Talking Points for Responding to New York Times Editorial

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The provocative *New York Times* (NYT) Editorial entitled "Who Should Provide Anesthesia Care"[1] has stimulated considerable discussion, and will be cited in future discussions involving health care planners, legislators, regulators, and the public. The editorial is replete with inaccuracies, speculations, unsupported judgments, and misleading statements at a time when clarity and transparency — not obfuscation — are needed. The superficial research and subsequent flawed judgment comprising this editorial tarnishes the reputation of the NYT.

For generations we have counted on the NYT tradition of "All the News That's Fit to Print." Sadly, with this editorial, the NYT has allowed itself to be manipulated by those who distort and "spin" actual facts for their own political agenda.

Below are "**Talking Points**" to serve as a resource for those among us who will be addressing this opinion piece and the many issues raised in it. The points are presented as a ***phrase-by-phrase dissection*** of this poorly constructed editorial. In addition, some of the published[2] and unpublished *Letters to the Editor* submitted to the NYT may be found on the CSA web site.

- "**Who should *provide anesthesia care*?**" Medical care is still an art as well as a science, although that crucial fact is awkward to plug into a mathematical formula for planners to assess quality and efficiency. Physicians are well-educated professionals who apply the art and science of medicine to their patients on an individualized basis. As such, they are not cogs or tools, mere technicians, or "providers." **Anesthesiologists practice medicine.** We do not *provide* anesthesia care.
- What is ***"close medical supervision?"*** It is assuming ultimate responsibility and making sometimes difficult medical judgments while supervising or directing an anesthesiology resident, anesthesiologist assistant, nurse anesthetist, student anesthesiologist assistant, or student nurse anesthetist. Competent nurse anesthetists usually do not need to have their hands held, but when true expertise in problem solving with respect to patient care becomes necessary (this is *not* a rare event), then in

the name of patient safety, almost all are grateful to have a physician make the ultimate judgment as to how to proceed. After all, anesthesiologists rely on their education and training as physicians to resolve unexpected as well as anticipated medical problems in the peri-operative period.

- The issue that the editorial seeks to address has, in fact, been smoldering for decades, and has <u>not</u> ***"recent[ly] emerged."*** The concept of *"opting out"* of the long-standing federal requirement for there to be physician supervision of nurse anesthetists caring for Medicare patients was first promulgated in the last days of the Clinton administration, when the President (whose mother was a nurse anesthetist) opted every state out. President Bush, as a compromise, modified this regulation to permit, under certain conditions, each individual state to "opt out." In 2009 California became the 15th state to make this declaration, despite this action being in stark violation of California law. The matter is by no means settled, and is now before the courts in California.

- ***"Potentially important to patients?"*** Because flying in commercial aircraft has become so safe, should we economize by using "junior pilots?" How often does a flock of birds get sucked into a jet taking off, and how much training is needed to land such a plane? Advances in anesthetic care, driven solely by the scientific advances of anesthesiologists, have made surgical procedures much safer and more comfortable. Is the public ready to accept the risk to themselves from nurses who do not have to answer to physicians in critical situations? Nurse anesthetists who later have become physician anesthesiologists echo Dr. Jane Fitch's[3] rationale: "I got frustrated… I just didn't know enough" to tell whether a patient was ready to undergo surgery safely. "There is no comparison" between what she knew then and what she knows and can do now.[4] Anesthesiologists draw upon the full breadth and depth of their education, training, and experience when they must act under conditions that are challenging to the well being of their patients.

- *"**Studies — hotly disputed?"*** There is no discussion as to why anesthesiologists find these studies methodologically inadequate, and their conclusions unsupported and disturbingly disingenuous. Nurse anesthetists funded these "studies": the "researchers" who authored the *Health Affairs* article were paid by the American Association of Nurse Anesthetists, surely an insurmountable [not, as stated in the editorial, a ***"potential"***] conflict of interest in light of the fact that the conclusions argue for an economic advantage to the study's sponsor. In recent years, we have seen repeatedly that being at ***"respected organizations"*** does *not* necessarily equate to ethical conduct or competence.[5]

- In examining in greater detail some of the flaws in these ***"studies,"*** it is notable that the conclusions are derived from *"administrative data,"* and are essentially unadjusted for risk. First, nurse anesthetists are much more likely to care for healthy patients, while anesthesiologists typically render anesthesia to the sickest patients, even for those having the simplest of surgical procedures. Second, there is *no* determination as to whether deaths are from surgery or anesthesia. Third, there is *no* discussion of the frequency of expected deaths versus actual deaths, but rather, only a coarse examination of gross data from one state to another. Fourth, in an *"opt-out state,"* there is *no* clear separation of cases by nurse anesthetists acting alone from those participating in the anesthesia care team model with anesthesiologists supervising and directing the care of the patient. Fifth, the determination of the reporting codes underlying the data upon which these studies are based is inconsistent, using different rules and methods from location to location, and frequently may be influenced by financial incentives.

  Administrative data, mostly generated from billing records, are useful for forming hypotheses, but not for scientific proof. Data can be deployed to "prove" most anything, and the studies cited in the editorial are that in spades. In order to develop an evidence-based understanding of the differences between types of practitioners, one needs substantially more *clinical data* from actual patient care, assuredly *not* billing data that are notoriously inaccurate and incomplete. Moreover, because anesthesiologists tend to care for sicker patients than do unsupervised nurse anesthetists, the expected mortalities in less complex patients cared for by nurse anesthetists should be less. Yet, the mortality data are comparable, suggesting better outcomes when anesthesiologists render care. Furthermore, there are many intra- and post-anesthetic complications besides death that must be analyzed to make any logical statements about "equivalence" [in the words of the editorial, ***"no significant difference"***] of care.

- ***"Not too much difference in the amount of training in administering **and monitoring** anesthetics?"*** Nonsense! An anesthesiologist receives a minimum of 12 years of education and training! Four years of college leading to four years of medical school versus three to four years of nursing school does, indeed, provide anesthesiologists with, in the words of the editorial, *"a big advantage… in their much longer and broader medical training that… better equip them to handle complex cases and the rare emergencies that can develop from anesthesia."* Then, four years of specific post-doctoral physician training with

progressively more independence and more difficult surgical cases (including neonatal), pain management and critical care, in stark contrast to nursing experience in the ICU plus a mere two years of nurse anesthetist training. There is a meaningful difference between how doctors and nurses are trained to think, and the basis upon what this thought is based. Consider, for example, the complexity of diagnostic reasoning and the biases introduced by Type I reasoning (intuitive judgments and pattern recognition) versus the refinements of Type II reasoning ("reflection in action").[6] Indeed, this qualitatively different method of thought is relevant in a field that is only partly technical and increasingly cognitive.

** The failure of the authors of the editorial to realize that "monitoring" is but one aspect of "administering anesthetics" is in itself revealing of their lack of understanding of the subject they so ill-informatively address.

- ***"Miniscule risk?"*** When an adverse event does occur, no matter how unlikely, those patients so affected deserve the most educated, qualified, and experienced practitioner to rescue them. Isn't that what you would want? Playing with probabilities may seem like a sensible approach across a population of patients, but in a specific instance with a specific patient, all of that population risk is focused upon that one individual patient.
- ***"California's move is being challenged… on procedural technicalities?"*** In California, the "opt out" of the Medicare mandate for physician supervision of nurse anesthetists was undertaken in flagrant violation of state law, which explicitly requires such supervision. To characterize this as a "procedural technicality" trivializes an illegal and irresponsible act by Governor Schwarzenegger.
- ***"The state's [California] reasoning, which appears sound?"*** There has been no consultation with the state's medical board about problems of access and quality, as the federal regulations for opting-out require. In fact, there is no data that problems exist with anesthesia care or access. Rather, some hospitals may see an opportunity for financial advantage by employing unsupervised nurse anesthetists, and business interests surely have lobbied the Governor, spinning the facts to support their arguments. The opt-out has the appearance of being politically motivated, done by a lame duck governor furious with California physicians for opposing his version of health care reform (with a doctor "tax" he called a "fee"), and particularly angry with anesthesiologists

for contesting regulations about chiropractic spinal manipulation under anesthesia for his chiropractic friends.

- ***"Savings to the health care system if nurses delivered more of the [anesthetic] care?"*** As physicians, anesthesiologists not uncommonly help to prepare patients for surgery by diagnosing and evaluating various complex medical conditions, which often require a weighing of competing priorities. Cardiologist, pulmonologist, neurologist, nephrologist, hematologist, hepatologist, and endocrinologist—an anesthesiologist is in essence many physicians all at once, and may be called upon to make judgments as to how to make patients ready for surgery and anesthesia, to determine when they are ready, to intervene medically intra- and post-operatively as required, and serves as the last remaining physician advocate to keep the patient out of harm's way. Often, medical consultations can be foregone, saving untold resources, while a nurse anesthetist would be incapable of the required diagnostic skills. Avoiding complications, both intra- and post-operatively, is a highly prized and effective method for saving health care costs.

- The only mention of "substantiation" for "savings" is the report by the *Lewin Group* which *"judged nurse anesthetists acting without supervision as the most cost-effective way to deliver anesthetic care,"* a fatally flawed study in how it addresses quality and cost differences, and one that was *funded* by the AANA, the ugly head of conflict of interest arising once more. It is notable that nurse anesthetists generally work eight-hour work shifts, and thus 24-hour staffing would require multiple personnel. Furthermore, anesthesiologists work far greater hours[7] and fund their own practice overheads, liability and disability insurances, and retirements, all facts that substantially explain a difference in salaries. In actual fact, the payment by insurance carriers, including Medicare, for a particular case is the *same* for a nurse anesthetist as for a physician. Hence the cost for a physician or a nurse anesthetist is essentially the same.

- ***"Costs absorbed by various institutions and public programs?"*** It is true that it costs more to educate an anesthesiologist than a nurse anesthetist, but the same can be said of an internist compared to a nurse practitioner, a surgeon to a non-physician first assistant, and a senior commercial pilot to a junior flight officer. The federal and state governments do not nearly fully pay for the costs of educating physicians, who, on average, graduate medical school with $100-200,000 in debt. Repeal of the egregious Teaching Rule for anesthesiology residents has permitted better funding for anesthesiology teaching programs, but this

federal support represents a long overdue and unfulfilled obligation to pay more equitably for the care of Medicare/Medicaid patients who, for decades, were given a free ride. Furthermore, the federal and state governments continue to fail to pay their fare share of charges for anesthesiologists: Medicare still now pays at 33 percent of usual contracted insurance rates, comparing poorly with the 80-120 percent paid for other specialists and primary care physicians.

- Indeed, the costs of training ultimately are absorbed into the system, but to this tally one should consider adding the items of anesthesiologists' longer working hours, more cost effective rendering of anesthetic services (minimize unnecessary consultations and avoid intra- and post-operative complications), and scientific innovation that improves quality of care. Just what is the price tag for safety? Are informed patients willingly going to accept the concept of the government demanding increased value for Medicare when the ultimate plan is to control costs, and the methods for determining quality are based upon flawed administrative data?
- Medicare beneficiaries prefer a physician anesthesiologist rather than a nurse anesthetist by a wide margin.[8] Most patients are given neither the choice nor the correct information (including qualifications) about who would be responsible for their anesthetic. Indeed, if the misguided contention that nurse anesthetists are much less expensive for the health care system were correct, then how does one explain:

  "that even countries with single-payer, government-run health systems (Canada, Western European nations) have not replaced physician anesthesiologists with nurses. There is simply too little to be gained in cost reduction and too much to lose in patient safety." [9]

In summary, physician direction and supervision of nurse anesthetists, as with any other physician and nurse-extender, creates the highest culture of safety for our healthcare system. Anything less is a subtle and insidious rationing of healthcare, and to suggest otherwise without credible scientific data is disingenuous.

1. Published on September 6, 2010 and available at <http://www.nytimes.com/2010/09/07/opinion/07tue3.html?scp=1&sq=who%20should%20provide%20anesthesia%20care?&st=cse>.
2. <http://www.nytimes.com/2010/09/12/opinion/l12anesthesia.html?_r=1&emc=eta1>.
3. Jane Fitch, M.D., formerly a nurse anesthetist, is Chair of the Department of Anesthesiology at the University of Oklahoma.

Talking Points (cont'd)

4. McCaughey B. Dumbing Down Medical Care: Substituting nurses for doctors can be hazardous to your health. The Hudson Institute, February 1, 2001. <http://www.hudson.org/index.cfm?fuseaction=publication_details&id=1435>
5. Van Norman G, Jackson S. Publication Ethics: Obligations of authors, peer-reviewers, and editors. In: *Clinical Ethics in Anesthesiology* (eds. Van Norman, Jackson, Rosenbaum, Palmer). Cambridge University Press. pp. 209-215, 2010.
6. Pauker S, Wong J. How (Should) Physicians Think? A journey from behavioral economics to the bedside. *JAMA* 304: 1233-1234, 2010.
7. Daugherty, Lindsay, Fonseca, Raquel, Kumar, Krishna, Michaud. An Analysis of the Labor Markets for Anesthesiology. RAND Corporation <http://www.rand.org/pubs/technical_reports/TR688/>.
8. The Tarrance Group. National Anesthesia Study III: A Survey Of Public Opinion Attitudes. 2001, as cited by Hannenberg AH in *Becker's ASC Review.* <http://www.beckersasc.com/anesthesia/asa-president-offers-7-reasons-to-question-anesthesia-cost-containment-study.html>
9. Koontz A, Maccioli G. Assuring the Safest Anesthesia. *The News Observer.* September 25, 2010. <http://www.newsobserver.com/2010/09/25/v-print/700746/assuring-the-safest-anesthesia.html>