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MEMO IN OPPOSITION
A6958A (Reyes) / S769A (Cooney)
CRNA Independent Practice

The New York State Society of Anesthesiologists urges you to REJECT legislation that would compromise patient safety and create a two-tiered standard of anesthesia care for patients in New York State. This proposed legislation would imperil patient safety in the delivery of anesthesia care. The New York State Society of Anesthesiologists, Inc. (NYSSA), consisting of over 4,300 physician anesthesiologist members, supports licensure of the 1,200 certified registered nurse anesthetists in our state but NOT to the detriment of patient safety. NYSSA strongly supports the A1890 (Bichotte Hermelyn) / S3000 (Gounardes) bill which achieves this goal.

- **New York state patients deserve the highest level of anesthesia medical care, which is the physician anesthesiologist led team approach to the delivery of anesthesia care. This bill undermines and voids the time-tested standard of anesthesia care that has resulted in dramatically improved patient safety.**

- **The existing law[1] was established nearly 30 years ago and has saved countless lives. Currently, a patient undergoing medical treatment requiring anesthesia is guaranteed that a physician anesthesiologist will administer the anesthetic or will supervise a nurse anesthetist in the administration of anesthesia, or the operative surgeon will accept responsibility for supervising a nurse anesthetist. The key components of the physician-anesthesiologists led care team include:**
  - Physician anesthesiologists are physically present for all phases of anesthesia care including preoperative medical assessment, determination and ordering of the narcotics to be used, induction, and emergence and they are immediately available to respond and medically intervene when a patient crisis occurs
  - Physician anesthesiologists are responsible for the medical management of the patient - they determine which perioperative risks, if any, may be delegated nurse anesthetist, but assume the overall medical responsibility for the patient;
  - Physician anesthesiologist led care consists of physician anesthesiologists and nurse anesthetists working together as a team to achieve best results.

- **With the amendments to this proposal, the sponsors are:**
  - Authorizing nurse anesthetists to conduct all phases of anesthesia independently. This creates an ambiguous direction standard that will replace the physician anesthesiologist's authority to supervise the

[1] See NYCRR Section 405.13(a)(1) (Hospitals); NYCRR Section 755.4 (Ambulatory Surgery Centers) [Subject to Executive Order No. 4]

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administration of anesthesia services of the nurse anesthetist in the hospital or ambulatory surgical center; this conflicts with the standards established by NYS Health Code.

- The proposed new anesthesia standard of care will supersede current established operating standards and create conflicts.
  - Lack of definition of the relationship between the physician anesthesiologist and the operative physician and the nurse anesthetist will create conflicts and is unprecedented in NYS.
  - The proposed bill contains definitions that are ambiguous and dangerous to patient safety by failing to ensure that the critical components of anesthesia care will be preserved (e.g., there is no articulation of how the medical management of the patient will occur, it fails to recognize the licensure limitations of the practitioners listed to administer anesthesia, it fails to require any physician anesthesiologist be present and available on site to immediately respond).

- **An ill-defined oversight standard will create confusion in the OR (operating room) and other anesthesia care settings which will result in adverse patient outcomes. Some critical questions to contemplate:**
  - How can there be effective communication between a nurse anesthetist and a physician during a patient crisis? Intervention during surgery must be made in seconds - nurse anesthetists are not adequately trained to manage these types of crises on their own.
  - The nurse anesthetist would be the ultimate decision-maker and responsible for the patient in all phases of the anesthesia and medical decisions in the OR – the physician has not seen the patient and is not physically present – how can a physician exercise medical authority when there is a disagreement between the nurse anesthetist? There is no clear means to address nurse anesthetist / physician disagreements – especially in the OR.
  - Since a physician is no longer required to be physically present to perform the pre-anesthesia assessment, including an overview of the narcotics to be used: how does the nurse anesthetist ensure that the patient is physically fit for surgery? How can there be effective “coordination” during this critical phase? We contend effective medical intervention cannot occur.
  - The sponsor’s use of the terms defining “direction” and “coordination and communication” are not defined which will lead to uncertainty and confusion.
    - Additionally, the amended bill uses the term “oversee”; how does the physician assume the role of “overseeing” the nurse anesthetist with more than 3,500 hours when the role of the physician is not addressed?
    - What is intended by claiming an interdependent relationship exists between the physician and nurse anesthetist? Interdependent means both parties are mutually dependent on each other - this does not reflect the existing anesthesia care team standards. The existing standard authorizes the physician anesthesiologist to delegate tasks to the nurse anesthetist, as determined by the physician anesthesiologist, with the understanding that the physician anesthesiologist assumes the ultimate authority to determine what is best for the patient. While the care team approach allows both professionals (with different skill sets) to work together for the benefit of the patient, the physician anesthesiologist independently uses his / her advanced clinical training to determine the medical intervention required.
  - The sponsors, in establishing an extremely broad scope of practice for the nurse anesthetist (without incorporating critical anesthesia supervision standards in existence for decades), are 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:

- Has never been tested in the operating room environment in NYS;
- Will lower the standard of care;
- Fails to address critical issues that arise in the operating room and will lead to confusion when critical lifesaving decisions must be made in seconds ;
- Does not provide supporting independent analysis, peer-reviewed studies, or data to support this radical policy change;
- Will impact every patient undergoing a surgical procedure with anesthesia
- Will render null and void the anesthesia standard set forth in the NYS Health Code; and
- Will render null and void the Office Based Surgery (OBS) Anesthesia Accreditation standard requiring physician supervision of a nurse anesthetist – the OBS accreditation standards were promulgated to enhance patient safety in the office based setting.

- **This model of anesthesia care creates a new, unproven, and lower standard of care in New York state.**
  - The sponsors' proposals will create a two-tier anesthesia delivery system. Without a statewide uniform requirement, as currently exists in the NYS Health Code, hospitals and ASCs will be free to permit nurse anesthetists to administer anesthesia independently. This decision could affect patients based on their location (more particularly the marginalized community) or based on their insurance status or other economic considerations. This could intensify conditions in communities already experiencing a lower standard of healthcare.
  - The physician "overseeing" or, "coordinating" or, "communicating" with the nurse anesthetist 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. This 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 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*).
  - A Recent JAMA survey[2] found that "Evidence now demonstrates that administrative or policy decisions that force reduction of [physician] anesthesiologist involvement in care will result in patient harm". Importantly, the findings of this study emphasize the critical importance and value of the physician anesthesiologist's involvement in the care of each patient undergoing anesthetic care.

- **This proposal is being advanced based upon fundamental misconceptions.**
  - **This proposal is not consistent with the extent of a nurse anesthetist's training and existing practice nor is it consistent with other states**.
    - This bill represents an inappropriate and unnecessary expansion of the nurse anesthetist's practice by permitting independent practice, including the right to (i) prescribe narcotics and develop the anesthesia plan during the "peri-anesthetic period" when the role of a physician anesthesiologist is most critical to assess the patient's tolerance for certain narcotics based on the patient's medical condition; and (ii) make pre-operative assessments (including ordering an evaluating laboratory and diagnostic tests) instead of the physician anesthesiologist who has the medical training to make critical decisions for patient safety such as immediate medical intervention, appropriate patient monitoring, or to delay surgery until the patient's medical status is suitable.

[2] Burns et al. Association of Anesthesiologists Staffing Ratio with Surgical Patient Morbidity and Mortality. JAMA Surg July 20, 2022

- 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. It provides no training in independent practice and limited training on the use of narcotics. *[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.]*
- A majority of states and hospitals credentialing anesthesia providers 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.

➢ **This legislation will NOT increase the number of anesthesia providers in New York state and therefore is NOT necessary.**

- **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 have 12,000–16,000 hours of clinical training compared to a nurse anesthetist's 2,500 hours of clinical training.

➢ Physician anesthesiologists perform risk-benefit analysis during surgery and have the credibility to prevent unsafe surgeries. This advocacy on behalf of the patient requires the knowledge and status of a physician.

Put patient safety first by voting NO on A6958A (Reyes) / S769A (Cooney)!