2. "With America's population aging, we are the answer to the challenge of keeping pace with the demand for quality health care services."
3. "Our members are not physician adjuncts, and are independently responsible for their actions, regardless of whether physicians are involved."

You have probably heard little, perhaps nothing, in your medical school education about the issues I have briefly addressed, yet these are major, "real world" issues that ASA and AMA are attempting to address on behalf of every physician in the nation. The outcome of these issues will affect the way you practice medicine for the rest of your career.

Staying on the sidelines, "above the fray," with others fighting the battle for you is not an honorable or acceptable option. The minimal acceptable level of participation is membership in the organizations of medicine (your local and state medical associations, the AMA, your local and state anesthesia societies and the ASA) and at least the minimum contributions to all of these organizations' PACs (political action committees).

Let me close with the wise words of the 2006 president of the ASA, Dr. Orin F. Guidry: "We must be politically active and politically astute in medical politics as well as in governmental politics. AMA is important (really important!)."[5]

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CHAPTER 27

Pediatric Anesthesiology and The Society for Pediatric Anesthesia

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Pediatric Anesthesiology

The practice of pediatric anesthesiology is an exciting and challenging subspecialty of anesthesiology practice. Working with children requires a broad understanding of the fundamental anatomical, physiologic and pharmacologic differences between the pediatric and adult populations. The unique mix of developmental age, temperament, parental relationships, health, illness and surgical needs ensure that the practice of pediatric anesthesiology is consistently engaging.

It is not uncommon when having a routine procedure, such as tonsillectomy, that the parent is most concerned about the anesthetic. The art of pediatric anesthesiology entails the ability to communicate effectively with children and parents, and engender their trust in a limited period of time.

Since the inception of anesthesiology practice in the 1840s, anesthetic techniques have evolved and are increasingly tailored to the unique needs of children. The ability to perform increasingly complex surgical procedures is a direct result of the increased safety of pediatric anesthesiology perioperative care. Pediatric anesthesiology practice has progressed from the ability to provide three to four minutes of unconsciousness after inhaling from an ether-soaked rag to the ability to safely anesthetize a 600 gram, 24-week premature infant for a tracheoesophageal fistula repair.

Anesthesiology residency training can include exposure to general pediatrics during the intern year and pediatric anesthesiology rotations during the CA-2 and CA-3 years (though some programs offer rotations during the CA-1 year). The goal is for the resident to manage the perioperative care for children with diverse age ranges, variations on the health-illness continuum, and who require a variety of surgical procedures. The management of pediatric acute, chronic and perioperative pain is also an important aspect of pediatric anesthesia practice.

Additional training through a one-year fellowship in pediatric anesthesia is available. Pediatric fellowship presents the opportunity to develop the clinical judgement and skills to provide perioperative care for complex patients such as neonates, children with craniofacial and metabolic syndromes, and children with congenital cardiac defects. The fellowship also includes experience in the management of critically ill children in the pediatric intensive care unit, management of chronic pain, and performance of regional techniques such as peripheral nerve blocks and epidurals under general anesthesia.

The Society for Pediatric Anesthesia

The Society for Pediatric Anesthesia (SPA) has been and continues to be instrumental in the advancement of pediatric anesthesiology. Established in 1986, their mission "to foster quality anesthesia perioperative care and alleviate pain in children" is an ongoing venture. This mission is accomplished by: 1) Assembling in one group anesthesiologists who practice and have a strong interest in pediatric anesthesia, 2) Advancing the study of pediatric anesthesia and contributing to its growth and influence, 3) Encouraging research and scientific progress in pediatric anesthesia, 4) Serving as a forum for discussion of issues (scientific and political) of importance to pediatric anesthesia, and 5) Supporting the goals of the American Society of Anesthesiologists (ASA) and the American Academy of Pediatrics (AAP).

The membership of the SPA includes more than ***3,000*** members from the United States and abroad, and the membership is comprised of anesthesiologists from a broad spectrum of practice models. The biannual SPA meetings, held in conjunction with the American Academy of Pediatrics (AAP), provide a venue for critical review of current research, lectures, skills workshops and networking. The membership of the AAP provides invaluable expertise regarding the care of the pediatric patient, and the SPA–AAP collaboration is a key component to the richness of the SPA learning experience.

Subspecialty research grants are provided by the pediatric counsel of the Foundation for Anesthesia Education and Research (FAER). The grants target budding researchers at both the resident and faculty level. The research grants support individuals with a focus on education, clinical and basic research, and development of the skills required to compete for National Institutes of Health funding.

Medical students who are interested in anesthesiology, pediatrics, pain management, teaching and research will find the subspecialty of pediatric anesthesiology to be a fulfilling career.

Please refer to the SPA website (**www.pedsanesthesia.org**) for additional information about pediatric anesthesiology, SPA, and the SPA quarterly newsletter.

CHAPTER 28

The American Board of Anesthesiology: Part of Your Lifelong Career

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American Board of Anesthesiology

The American Board of Anesthesiology (ABA) is the certifying body for physicians who have completed residency training from a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME accredits residency programs in all specialties and many subspecialties. As distinct from board certification, ACGME accreditation of a residency program signifies that the program is meeting national standards for its faculty, its breadth of patient conditions and types of clinical training, its teaching facilities, and its educational and research programs. Board certification of individuals who graduate from such programs indicates that they have satisfactory professional standing and have demonstrated expertise in the specialty at the level of a consultant. The key distinction is that the ACGME and its individual Residency Review Committees (RRCs – one for each specialty) accredit programs, while the ABA certifies individuals.

Anesthesiology residency training consists of a clinical base (CB) year plus three years of clinical anesthesia training (CA-1 to CA-3 years). Prospective anesthesiology trainees entering the National Internship and Residency Matching Program (NIRMP) may match either into a categorical internship as part of an overall four-year CB and CA program. Alternatively, they may match into a preliminary internship that will serve as the CB year, plus match into a separate "advanced" anesthesia residency position for the CA-1 through CA-3 years of training. On a case-by-case basis, departments can apply to both the Anesthesiology RRC and the ABA for approval to offer a prospective combined five-year program consisting of a CB year, a residency, plus an extra year of unaccredited research, or a CB year, a residency, plus an extra year of accredited fellowship training. In the scenario of a combined residency plus fellowship, at least three-fourths of the fellowship training time must occur in the fifth year, when the resident has sufficient experience to function at the fellowship level. A department offering either or both such an options usually has a small number of such positions, e.g., one to five. There can be a separate NIRMP match number for those five-year combined programs, requiring a commitment from the graduating medical student for the full five years.