Peering Over the Ether Screen:
Nurse Anesthesia Supervision and Online Opinion

By Karen S. Sibert, M.D., Associate Editor

Recently I wrote an online column for the "KevinMD" website, which was published under the headline: "Unsupervised anesthesia care by a nurse anesthetist is a threat to patient safety." I was inspired to write the column after the Centers for Medicare and Medicaid Services (CMS) published new rules in October 2011. Many anesthesiologists were deeply concerned that the new rules might eliminate the requirement for physician supervision of nurse anesthetists; happily, the new rules did not. My column praised the CMS decision, with the goal of educating other physicians and the public about why it matters.

As of this writing, that article still tops the list on "KevinMD" as the most commented-upon column in recent weeks. Commenters wrote passionately, although not always politely, on both sides of the argument—in favor of and opposing nurse anesthetist supervision. Below follows a reprint of the column, and afterward a selection of what I found the most noteworthy and printable comments.

> No matter how quickly you tried to switch the television channel lately, you probably couldn't escape the trial of Dr. Conrad Murray or avoid hearing about propofol, an anesthesia drug that can be fatally easy to use.
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> What you may not have heard is that the American people just dodged a serious threat to their anesthesia care, and most don't know how near a miss it was.
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> The Centers for Medicare and Medicaid Services (CMS) recently issued new rules concerning the conditions of participation in Medicare and Medicaid for hospitals and health care providers. Despite intense pressure, CMS sensibly left in place the rule that requires nurse anesthetists to be supervised by physicians. We should all be thankful, and stay on guard in case anyone tries to change that rule again.
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> The new rules are open for comment until mid-December, and lobbyists no doubt will continue to argue that all anesthetics can "just as easily" be given by nurse anesthetists alone. This is a bad idea, and CMS should stand firmly against it.

Here's the background. This year, the Obama administration announced a plan to reform health care regulations that were unnecessary in its view. In particular, the administration said, the "use of advanced practice nurse practitioners and physician's assistants in lieu of higher-paid physicians could provide immediate savings to hospitals." In the new rules, CMS reasonably proposes to remove barriers to the work of physician extenders, for example by not making them seek out a physician to co-sign every order.

But if lobbying efforts had succeeded, nurse anesthetists—alone among other mid-level providers—would be allowed to practice without any supervision at all. Hoping to make anesthesia services more profitable for hospitals and insurers, lobbyists purposely blur the differences between the education of physicians and nurses. They want to get rid of the cost-effective anesthesia care team model, where nurse anesthetists or anesthesiologist assistants work under physician direction.

Mid-level providers on every team are essential to health care. When patients go to a primary care doctor's office, they are likely to see a nurse practitioner or a physician's assistant who can treat routine complaints, manage chronic illnesses like high blood pressure, and write prescriptions under the doctor's authority. If you need surgery, a physician's assistant may assist your surgeon in the operating room, and a nurse anesthetist may look after you under the supervision of your anesthesiologist. They're working as part of the team, not replacing the physicians.

Dr. Jane Fitch, recently elected First Vice President of the American Society of Anesthesiologists, began her career as a nurse anesthetist with a master's degree. Troubled by her limited knowledge compared to the physicians she worked with, she soon went back for eight more years of education—completing medical school, residency, and then a fellowship in cardiac anesthesiology. While she was a nurse anesthetist, "I didn't know how much I didn't know," Dr. Fitch says.

Military families may be surprised to learn that if you become a patient in a U.S. military hospital (which isn't bound by CMS rules), you may receive anesthesia from a nurse anesthetist who isn't required to work with an anesthesiologist. This rule applies whether the patient is a healthy civilian having a minor procedure, or a grievously wounded soldier needing major surgery. The anesthesiologist may be called in to rescue the patient only when complications have already occurred.

"Suddenly it's my case, and my problem," says a Navy anesthesiologist in frustration.

President Clinton (whose mother was a nurse anesthetist) signed into law in 2001 a rule that permits states to "opt out" of the CMS requirement for nurse anesthetists to be supervised by a physician. Sixteen states—unfortunately including my own state of California—have adopted this rule to date. While it was originally intended to help rural areas improve access to care, the "opt out" rule supports any hospital that seeks to cut costs by allowing nurse anesthetists to work alone.

By signing the "opt out" rule, President Clinton apparently meant that anesthesia care by a nurse anesthetist working without supervision is all right for you and for other people. When Clinton himself needed heart surgery, a physician specializing in cardiac anesthesiology headed his anesthesia team. The same was true of Governor Schwarzenegger, who signed the letter in 2009 allowing the state of California to opt out of physician supervision of nurse anesthetists. When he needed surgery, a board-certified anesthesiologist personally provided his anesthesia from start to finish.

Now there's a new threat to patient safety. Section 2706 of President Obama's Patient Protection and Affordable Health Care Act (PPACA) prohibits discrimination by insurance companies against health care providers as long as they are acting within the scope of their licenses.

It sounds innocuous. But this "non-discrimination" clause opens the door for non-physicians—like nurse anesthetists or chiropractors—to open clinics without physician oversight and bill insurers directly for anesthesia nerve blocks, epidurals, and other complex pain management procedures. These techniques benefit many chronic pain patients, but they carry the risk of life-threatening complications. Under the misguided logic of this law, I could deliver babies or take out gallbladders because I'm a licensed doctor, even though I'm not an obstetrician or a surgeon.

The Obama administration expresses concern about the "impending shortage" of physicians as a reason to allow more latitude to advanced practice nurses. Certainly, public health nurses in the community don't need immediate physician supervision to deliver care safely within their scope of practice. But anesthesia and surgery always carry the risk of sudden complications requiring physician intervention, whether in a hospital or an outpatient surgery center.

If we cut out physician involvement in order to make anesthesia cheaper, we're kidding ourselves to think that quality and safety won't suffer. The American people deserve better.

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Selected Comments (abridged but not edited)

From a general surgeon:

I have worked with many fine CRNAs but as a general surgeon the problem I always had was: when things are going well in the operating room, CRNAs act like they're a doctor; when things go to hell, it's suddenly, "Hey doc, what do I do, I'm just a nurse." Since at that point the surgeon is up to his neck in alligators too, it's a heckuva time for them to lose their confidence.

From a nurse anesthetist:

Your op-ed lacks any evidence whatsoever. That is the problem. It is "evidence by proclamation" and using fear mongering. Look, if you [the ASA] would just admit for once this is just about business and protecting your wallets I could at least understand it. However the continuous insinuation that this is a "safety" issue for patients is neither accurate, evidenced or fair.

From a military nurse anesthetist:

I am a military CRNA and have just spent the last year working independently in Afghanistan on a Forward Surgical Team with no anesthesiologist. I provided safe anesthesia for some of the worst traumas imaginable to American soldiers, civilian adults and children. I would have loved to have an extra hand in the OR from an anesthesiologist but not too many are volunteering to go to Afghanistan and supervise CRNAs there.

From a Navy anesthesiologist, responding to the above post:

While deployed, military CRNAs indeed do practice independently ... in some places. However, they're treating the healthiest and most aggressively and completely pre-screened patients on earth: young active duty military. Further, they're only doing trauma. Formulaic and procedural ... and let's be honest, even the local national casualties generally aren't sick. They're generally not vasculopaths, they don't have end stage renal disease, or cirrhosis ... and let's be even more brutally honest, even if the

local national patients are sick and they do die, there's no family waiting to sue in the wings. And then there's the Feres Doctrine protection. It is disingenuous to pretend that adequate care from independent CRNAs in Afghanistan proves or even implies that CRNAs should be working independently in the United States.

It is telling that within Afghanistan, there are fewer and fewer independent CRNA billets, because more and more deployed units are insisting on anesthesiologists. Keep an eye on the USMC locations.

Your parting shot to military anesthesiologists ("not too many are volunteering to go to Afghanistan") is simply wrong and insulting. Taskings come down from higher echelons in the military, and we step up to fill them just as you and the CRNA community do. Right now, I'm on the books to go. It will be my third deployment.

From ASA Immediate Past President Mark Warner, M.D.:

In this day and age, anesthesia has become extremely safe. The available monitoring equipment, medications, and knowledge gained through research and development have advanced this profession to the point where severe complications are a rarity. With that being said, complications still do occur. And when they occur, they are often unexpected and require a quick response. Closed claims reviews have shown without a doubt that having an anesthesiologist and a second provider in the operating room on induction and emergence provides the safest delivery of an anesthetic in the event of a catastrophic complication…

Simple anesthetic management principles seem to have a major effect on perioperative mortality. The routine use of an equipment checklist (odds ratio, 0.61), direct availability of an anesthesiologist to help lend a hand or troubleshoot when needed (odds ratio, 0.46), the use of full-time compared with part-time anesthesia team members (odds ratio, 0.41), the presence of two members of the anesthesia team at emergence (odds ratio, 0.69), and reversal of muscle relaxants at the end of anesthesia (odds ratio, 0.10) had dramatic, positive effects that were associated with reduced perioperative mortality within 48 h after surgery and anesthesia. [Arbous et al., *Anesthesiology*, February 2005]

From the President of the American Association of Nurse Anesthetists:

The anesthesia care team model is far from the most cost-effective anesthesia delivery model. According to a study conducted by Virginia-based The Lewin Group and published in the May/June 2010 issue of the *Journal of Nursing Economic$*, the most cost effective model of

anesthesia delivery is a CRNA acting as the sole anesthesia provider. The study, titled "Cost Effectiveness Analysis of Anesthesia Providers," considered the different anesthesia delivery models in use in the United States today, including CRNAs acting solo, physician anesthesiologists acting solo, and various models in which a single anesthesiologist directs or supervises one to six CRNAs. The results show that CRNAs acting as the sole anesthesia provider cost 25 percent less than the second lowest cost model. On the other end of the cost scale, the model in which one anesthesiologist supervises one CRNA is the least cost efficient model. The study's authors also completed a thorough review of the literature that compares the quality of anesthesia service by provider type or delivery model. This review of published studies shows that there are no measurable differences in quality of care between CRNAs and anesthesiologists or by delivery model. And, in the name of transparency, it is important to note that the study was supported by the AANA Foundation, but that was where the Foundation's involvement in the research or publication of the results ended…

Supervision is not for CRNA practice. Supervision is for reimbursement of Medicare part A (facility charges) only. Quit twisting reality.

From an anesthesiologist:

Wow, as a recently minted board certified anesthesiologist, coming from a training program with zero CRNA exposure I had little idea the threat mid-levels pose. This article has been a real eye opener. I was directed to this site by someone at work. Up until now, I always viewed working with CRNAs as a cordial symbiotic affair. I need to re-evaluate this attitude… Writing my check to the ASAPAC right after I get off the computer!

For more comments, including those less fit to print, go to: http://www.kevinmd.com/blog/2011/11/unsupervised-anesthesia-care-nurse-anesthetist-threat-patient-safety.html