FINAL Report of Preliminary Findings and Recommendations

By the

Technical Committee for the Review of the

CRNA Application for a

Change in Scope of Practice

To The

Nebraska Board of Health,

Director of Health,

and the

Nebraska Legislature

April 24, 1990

The members appointed by Gregg F. Wright, M.D., M.Ed., Director of Health, to serve on the Certified Registered Nurse Anesthetist Technical Review Committee are as follows:

Patricia McQuillan, Chairperson, Member of the Nebraska State Board of Health (Greeley)

Jane Embry, Account Assistant with Alexander and Alexander, Inc. (Omaha)

Dallas E. Wilhelm, Jr., Ph.D., Associate Professor and Chairman of the Biology Department, Hastings College (Hastings)

Ruth Vacha, R.N., Lutheran Community Hospital (Norfolk)

Dwaine J. Peetz, M.D., Private practitioner (Neligh)

Margaret Moravec, M.D., St. Elizabeth Hospital (Lincoln)

Steven R. Wooden, C.R.N.A., Broken Bow Community Hospital (Broken Bow)

INTRODUCTION

The Nebraska Credentialing Review Program, established by the Nebraska Regulation of Health Professions Act (LB 407) in 1985, is a review process advisory to the Legislature which is designed to assess the necessity of the state regulation of health professions in order to protect the public health, safety, and welfare.

The law directs those health occupations seeking credentialing or a change in scope of practice to submit an application for review to the Director of Health. At that time, an appropriate technical committee is formed to review the application and make recommendations after a public hearing is held. The recommendations are to be made on whether the health occupation should be credentialed according to the four criteria contained within Section 71-6221 Nebraska Revised Statutes; and if credentialing is necessary, at what level. The relevant materials and recommendations adopted by the technical committee are then sent to the Board of Health and the Director of Health for the review and recommendations. All recommendations are then forwarded to the Legislature.

SUMMARY OF COMMITTEE CONCLUSIONS AND RECOMMENDATIONS

A majority of technical committee members recommended approval of the applicant's proposal, with the proviso that an anesthesiologist remain on the CRNA Advisory Council, and that a CRNA be added to the Board of Medical Examiners as and when that body considers matters related to anesthesia practice. The committee members also recommended that the Medical Board and the Board of Nursing jointly oversee the profession.

SUMMARY OF THE APPLICANTS' PROPOSAL

The Certified Registered Nurse Anesthetists in their proposal seek to change the statute that regulates their profession in such a way as to eliminate the requirement that nurse anesthetists must be supervised by a licensed practitioner. The proposal would also remove CRNA's from the authority of the Board of Medical Examiners while keeping them under the authority of the Board of Nursing. The proposal also authorizes CRNAs to practice in dental and podiatric offices.

1. Is there harm Inherent in the Current Practice Situation of CRNA's in Nebraska?

Applicant Group Comments

The applicant group stated that the current practice situation of CRNA's is a direct source of social and economic harm, and potentially a source of physical harm as well. The applicants stated that current statutory restrictions on CRNA's that prohibit them from working in dental and podiatric offices deprive many Nebraskans of good-quality anesthesia services. These restrictions have their greatest impact in rural areas of Nebraska, where residents lack easy access to the services of an anesthesiologist. This situation makes getting access to good-quality anesthesia services costly and inconvenient for many rural Nebraskans. (Transcript of the Public Hearing, p. 18)

The applicants stated that these restrictions also create potential for physical harm to the public because of the fact that untrained personnel in dental and podiatric offices often administer and monitor anesthesia. (The Applicants' Proposal, p. 28.)

The applicants expressed concern about the fact that the current statutes regulating CRNA's require surgeons to supervise the work of CRNA's. The applicants stated that many surgeons perceive this supervisory role as increasing their liability. This concern has prompted some physicians to utilize the services of physician anesthetists rather than use those of CRNA's. This increases the costs to the consumer because a physician's

services are more expensive than those of a CRNA. (The Applicant's Proposal, p. 28.)

The applicants presented geographical evidence to show that nurse anesthetists are much more evenly distributed in Nebraska than are anesthesiologists. This evidence revealed that anesthesiology services in Nebraska are concentrated very heavily in urban areas, and that nurse anesthesia services are more readily accessible to people living in remote rural areas of Nebraska. The applicants stated that the current statutes which require that CRNA's be supervised by surgeons diminish access to good-quality surgical services for rural Nebraskans because surgeons are reluctant to provide surgical care in areas where they would have to work with a CRNA rather than an anesthesiologist. Removing the requirement that surgeons must supervise CRNA's would make surgeons less reluctant to work with CRNA's because they would no longer be concerned about being liable for what CRNA's do. This in turn would remove the disincentive for surgeons to provide services in rural areas, and make them more willing to cooperate with CRNA's already working in these areas. (Transcript of the Public Hearing, p. 81.)

The applicants argued that the statutory language requiring physician supervision of CRNA's is confusing and unnecessary. The language of part of the statute in question states, "immediate personal supervision or physical presence of the supervising licensed practitioner shall not be required in all circumstances." The applicants stated that there is insufficient

guidance as to when the law requires personal supervision and when it doesn't. The applicants stated that CRNA's are the experts in anesthesia administration, and that medical doctors defer to them when questions regarding techniques of anesthesia administration arise. The applicants stated that because of this there is no reason why medical doctors should be required to supervise the work of CRNA's. Such a requirement creates a potential impediment for the conduct of CRNA duties and responsibilities. (Transcript of the Public Hearing, pp. 34, 36-37.)

Opponent Comments

The opponents stated that the current practice situation of nurse anesthetists is not a source of harm to the public. They stated that the current situation provides important safeguards for the protection of public health and welfare. The opponents argued that there is a definite trend in anesthesia and in surgery toward doing more complicated and risky surgeries on older and sicker and more-debilitated patients. They stated that this trend argues strongly for a tightening and a strengthening of supervision over CRNA services by physicians, not a relaxation of standards and requirements for supervision. (Transcript of the Public Hearing, p. 40)

The opponents argued against the separation of anesthesiology and nurse anesthesia because anesthesia care requires more detailed knowledge of more aspects of medicine than any other subspecialty branch of medicine, and only a medical

doctor would have mastered this subject sufficiently to function as an independent practitioner. They stated that because of the increasing complexity of this branch of medicine, the supervisory attendance of an anesthesiologist in all instances of anesthesia delivery would be beneficial to the public health and welfare. (Letter from Paul W. Post, M.D. to the Chairperson of the CRNA Technical Committee.)

The opponents stated that most anesthetists can manage normal anesthesia delivery quite well, but that it is the abnormal emergency situation or patients with complex medical problems that require a broader knowledge-base than what CRNA's possess in order to be in independent practice. They stated that nurse anesthetists are technicians of anesthesia, whereas the anesthesiologist is the overall conceptual manager of the progress of a patient's surgical situation. The anesthesiologist because of his superior training and education better understands the "whys" of anesthesia care than does the nurse anesthetist. The opponents stated that the training of the nurse anesthetist focuses more on the "hows" of anesthesia care than on the "whys". (Letter from Paul W. Post, M.D. to the Chairperson of the CRNA Technical Committee.)

The opponents stated that the current statute contains a general supervision requirement and specifically does not require the immediate presence of a physician or actual control over the methods of the CRNA. The statute in question does recognize the legal responsibility of CRNA's for their professional actions.

The opponents added that the current statute does reflect the actual practice of CRNA's throughout the country, and that it should not be changed. (Jerry J. Hynes, M.D., M.D., "Follow-Up Information in Opposition to Applicant Proposal".)

The opponents agreed that gaining access to the services of anesthesiologists in many rural areas of Nebraska is difficult. The opponents stated that there aren't enough anesthesiologists in Nebraska to take care of the needs of all rural communities in Nebraska. The opponents stated that efforts have been made to provide in-services in some of these communities, but that there isn't sufficient staff to serve these communities on a full-time basis. The opponents also noted that most anesthesiology graduates seek employment in urban rather than rural areas. (Transcript of the Public Hearing, pp. 51 and 56.)

One opponent testifier stated that concerns about access to anesthesia care have been overstated. This testifier stated that anesthesia services must be discussed within the larger context of surgical services in general. Anesthesia is only one of many procedures that are part of the surgical process, which includes pre-operative care, post-operative care, pulmonary care, and the surgical care itself. The opponents felt that it is the overall quality of the various surgical procedures that matters the most, not access to one particular dimension of such care. (Transcript of the Public Hearing, pp. 58 and 59.)

The opponents also stated that there is no evidence to support the argument that surgeons are reluctant to work with

nurse anesthetists because of concerns about liability. The opponents stated that liability for the actions of CRNA's is part and parcel of the overall liability that a surgeon has for the well-being of his or her patient during a surgical procedure, and that this is accepted by the medical community as a necessary part of surgical practice. (Minutes of the Second Technical Committee Meeting on January 17, 1990; and Transcript of the Public Hearing, pp. 72 and 74.)

2. Is there harm inherent in the Applicants' proposal for a change in CRNA scope of practice?

Proponent Comments

The applicants stated that evidence they submitted to the committee documents their claim that opponent assertions that patients will receive a lower quality of care from a nurse anesthetist than from an anesthesiologist are not true. One proponent testifier stated that studies have shown that there is no significant difference in quality of care between the services of nurse anesthetists and anesthesiologists. (Transcript of the Public Hearing, pp. 78 and 79.)

The applicants stated that their proposal represents an effort to get Nebraska law to recognize the fact that CRNA's already perform their services independently and that they alone should be held accountable for their actions. The applicants stated that the proposal does not seek to give CRNA's authority to manage patient care as has been implied by opponents to the proposal. They stated that surgeons ought to have responsibility

for patient care. However, they stated that the old "captain of the ship" doctrine no longer applies. The surgeon is no longer responsible for everything that happens in the operating room. Other professionals are now recognized as having independent responsibilities within the context of surgical procedures. Nurse anesthetists are responsible for that slice of the surgical process that involves the administration of anesthesia. (Transcript of the Public Hearing, pp. 79 and 80.) The applicants stated that the proposal does not constitute an usurpation of the authority of the surgeon, but is rather an effort to make the law reflect the fact that in actual practice nurse anesthetists have independent authority and responsibility over that portion of surgical procedure that lies within their area of expertise.

The applicants stated that in the actual conduct of surgery, surgeons and nurse anesthetists work together as coequal members of a surgical team, neither being subordinate to the other. The current proposal, if passed, would in no way alter the way in which nurse anesthetists and surgeons currently collaborate to serve the needs of patients undergoing surgery. (Transcript of the Public Hearing, p. 19.)

One applicant testifier stated that the content and design of nurse anesthesia educational programs is such that the students are prepared to enter the professional and practice without supervision. This testifier added that the national trend is towards greater autonomy for such nurse practitioner

groups as CRNA's, and that Medicare recognizes this group as independent providers and does not require supervision by any other profession or authority. (Transcript of the Public Hearing, p. 29.)

The applicants stated that in California, Utah, Colorado, Minnesota, Montana, Oregon, and Wisconsin, CRNA's are already engaged in independent practice and are recognized as independent licensed providers. (The Applicants' Proposal, p. 31.)

One opponent testifier stated that applicant group characterizations of nurse anesthesia practice in the above-mentioned states are not accurate, and that overall physician supervision of CRNA practice has not been relinquished in these states. This testifier also cited cases from Colorado and Kansas where courts have upheld the concept of physician supervision over nurse anesthetists. (Transcript of the Public Hearing, pp. 64 and 65.)

Opponent Comments

The opponents stated that the applicants in their proposal are seeking to assume medical and legal responsibility for the medical aspects of anesthesia care, and that this constitutes an attempt to give CRNA's the right to perform nondelegable medical functions that are beyond the scope of their education and training. (Jerry J. Hynes, M.D., J.D., "Follow-Up Information in Opposition to Applicant Proposal".)

The opponents stated that CRNA functions are inextricably linked to the practice of medicine. They stated that when

anesthesia is practiced by CRNA's, it is a delegated medical function, and is not the practice of nursing, as was suggested by the applicant group. The opponents stated that the ultimate responsibility for patient care must remain with the physician through all phases of the surgical process. The opponents stated that at all phases of this process, there is a need for medical management of a patient's condition, and that the management of anesthesia does require the unique knowledge and skills of a physician. (Transcript of the Public Hearing, pp. 62 and 63.)

The opponents stated that nurse anesthetists do not have the necessary medical knowledge to assume the degree of responsibility for patient care that is requested in the applicant's proposal. The opponents stated that nurse anesthetists are not prepared to manage independently those aspects of the surgical process that require diagnosis and treatment. The opponents added that nurse anesthetists are not sufficiently trained to manage arterial pressure monitoring catheters, central venous intravenous lines, or pulmonary artery catheters at the same level of competence as is expected of a physician. The opponents also stated that nurse anesthetists are not sufficiently trained to manage intra-operative events independently. The opponents stated that to allow independent CRNA practice would be to create an inherent double standard of care depending on whether an anesthesiologist or CRNA is present. (Jerry J. Hynes, M.D., M.D., "Follow-Up Information in Opposition to Applicant Proposal".)

The opponents also stated that they were concerned about those portions of the proposal that called for the regulation of CRNA's to be removed from the Board of Medical Examiners and placed under the Board of Nursing. The opponents stated that because anesthesia is a medical function, there is a need for physician input on any board that plays a role in regulating CRNA's. The opponents felt that this aspect of the proposal was a source of potential harm to the public. (Transcript of the Public Hearing, p. 75.)

3. How Does the Proposal Compare in Cost-Effectiveness to Those of Other Alternatives in Addressing the Harm Identified by the Applicant Group?

Proponent Comments

The applicants stated that their proposal is the most cost-effective means of addressing the problems associated with the current practice situation of nurse anesthetists. (The Applicant's Proposal, p. 35.) The applicants stated that the proposal would greatly improve public access to anesthesia care, especially in remote rural areas of Nebraska. They stated that the public would also benefit from the fact that the proposal would allow CRNA's to practice in dental and podiatric offices. This, they felt, would improve the quality of anesthesia care in these offices. The applicants stated that the cost of services to the public would not increase, and might actually decrease as a result of the increased utilization of CRNA's services that would result from the implementation of the proposal. (The

Applicants' Proposal, p. 35.)

The applicants stated that removing the supervisory requirement from the statute would have the impact of constraining health care costs by making surgeons feel more comfortable about using the services of a CRNA, which are generally lower in cost than the services of an anesthesiologist. The applicants added that recognizing that CRNA's practice independently would increase Nebraska's ability to attract and retain both surgeons and nurse anesthetists to practice in Nebraska. (Transcript of the Public Hearing, p. 10.)

The applicants stated that the benefits of the proposal can be achieved without a loss in quality of care. The applicants stated that the quality of care in such settings as dental and podiatric offices would actually improve due to the presence of high trained CRNA's in these offices. (Transcript of the Public Hearing, p. 13.)

Opponent Comments

The opponents stated that the proposal would do harm to the public health and welfare of Nebraskans. They were concerned that the proposal would result in lowered quality of care, even though it might improve access to care. The opponents felt that quality of care must not be sacrificed for an improvement in access to care. (Transcript of the Public Hearing, pp. 84 and 85.)

The opponents presented testimony which indicated that independent CRNA practitioners would charge more for their

services than is the case under the present system. (Transcript of the Public Hearing, p. 46.) They felt this discredits the idea that the proposal would result in lower-cost anesthesia services for the public. The opponents also stated that the proposal would result in patients receiving a separate billing for anesthesia in addition to the bill for the surgical procedure, whereas under the current practice situation, the patient is billed only once for the entire surgical process. (Transcript of the Public Hearing, p. 71.)

Neutral Commentary

Testimony was received from the Nebraska Dental Association on the proposal which stated that CRNA's should be allowed to work in certain "permitted" dental offices, but that in their opinion this could be done with or without changing the necessity for supervision. However, the Dental Association testimony went on to state that the passage of the Dental Anesthesia Act has diminished anesthesia problems to the point where they are nonexistent in Nebraska, and that this fact lessens the need for the proposal. Their testimony also stated that contrary to applicant group comments about anesthesia in dental offices, only well-trained dentists take independent action during the provision of anesthesia. Untrained personnel perform routine reporting and monitoring tasks, but do not take independent action. (Letter of February 22, 1990 from Richard M. Tempero, D.D.S., M.D. to the Technical Committee.)

However, testimony was also received from a dentist

practicing in a rural community in Nebraska which stated that having a CRNA in a dental office would allow much more timely treatment of problems that might arise from the administration of anesthesia. This testifier added that she would feel more comfortable working on a patient who is being monitored by a trained anesthetist than trying to sedate a patient himself and at the same time work on the dental procedure being performed. (Letter from Paula L. Harre, D.D.S.; to the technical committee.)

COMMITTEE CONCLUSIONS AND RECOMMENDATIONS

At their fourth meeting the committee members met to formulate their recommendations on the proposal by voting on the four criteria that pertain to the proposal. On the first criteria, Steve Wooden moved that, "The present scope of practice or limitations on the scope of practice create a situation of harm or danger to the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument." Dr. Peetz seconded the motion. In the discussion that followed, Steve Wooden stated that harm is resulting from the fact that surgeons are reluctant to come to remote rural areas of Nebraska because they are concerned about the liability implications of having to work in areas where CRNA's rather than anesthesiologists provide anesthesia care. Mr. Wooden stated that the proposal would solve this access problem by making CRNA's independent practitioners and thereby making them, rather than surgeons, liable for their own actions. Ruth Vacha agreed that gaining access to anesthesia services in rural communities is difficult. Dr. Moravec stated that the benefit of the current statutory restrictions is that it ensures quality care, and expressed concern than the proposal would lower standards of care for the sake of increasing access to anesthesia care. The committee members then voted on criterion one. A majority of five to one with one abstention voted to support the proposal on this criterion. (Minutes of the

March 19, 1990 technical committee meeting.)

On the second criterion, Dr. Peetz moved that, "The proposed change in scope of practice does not create a significant new danger to the health, safety or welfare of the public." Steve Wooden seconded the motion. The discussion on this criterion focused on concerns about potential harm that might result from CRNA's being removed from the jurisdiction of the Medical Board of Examiners. Chairperson McQuillan stated that there is a need for some medical overview of CRNA services, and that leaving nurse anesthetists under the Medical Board of Examiners would be one way to accomplish this. Mr. Wooden responded to these concerns by stating that CRNA's have no representation on the Medical Board, and that some members of this board have expressed negative views on CRNA's. Vicky Burbach, a Department of Health employee with the Bureau of Examining Boards, stated that there have been no reported problems associated with CRNA practice within the last four years, and that the Medical Board hasn't taken an active role in the CRNA regulation within the above-mentioned time frame. Mr. Wooden stated that the applicant group would attempt to provide for medical input on CRNA issues in any bill that the applicants would write in an attempt to implement their proposal legislatively. The committee members then voted on criterion two. A majority of five to one with one abstention voted to support the proposal on criterion two. (Minutes of the March 19, 1990 technical committee meeting.)

Steve Wooden moved "Enactments of the proposed change in

scope of practice would benefit the health, safety, or welfare of the public." Dallas Wilhelm seconded the motion. The committee members then decided to vote on this criterion. A majority of five to one with one abstention voted to support the proposal on this criterion. (Minutes of the March 19, 1990 technical committee meeting.)

Steve Wooden moved that "The public cannot be effectively protected by other means in a more cost-effective manner." Ruth Vacha seconded the motion. Dr. Moravec stated that one alternative to the proposal that needs to be considered is to revise the rules and regulations for CRNA's so as to improve access to care. Steve Wooden responded by stating that the proposal is the most cost-effective means of addressing the problems of access to anesthesia care in Nebraska. The committee members then voted on this criterion. A majority of five to one with one abstention voted to support the proposal on this criterion. By this vote, the committee members had decided to recommend approval of the proposal. (Minutes of the March 19, 1990 technical committee meeting.)

The committee members then discussed what additional recommendations they might want to make on the proposal. Steve Wooden moved that the committee members recommend that an anesthesiologist be added to the CRNA Advisory Council, and that a CRNA be added to the Board of Medical Examiners, and that the Medical Board and the Board of nursing jointly oversee CRNA's. Jane Embry seconded the motion. The committee members voted to

support this motion unanimously. (Minutes of the March 19, 1990 technical committee meeting.)

OVERVIEW OF COMMITTEE PROCEEDINGS

The CRNA Technical Committee members met on December 18, 1989 in Lincoln at the Nebraska State Office Building for their first meeting. Staff described the role, duties, and responsibilities of the committee under the credentialing process. Other areas touched upon were the charge to the committee, the four criteria for credentialing contained within Section 21 of the Credentialing Review Statute, and potential problems that the committee might confront while proceeding through the review.

The committee members met for their second meeting on January 17, 1990 in Lincoln in the State Office Building. At this meeting, the committee members formulated a set of questions and issues it felt needed to be addressed at the public hearing. Contained within these questions and issues were specific request for information that the committee felt was needed before any decisions could be made.

The committee members convened on February 16, 1990 in Lincoln at the Nebraska State Office Building for the public Hearing. A ten-minute rebuttal period was provided near the end of the hearing. Interested parties were given ten days to submit final comments to the committee.

The committee members met for their fourth meeting on March 19, 1990 in Lincoln at the State Office Building. After studying all of the relevant information concerning the proposal, the

committee formulated their recommendations on the proposal by voting on the four criteria of the credentialing review statute pertinent to the proposal.

On the first criterion, Steve Wooden moved that, "The present scope of practice or limitations on the scope of practice create a situation of harm or danger to he health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument." Dr. Peetz seconded the motion. Voting aye were Embry, Peetz, Vacha, Wilhelm, and Wooden. Voting nay was Moravec. Chairperson McQuillan abstained from voting.

On the second criterion, Dr. Peetz moved that, "The proposed change in scope of practice does not create a significant new danger to the health, safety or welfare of the public." Steve Wooden seconded the motion. Voting aye were Embry, Peetz, Vacha, Wilhelm, and Wooden. Voting nay was Moravec. Chairperson McQuillan abstained from voting.

Steve Wooden moved "Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public." Dallas Wilhelm seconded the motion. Voting aye were Embry, Peetz, Vacha, Wilhelm, and Wooden. Voting nay was Moravec. Chairperson McQuillan abstained from voting.

Steve Wooden moved that "The public cannot be effectively protected by other means in a more cost-effective manner." Ruth Vacha seconded the motion. Voting aye were Embry, Peetz, Vacha, Wilhelm, and Wooden. Voting nay was Moravec. Chairperson

McQuillan abstained from voting. By this action, the committee members had decided to recommend approval of the proposal.

The committee members then discussed what additional recommendations they might want to make on the proposal. Steve Wooden moved that the committee members recommend that an anesthesiologist be added to the CRNA Advisory Council, and that a CRNA be added to the Board of Medical Examiners, and that the Medical Board and the Board of Nursing jointly oversee CRNA's. Jane Embry seconded the motion. Voting aye were Embry, Peetz, Vacha, Wilhelm, Wooden, Moravec, and McQuillan.