The New York State
Society of Anesthesiologists, Inc.
110 East 40th Street, Suite 300, New York, NY 10016 USA
TELEPHONE: 212-867-7140 | FAX: 212-687-1005 | INTERNATIONAL: +00 followed by number | WEBSITE: www.nyssa-pga.org

MEMORANDUM IN OPPOSITION
S3501 (Bailey) and A8007 (Gottfried)
CRNA Collaborative Practice

The New York State Society of Anesthesiologists, Inc., urges you to REJECT legislation that would compromise patient safety!

- **These bills render null and void the existing and time-tested standard of anesthesia care that has resulted in dramatically improved patient safety.**
  - Under existing law[1], established nearly 30 years ago, a patient undergoing any medical treatment requiring anesthesia is guaranteed a standard of care that requires a physician anesthesiologist to administer the anesthetic or to supervise a nurse anesthetist in the administration of anesthesia, or the operative surgeon accepts responsibility for supervising a nurse anesthetist.
  - With this proposal, the sponsor is removing the physician anesthesiologist entirely from the treatment team, including the preoperative assessment of the patient, the preparation of the anesthetic plan, and post-anesthesia care.
  - Instead, the sponsor is promoting a model of anesthesia care wherein a nurse anesthetist independently administers anesthesia, without a physician anesthesiologist immediately available or an operative surgeon accepting responsibility for the supervision of the nurse anesthetist, through a delivery care model that: (i) has never been tested in the operating room environment in New York state, (ii) will lower the standard of care, (iii) fails to address critical issues that arise in the operating room, (iv) does not provide supporting independent analysis, peer-reviewed studies or data to support this radical policy change; and (v) will impact every patient undergoing a surgical procedure with anesthesia.
- **The model of anesthesia care creates a new, unproven, and lower standard of care in New York state.**
  - The sponsor's proposal will create a two-tier anesthesia delivery system; without a statewide uniform requirement as currently exists, hospitals will be free to permit nurse anesthetists to administer anesthesia independently, a decision that could be based on patient payer status or other economic considerations.
  - The collaborative physician is not required to be immediately available or present. The operating room is a unique healthcare environment. If a patient undergoing anesthesia develops life-threatening complications, immediate medical intervention is required, which will not be accomplished. An independent study published in the peer-reviewed journal *Anesthesiology* found that mortality and failure-to-rescue rates were higher for patients who underwent operations without medical direction by a

[1] See NYCRR Section 405.13(a)(1) (Hospitals); NYCRR Section 755.4 (Ambulatory Surgery Centers)

LEGISLATIVE REPRESENTATION
Charles J. Assini, Jr., Esq. | *NYSSA Legislative Counsel and Representative* | Higgins, Roberts & Suprunowicz, P.C. | 1430 Balltown Road, Schenectady, New York 12309
TELEPHONE: 518-374-3399 | FAX: 518-374-9416 | E-MAIL: CJAssini@HRSLaw.us.com and cc: GKCarter@HRSLaw.us.com | WEBSITE: www.HRSLaw.us.com
Robert Reid, Shauneen McNally, Marcy Savage | *NYSSA Albany Lobbyists* | Reid, McNally & Savage, LLC | 1 Commerce Plaza, Suite 402, Albany, New York 12210
TELEPHONE: 518-465-7330 | FAX: 518-465-0273 | E-MAIL: Bobr@lobbywr.com and cc: Kellyk@lobbywr.com | WEBSITE: www.lobbywr.com

physician anesthesiologist (Silber JH, Kennedy SK, Even-Shoshan O, Chen W, Koziol LFL, Showan AM, Longnecker DE: Anesthesiologist direction and patient outcomes. *Anesthesiology* 2000; 93: 152-63.)

- The collaborating physician need not be a physician anesthesiologist; in fact, the collaborative party can be a hospital with absolutely no restrictions as to the number of nurse anesthetists with whom it can collaborate.

- **This proposal is also defective by allowing the nurse anesthetist broad prescriptive writing authority.**
  - It gives 1,240 nurse anesthetists full prescribing authority without common sense legal oversight at a time when New York state is combating prescription drug and opioid abuse, all with undefined training requirements other than obtaining a "certificate" from the Department of Health.
  - It fails to restrict a nurse anesthetist's prescriptive authority to his/her own patients.
- **These proposals are being advanced based upon two fundamental misconceptions.**
  - **These proposals are not consistent with the extent of a nurse anesthetist's training and existing practice, nor are they consistent with other states**. These bills represent an inappropriate expansion of the nurse anesthetist's practice by permitting independent practice. Nurse anesthetists are not trained as independent anesthesia providers. Clinical training of student nurse anesthetists provides the direct and personal supervision that the Health Code requires. They provide no training in independent practice. *[10 NYCRR Section 405.13(a)(1)(v): a student enrolled in a school of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Education Programs may administer anesthesia as related to such course of study under the direct personal supervision of a certified registered nurse anesthetist or an anesthesiologist.]* Most states require medical supervision or medical direction of nurse anesthetists.
  - **There are no healthcare cost savings**. Under Medicare and Medicaid, reimbursement for anesthesia services is exactly the same whether it is administered by a physician anesthesiologist or by a nurse anesthetist. Independent studies have shown that the odds of an adverse outcome are 80 percent higher when anesthesia is provided only by a nurse anesthetist as opposed to a physician anesthesiologist (*Memtsoudis SG, Ma Y, Swamidoss CP, Edwards AM, Mazumdar M, Liguori GA: "Factors influencing unexpected disposition after orthopedic ambulatory surgery." J Clin Anesth 2012; 24(2):89-95.*). Adverse outcomes lead to higher costs for patients in both monetary and physical terms when patients require longer hospital stays.
- **Physician anesthesiologists are most qualified to serve as the patient's advocate.**
  - The operating room environment requires the physician anesthesiologist to be immediately available for medical interventions that save patients' lives during all surgical procedures when anesthesia is administered.
  - Anesthesia care is an inherently dangerous undertaking. Some commonly used anesthetics are 1,000 times more powerful than morphine. Emergencies can arise without warning; there are no "routine" surgical procedures.
  - Physician anesthesiologists, who have 12,000–16,000 hours of clinical training compared to a nurse anesthetist's 2,500 hours of clinical training, are best able to perform risk-benefit analysis during surgery and have the credibility to tell a surgeon whether future surgery poses a danger to the patient. This advocacy requires the knowledge of a physician.

Put patient safety first! Support medical care by medical doctors by voting NO on S3501 (Bailey) and NO on A8007 (Gottfried)!