POSITION STATEMENT FROM THE PENNSYLVANIA ASSOCIATION OF NURSE ANESTHETISTS ON HB 1256

We, the Board of the Pennsylvania Association of Nurse Anesthetists, feel that the time has come to set straight the truth about why we support HB 1256, what we hope this bill will accomplish and why we feel we need this legislation. In the process, we hope to correct any misunderstandings about HB 1256 that have been instigated by those wishing to halt the progress of this legislation.

What is the current status of the Scope of Practice for CRNAs in Pennsylvania?

For more than twenty-four years, the CRNA scope of practice in Pennsylvania, as derived from regulatory ***PA code §21.17. Anesthesia,*** has been as follows:

> “(3) The certified nurse anesthetist is authorized to administer anesthesia in cooperation with a surgeon or dentist. The nurse anesthetist’s performance shall be under the overall direction of the chief or director of anesthesia services. In situations or health care delivery facilities where these services are not mandatory, the nurse anesthetist’s performance shall be under the overall direction of the surgeon or dentist responsible for the patient’s care.
> (4) Except as otherwise provided in 28 Pa. Code § 123.7(c) (relating to dental anesthetist and nurse anesthetist qualifications), when the operating/anesthesia team consists entirely of nonphysicians, such as a dentist and a certified registered nurse anesthetist, the registered nurse anesthetist shall have available to her by physical presence or electronic communication an anesthesiologist or consulting physician of her choice.
> (5) A noncertified registered nurse who has completed an approved anesthesia program may administer anesthesia under the direction of and in the presence of the chief or director anesthesia services or a Board certified anesthesiologist until the announcement of results of the first examination given for certification for which she is eligible. If a person fails to take or fails to pass the examination, the person shall immediately cease practicing as a nurse anesthetist. If the applicant, due to extenuating circumstances, cannot take the first scheduled examination following completion of the program, the applicant shall appeal to the Board for authority to continue practicing.
> (b) For purposes of this section, ‘‘cooperation’’ means a process in which the nurse anesthetist and the surgeon work together with each contributing an area of expertise, at their individual and respective levels of education and training.”[1]

This code was established on September 17, 1983, and it accurately describes how CRNAs work in cooperation with physicians, both anesthesiologist and non-anesthesiologist, every single day. It does not proscribe an independent scope of practice for the CRNA and let us be clear on this point, the Pennsylvania Association of Nurse Anesthetists has never sought independent practice and does not support such a concept. We strongly advocate that when a CRNA works with any physician other than an anesthesiologist, our scope of practice calls for “cooperation” in which the CRNA and the surgeon each contribute their own areas of expertise and respective levels of training. This leads us to a controversial issue, that of differing types of education between CRNAs and anesthesiologists as it relates to a nurse anesthetist’s ability to provide care to a patient when they work with a non-anesthesiologist.

What is the difference in education between a CRNA and an anesthesiologist?

Basically, CRNAS are advanced practice nurses who have chosen to complete a three-year, post-graduate sub-specialty training program in anesthesia, which leads to a Master’s degree in nursing or anesthesia. By 2015, we will see that requirement rise to a Clinical Doctorate as dictated by the national Council on Accreditation, which oversees CRNA education. CRNAs must achieve national board certification in order to be able to practice.

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[1] http://www.pacode.com/secure/data/049/chapter21/subchapAtoc.html

Anesthesiologists are medical school trained physicians who have completed a three-year long residency in anesthesia, of which the first year is a transitional year focused on general medicine and surgery. Only the last two years of residency are focused on anesthesia so that the clinical and didactic components of physician training in anesthesia are either the same or shorter than that of all CRNAs. Many physicians choose to follow their residency with a fellowship in some specific area of anesthesia such as pain management, but this is not a requirement to become an anesthesiologist.

The premise that the differences in education between CRNAs and anesthesiologists is the basis for CRNAs being inferior is a flawed concept that the Pennsylvania Society of Anesthesiologists (PSA) has tried to use as the basis for building a case against CRNA practice. It is of course true that the education received by CRNAs sometimes "differs in scope and duration" from the education received by physicians. However, this does not mean that such education is inadequate or inferior. In many instances, the education is substantively equivalent. Moreover, there are instances when the education received by CRNAs is more extensive in certain areas than the education received by anesthesiologists.

Discussions about scope of practice should not begin with their focus being 'Is the education received by anesthesiologists different in scope and duration from nurse anesthetists?' Rather, discussions about scope of practice should be based upon whether the particular provider is qualified to deliver the service contemplated, regardless of whether the provider's education "differs" from a physician's education. This is the rational, intelligent way to approach the differences between CRNA and anesthesiologist education and one we hope everyone would want to take.

Are there any differences in the scopes of practice described by the present PA code §21.17.Anesthesia and HB 1256?

PA code §21.17.Anesthesia	HB 1256
"(3) The certified nurse anesthetist is authorized to administer anesthesia in **cooperation** with a surgeon or dentist. The nurse anesthetist's performance shall be under the overall direction of the chief or director of anesthesia services. In situations or health care delivery facilities where these services are not mandatory, the nurse anesthetist's performance shall be under the overall direction of the surgeon or dentist responsible for the patient's care. (4) Except as otherwise provided in 28 Pa. Code § 123.7(c) (relating to dental anesthetist and nurse anesthetist qualifications), when the operating/anesthesia team consists entirely of nonphysicians, such as a dentist and a certified registered nurse anesthetist, the registered nurse anesthetist shall have available to her by physical presence or electronic communication an anesthesiologist or consulting physician of her choice.... **(b) For purposes of this section, ''cooperation'' means a process in which the nurse anesthetist and the surgeon work together with each contributing an area of expertise, at their individual and respective levels of education and training."**	(i) A certified registered nurse anesthetist shall administer anesthesia in **collaboration** with a physician or dentist. (ii) A certified registered nurse anesthetist's performance shall be under the overall direction of the chief or director of anesthesia services, provided, however, that in situations or health care facilities where anesthesia services are not mandatory, the certified registered nurse anesthetist's performance shall be under the overall direction of the **collaborating** physician or dentist. (iii) When the operating or anesthesia team consists entirely of nonphysicians, an anesthesiologist or consulting physician of the certified registered nurse anesthetist's choice shall be available to the certified registered nurse anesthetist by physical presence or electronic communication. (5) Nothing in this section shall be construed to prohibit the continued practice of certified registered nurse anesthetists who were authorized to practice in this Commonwealth on the effective date of this section.

To understand the similarities and/or differences between the current PA Code §21.17, a regulation under the Nurse Practice Act, and the proposed legislation HB 1256, one really needs to take the time to look at them side by side. For that purpose, the essence of scope of practice cited in both documents has been included above. As you can see by the areas highlighted in yellow, there are essentially no differences between the two. The singular exception is the substitution of the word "collaboration" (in HB 1256) for "cooperation" (in the regulation of the nurse practice act). The PANA strongly objects to this substitution and requests and reserves it support of HB 1256 to everything except this word. While this may seem minor, even irrelevant, to some, to CRNAs who have successfully practiced in PA under 21.17 for the last 24 years, the substitution of the term "COOPERATION" with "COLLABORATION" is a major problem.

Unlike other advanced practice nurses, CRNAs have not in their 125 years of existence been required to provide “written collaborative agreements”. Written collaborative agreements are documents which direct that the advanced practice nurse must work with a specific physician who, in turn, signs off on all orders written by that practitioner. CRNAs can, and do, work with a wide variety of physicians from anesthesiologists to psychiatrists. Specifying one physician or type of physician would severely restrict access to care for thousands of Pennsylvanians every day. While some states require CRNAs to collaborate with other providers, they rarely require a written protocol because a written protocol would not suit the way that CRNAs and other providers practice together. For example, the nature of the collaboration may be cooperative in the sense that each provider contributes his or her respective expertise to the overall well being of the patient. There is no need to memorialize this relationship in a written protocol. This is why the term “cooperation is defined within §21.17. Use of the term collaboration, especially as physician anesthesiologists have sought to require its use in other states in their argument for total supervision over all that CRNAs do, is a biased attempt at restricting the scope of practice of non-physicians practitioners.

When HB 1256 is passed, will it change how CRNAs and anesthesiologists work together and will it create an incentive for hospitals to let their anesthesiologists go?

The simple answer to this is no. The nature of the working relationship between anesthesiologists and CRNAs, aside from Department of Health regulations regarding hospitals, is defined by every hospital’s medical staff bylaws and the staff performance rules set by its credentialing committee. These are often equal to or are more restrictive than any guidelines, regulation or laws set by the state. We see no reason for this to change and we do not seek any changes in this regard. CRNAs and anesthesiologists will continue to work side by side to provide care just as we have for decades.

There is nothing in HB 1256 that might allow you to construe that this bill will create a disincentive for hospitals to utilize the services of anesthesiologists. Department of Health regulations state that when an anesthesiologist is on staff at a hospital, they will be the Chief of Anesthesia services. There is nothing in this bill to cause, nor do we seek to cause anesthesiologist unemployment.

Today the majority of hospitals look at their anesthesia departments with great scrutiny because reimbursements for professional anesthesia services are no longer adequate to cover the cost of employing anesthesiologists and CRNAs, but this is a healthcare business issue and has nothing to do with professional scope of practice. The answer to this serious economic concern is for CRNAs and anesthesiologists to work together to seek ways to streamline our provision of care, to reduce our costs by functioning more efficiently and to maximize the quality of care we provide to our patients by complying with national guidelines set forth in the National Surgical Care Improvement Project and by actively participating in the International Health Institute’s Save 100,000 lives initiative.

If the existing PA code §21.17 and proposed HB 1256 are so similar, how will HB 1256 help Pennsylvanians?

Obviously, PA Code §21.17 has been in existence in it’s present form for more than 24 years, but, as some of you may be aware, the Pennsylvania Society of Anesthesiologists, the Pennsylvania Medical Society and even the PA Board of Medicine have three times in the last decade launched vigorous attempts to change 21.17 in efforts to restrict the CRNA scope of practice. All three attempts were unsuccessful, but after the last attempt by the PSA a few years ago with HB 832, the PANA Board of Directors felt it was necessary to protect our scope of practice by asking the General Assembly to pass a law that would essentially codify the regulations which authorize our present scope of practice. It is critical to note that we are not seeking to expand our scope of practice, nor are we seeking independent practice. While we bear no animus toward the PA Society of Anesthesiologists, the PA Medical Society or the PA Board of Medicine, they have made it clear that their mission is to reign in and restrict the scopes of practice of many other types of health care providers and their attacks upon the profession of nurse anesthesia have been particularly vicious. While we work side by side in cooperation with anesthesiologists every day and feel that we enjoy a good working relationship with them, CRNAs don’t

just work in cooperation with anesthesiologists. We regularly work in cooperation with gastroenterologists, oral surgeons, psychiatrists, orthopedic surgeons, etc. Thousands of Pennsylvanians every day depend upon anesthesia services provided by CRNAs working in cooperation with physicians other than anesthesiologists, in hospitals in rural areas of the state, in offices and ambulatory surgery centers throughout Pennsylvania. In addition to this, insurance carriers constantly seek means to restrict or refuse payment to non-physician anesthesia providers forcing us to provide care without reimbursement. If we fail to protect our scope of practice, these patients will lose their access to high quality anesthesia care. Because of the unrelenting assaults on our scope of practice by various medical societies and insurance carriers, protecting our scope of practice in its current form is now more critical than it has ever been in our 125-year history.

We urge you to support HB 1256. We believe that passage of this legislation will result in fewer challenges from insurance carriers when we try to be paid equitably for the services we provide and it will put an end to the constant assaults on our scope of practice by the various medical societies.

The members of the Pennsylvania Association of Nurse Anesthetists and its Board of Directors wish to thank you for your time and for supporting passage of HB 1256.