children.

### **CSA Policy on Pediatric Anesthesia**

**Approved by the CSA House of Delegates on June 7, 2003**

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.

## **Policy Statement on Pediatric Anesthesia–Cont’d**

### **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.

