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Unsupervised anesthesia care by a nurse anesthetist is a threat to patient safety

KAREN S. SIBERT, MD | [PHYSICIAN](#) | NOVEMBER 17, 2011

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.

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.

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.

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.

Karen S. Sibert is an Associate Professor of Anesthesiology, Cedars-Sinai Medical Center.

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[stanley kristiansen](#) · 2 years ago

MD's by licensure have an unlimited liscence to practice medicine, if an institution will credential them they can do it, responsiable md's practice in the area they are trained just as CRNA's do. This cannot happen with CRNA's who have a deliniated scope of practice, with MD's it can and does and it is all LEGAL.

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[davemills555](#) · 2 years ago

Maybe couldn't handle the heat so you went whining to management?

2 ^ | ▾ Share >

[Ridics](#) → [davemills555](#) · 2 years ago

Hahah...I am clearly not who you think I am

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[davemills555](#) · 2 years ago

Gee Ridics,

I'm restricted...Did I offend you?

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[Ridics](#) → [davemills555](#) · 2 years ago

Not sure what you are refering to...? I dont have the ability to restrict anyone

^ | ▾ Share >

[Bill Wagner, DNP](#) · 2 years ago

Dr. Silbert,

There is an abundance of evidence in the literature supporting the history of safe and very effective care delivered by autonomous Advanced Practice Nurses (APNs). And if you do a top-notch lit review, you will discover what the AMA has always been aware of: there has never been a single study, nor does there exist any actuarial data to suggest or support your opinion that APNs are not safe and effective health care providers when we deliver care within our scope of practice. In most jurisdictions in this country, Dr. Silbert, Nurse Practitioners (NPs) have been practicing as fully autonomous and independently licensed and insured practitioners for more than a half century, and not, as you incorrectly note, practicing or writing prescriptions "under the doctor's authority", or requiring a physician to co-sign our orders and clinical notes.

Nurse Anesthetists have been practicing, largely as fully autonomous providers, for around 150 years. In that time, the doomsday predictions of an imminent "threat to public safety" that you and other physicians continue to forecast despite the growing evidence to the contrary, have never been actualized.

As health care providers, our clinical work is now largely informed by evidence-based practice guidelines.

If your arguments are earnestly rooted in an honest concern for the safety of human lives, and if you value higher level studies as evidence, it is puzzling to me how seemingly easy it is for you and for others who may share your opinion, to continue to ignore the mounting evidence that consistently refutes your opinions. The rationale that remains then, after evaluation and evidence is removed, seems to be a vigorous defense of purely your own self interests, transparently veiled as altruism.

Given the challenges facing the health of our nation and the world today, would not the energy and the resources currently directed toward defending your turf and self-interests be more productively and beneficially applied in a collaborative multi-disciplinary partnership actually focused on...the patients?

Bill Wagner, DNP

97 ^ | 2 v Share ›



davemills555 • 2 years ago

RE: <http://capsules.kaiserhealthne...>

The silent majority is waking up and they are voting with their feet. Now, if only WalMart would form an ACO!

^ | v Share ›



davemills555 • 2 years ago

Anesthesia? For goodness sake, there are people within the 50 million uninsured and 25 million more who are underinsured who would simply love to have the cancer operation they need by using a lousy bottle of whiskey and a hunk of leather to bite down on as there sole source anesthesia. However, if it's up to the AMA and AHIP and Big PhRMA, they ain't even getting that! In today's profit driven health care system, money talks and BS walks! What these professional morons don't quite get is that the cows teats are drying up. You've milked the animal for far too long and there's no more milk!

3 ^ | v Share ›



davemills555 • 2 years ago

I say, the best suggestion on here is to return to the days when surgery was performed by the local barber in the corner barber shop. I understand they always had an ample supply of chloroform! Best of all, anyone could afford surgery at the barber shop because it wasn't any more expensive than a shave and a haircut! Two-bits!

^ | v Share ›



wahoo2 · 2 years ago

Michael-

You have made some good points, but it is difficult (if not impossible) to comment on a lecture without the full presentation in addition to the added interpretation of the lecturer himself. Also, one must remember that Dr. Lema is an academic who gave this talk over 4 years ago. The ASA's general stance is expanding the role of the anesthesiologist to all arenas of perioperative care: ICU, chronic and acute pain, preop clinics, OR administration and more. They believe that the anesthesiologist should be a perioperative physician. Implicit in their argument is that there are not enough anesthesiologists to meet this demand. With this in mind, they have fully embraced the ACT model. Some like Dr. Lema have taken it even a step further and suggested managing OR's like ICU's (thus the 10:1 supervision). Others have gone even beyond that to postulate remote consulting (i.e. telemedicine for anesthesia).

Cost is certainly a big factor (our health care system and country are broke), but I do not think Lema believes it is the only factor. If he didn't think his model was safe and cost-effective, he would never advocate for it. I also think that "safety" is implied in "quality." How can you deliver quality care that isn't safe? So I believe the focus of the lecture was to outline a cost-effective AND high-quality (i.e. safe) model. Below are the

[see more](#)

2 ^ | v Share ›



Michael Bentley · 2 years ago

If safety was the issue, why did the ASA President in 2007 suggest a 10:1 ratio? How can an anesthesiologist be in 10 places at once? Again I will post what I wrote and wait for comments:

Regardless of the anesthesia provider, anesthesia is safe. In fact here is a bit of information taken from a Harvard lecture on Anesthesia Safety: Anesthesia mortality has fallen from 1/ 3,000 in 1985 to 1/ 30,000 or 1/300,000 in 1996 (and has remained there)

$1/295,118 = 6 \text{ sigma}$

Please note that this is 15 years ago. It is commonly accepted by many authorities to be over 1 in 400,000 today. Anesthesia is six sigma regardless of the provider.

Also, I would like to bring to your attention comments made by Mark Lema, MD, PhD who was President of the ASA in 2007. He gave a lecture at the ASA Practice Management Conference titled "21st Century Anesthesiology - Preparing for the Future Paradigm". He first begins by detailing the shortage of providers by stating that the expansion of anesthesia services into offsite/unusual anesthetizing locations creates greater demand with reduced efficiency. He then admits that the Pain Medicine specialty has further

[see more](#)

30 ^ | v Share >



snozcumber · 2 years ago

You will find anaesthetists " rule the theatre roost " in England, Australia and New Zealand (countries I have worked in) .No kow towing to surgeons. Anaesthetists run the Intensive Care Units , manage pain clinics and are available for all emergency situations. Anaesthetists are on the exact same pay scale as their colleagues (fellow physicians) working within the public healthcare setting. ie surgeons, oncologists, urologists etc. They are highly regarded and valued for their skills as Consultant Medical Specialists/Physicians.

11 ^ | v Share >



Earl Mueller · 2 years ago

Ever so cost concious European colleagues do not embrace it because in Europe's socialized medical world, Anesthesiologists a.k.a. "Anesthetists" (England) are paid significantly lower salary than here in the U.S. Furthermore, are viewed much more as a "technician" rather than on par full physician. Job satisfaction is an issue in the field in England...if it remains so, you just might see the socialized healthcare industry there go exactly the way it is here.

3 ^ | v Share >



Ridics → Earl Mueller · 2 years ago

Hahaha...earl you have proven that you know very little with the above statement...just see snozcumber's post above...you would be correct though that the difference between the two systems is likely secondary to the economical difference between the two systems.

1 ^ | v Share >



Earl Mueller · 2 years ago

Mr. Ridics, Could you please site the statute that requires CRNA's to be supervised by an "Anesthesiologist". I can't seem to find it. Yes, CRNA's are to practice under the supervision of a physician, not specifically an anesthesiologist. Hence the reason CRNA's are the only "anesthesia" provider in most cases in America today. The Gastroenterologist doing the EGD or Colon, Plastic Surgeon doing what ever case, heck, even oral surgeon doing a case.... those are all physicians. Do they know a hill of beans of about anesthesia?? No they do not. Furthermore, the legality of "captain of the ship" has fallen by the wayside, hence can no longer be used by MDA's to purport liability to surgeons for care given by the CRNA. If that were the case, I would not need to cover liability insurance for my own practice, correct?? So obviously there is a surgeon or MD involved somewhere with the CRNA... because after all, why would a CRNA even be there if it were not for the MD doing "something" to a patient that needs them to remain still, be free from pain, etc. We as CRNA's independant or not are not simply going to go around knocking people out or sedating patients just for giggles. So, seriously, please site the federal statute that says an Anesthesiologist must be present for supervision of

site the federal statute that says an Anesthesiologist must be present for supervision of all CRNA's, that only applies in areas of the VA health system.

Good day and Happy Turkey's to all....

16 ^ | 1 v Share >



[Ridics](#) → Earl Mueller • 2 years ago

Earl not what I said....I said that a physician must supervise an anesthesia nurse (CRNA)...why would you have a cardiologist, dermatologist be the supervising physician when they know nothing about anesthesia when you could have a anesthesiologist who is a physician supervise the anesthesia nurse...just seems logical to me. Again never mentioned anything about "captain of the ship". I guess my question to you would be if your family member was having surgery and something went wrong would you rather have a physician anesthesiologist for back-up or a physician gastroenterologist...I think I know the answer 99% of the population would have.

1 ^ | v Share >



[DebbieMalinaCRNA](#) → Ridics • 2 years ago

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

9 ^ | v Share >



[Ridics](#) → DebbieMalinaCRNA • 2 years ago

Debra, AANA President

Supervision is for CRNA practice, the vast majority of CRNA's are supervise and should be. Ms AANA President, please post requirements for your student in regards to major vascular, hearts, regional etc for all to see. Also when you post these numbers please explain to everyone that when the requirement states management of regional procedures it does not equate to performance of those particular procedures. I can tell you for a fact I have had student anesthesia nurses when I was a resident watch me perform carotid endarterectomies, abdominal aortic aneurysm repairs, and heart surgeries etc just so they could record it so they could graduate. Also they just have to manage blocks and watch physicians place them. How does the equate to a practitioner that is able to graduate and practice independently....it clearly does not. Anesthesia nurses should be supervised by an anesthesiologist.

3 ^ | 2 v Share >



Guest → DebbieMalinaCRNA • 2 years ago



Supervision is for patient safety! Quit trying to put patients at risk.

4 ^ | 2 v Share >



[davemills555](#) • 2 years ago

It's amusing to read fearful post coming from corrupt providers that see the handwriting on the wall. They are so fearful that their status quo health care system, the same broken system that only benefits them, the health care insurance companies and Big Pharma, is slowly crumbling and coming to an end. ACOs are buying up private practices in record numbers all across America. The single-doctor private practice model will soon be history. Wellness and good outcomes will soon replace our current and failed fee-for-service model and beaten-down consumers will flock to "big box" health care centers in droves. The party is over for you small profit driven maniacs. The abuse of our Medicare consumers and the abuse of health care consumers in general must end. We need to put consumers on the top rung instead of the bottom. Many local hospitals in my region already have the ACO model in place and they continue to buyout the smaller providers. They are just waiting to announce their grand opening. Many critics will say, "You'll be sorry if the ACOs take over!" They say, "Quality will suffer!" To these critics I say, providers had your chance to make things better for the consumer. The insurance companies had their chance too. Big Pharma had their chance to make their products more affordable. Guess what? All three kept profits as their top priority and kept the consumer at the bottom. I say, anything is better that what we have today. Spending 18 percent of GDP on health care and we rank 37th worldwide with 50 million plus uninsured and another 25 million underinsured? What's so good about that? If anything, we need more nurses and less doctors, at least in primary care and in anesthesia care.

9 ^ | v Share >



[Ridics](#) → [davemills555](#) • 2 years ago

It is amusing that you think that a ACOs are the answer. Do you think ACOs that are buying up PP groups in record numbers is because they are going to make healthcare cheaper and a higher quality...sorry dave it is so it insures that they can get a bigger piece of the medicare pie. Trust me this will not make it cheaper...just like HMO, PPO, etc...did not make anything cheaper for anyone now like they were suppose to decades ago

6 ^ | v Share >



[davemills555](#) → [Ridics](#) • 2 years ago

The major difference between the ACO model and "just like HMO, PPO, etc..."?

The ACO model pays their "employees" a "salary".

The failed fee-for-service model is tossed out the window. Fee-for-service rewards volume and sickness. The ACO model rewards wellness and

good outcomes. Unlike in today's broken system where a filled waiting room means big profits. The ACO does best when there's nobody in the waiting room and the professionals still get paid. All the "so-called" brains we have in the AMA and AHIP and PhRMA and nobody could figure this out? What a bunch of complete morons?

1 ^ | v Share ›



Ridics → davemills555 • 2 years ago

Dave, what happens when a hospital gets a bundled package payment that does not cover the cost of the patients care? Do you really think that society is going to be ok with hospitals saying sorry there is no more money left in your bundled payment to continue your care...nope and the payments will increase based on that pressure. The absolute only way to change the continued increased cost of healthcare is to have a single payer system for everyone. Would this decrease the cost and limit care...yes...but the majority will similar care. ACOs will not work I promise you...but they only way to find out is to spend billions to establish ACOs and give them a shot I guess.

^ | v Share ›



davemills555 → Ridics • 2 years ago

As long as America's hospitals and their lobby group, the AHA, continue to wuss out and refuse to fight mandated emergency room care as aggressively as Republican ATs in red states are fighting the individual mandate, hospital stakeholders will be massive losers. The only thing I can figure is that hospitals love the abuse. It's amazing that some Republicans actually believe that the uninsured don't get health care when, in truth, they get the best and most expensive health care available. Are Republicans that stupid? Apparently!

Regarding ACOs, read and weep...<http://www.healthreformwatch.com/cate...>

^ | v Share ›



Ridics → davemills555 • 2 years ago

Well hospitals use to be able to denie mandated ER care but after a couple high profile cases...guess what there was a public outcry and a law was passed stating you cant refuse to care for a pt when presenting to the ER.

In regards to your link...I am still attempting to figure out what I am weeping about. I dont have time to pick apart that article and

explain why it wont work well on so many different levels.

^ | v Share ›



Ridics • 2 years ago

Hahah....the AANA president...Debra nice spin work

1) CRNAs have to be supervised by a physician. Anesthesiologist are physicians trained to deliver anesthesia and care for patients in the peri-operative setting thus we are the physicians supervising CRNAs. Would not be wise to have cardiologist supervise a CRNA.

2) opt out rule was signed into law by president Gearge W Bush.

On January 20, 2001, the incoming George W. Bush Administration announced a 60-day blanket moratorium on implementation of all regulations published in the final days of the Clinton Administration that had not yet taken effect which included the opt out rule. With the inauguration of President Bill Clinton in 1993, healthcare reform became a priority of the administration, and part of the reform included legislation that would have an impact on the practice of nurse anesthetists. On April 25, 1994, Representative Mike Kreidler (D-WA) introduced H.R. 4291 that sought to eliminate 3 existing Medicare barriers to the practice of Certified Registered Nurse Anesthetists (CRNAs). One of these was Medicare's hospital and ambulatory surgical center rule that CRNAs had to be supervised by a physician; Kreidler's bill sought to defer the matter to the states instead.

~~A few months later Senator Kent Conrad (D-ND) introduced S. 9919, the companion bill~~

[see more](#)

7 ^ | 1 v Share ›



DebbieMalinaCRNA • 2 years ago

Apparently accurate information and published research don't fit into Dr. Sibert's arguments about physician supervision of nurse anesthetists. Following are facts that can be checked simply by looking them up:

With regard to the recently issued new rules concerning conditions of participation, CMS left in place a rule that requires nurse anesthetists to be supervised by physicians, but that provides states a mechanism for opting out of this requirement. To date, 16 states have.

To be perfectly clear, federal laws and regulations do not require nurse anesthetists to be supervised by anesthesiologists. To assert otherwise is patently incorrect.

President Bill Clinton's mother was, indeed, a CRNA. However, the opt-out rule was signed into law by President George W. Bush during his first term in office [66 FR 56762-56769]. President Bush's mother was not a CRNA.

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,

[see more](#)

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Guest → [DebbieMalinaCRNA](#) • 2 years ago

Why in the world would a patient EVER want a burse (CRNA) performing their anesthesia instead of an anesthesiologist? The difference in training is staggering. AANA President: why has every anesthesiologist had to "bail out" a CRNA at one time or another? Simple: because CRNA aren't anesthesiologists. And you think that a CRNA can be properly supervise by anyone other than an anesthesiologist? Like a surgeon? Please....Oh I guess that you believe that unsupervised CRNA practice is safe; it's certainly not.

8 ^ | 9 v Share >

[davemills555](#) → Guest • 2 years ago

A burse? I'd never want a burse performing anesthesia on me. I don't even know what a burse is!

8 ^ | v Share >

[who_u_crappin](#) → [DebbieMalinaCRNA](#) • 2 years ago

Now don't you think there is a little issue of conflict of interest when these studies are sponsored by the AANA. Seriously, this is actually laughable. What type of studies were these? Were they blinded? Probably not. I'm willing to bet that they were conducted by collecting retroactive data. Which you should know (i hope) is the worst type of study. Also, what type of info was looked at to collect this data? One telling quote you mentioned, however, that I completely agree with was - "The Future of Nursing: Leading Change, Advancing Health," the IOM report urged policymakers to remove policy barriers that hinder nurses—particularly advanced practice registered nurses such as CRNAs—from practicing to the full extent of their education and training" The key being 'from practicing to the full extent of their education and training'. The training is just not adequate to practice unsupervised. I have worked at institutions that train SRNA's and can tell you firsthand that they did not learn blocks. I currently work with CRNA's and not a single one (out of fourteen) know how to perform a nerve block. They do not place epidurals either. Its not their fault, the training was just not appropriate to do these procedures.

14 ^ | 6 v Share >

[Phooey F](#) • 2 years ago

It is physician assistant and not physician's assistant.

^ | v Share >

[Close Call](#) • 2 years ago

I'm still really confused. It's too much for my old mind to process.

Who would be comfortable with a newly trained CRNA right out of training to practice independently without restriction on their loved one? Because that's what we're talking about here. It's not about the military CRNA with four decades experience - someone who has taken care of any complication and could deliver a baby while on horseback using just a wooden spoon if asked to do so. It's about that fresh, baby faced CRNA with maybe 1500-2500 hours of clinical care under their belt (from the AANA). Compared to that fresh faced MDA with maybe 11, 000 hours of clinical care experience (not counting med school). Is that a negligible difference?

Let me make a insane proposal: allow CRNA's to go through anesthesiology residency after they finish their didactics. That way they can get more experience in a supervised environment (similar to MDs and DOs). Everyone wins!

5 ^ | v Share >



[Mike MacKinnon](#) → Close Call • 2 years ago

Close

CRNAs have always been able to practice autonomously as a sole anesthesia provider right out of school in every state in the union. The removal of the CMS rule would only serve to remove the requirement (COP) for hospitals to bill medicare part A. Though this requirement is called "supervision" it does not require an anesthesiologist and has nothing to do with the layman term "supervision" but is a billing term. In other-words it is simply a removal of billing terminology as the practice already happens in every state.

Hope this helps to clarify the real issue here.

2 ^ | v Share >



[Close Call](#) → Mike MacKinnon • 2 years ago

Mike, I'm sorry. I'm just more confused now.

So every CRNA who graduates right now can practice autonomously in every state without needing an anesthesiologist within 100 miles of them?

The "supervision" part is just a technicality and doesn't really mean that the new CRNA has some sort of backup? Is this hubub really about billing? Why would it matter to the CRNA how the hospital bills? Unless this was really so that the CRNA could get paid more... then it makes more sense.

The next question would be: Why in the world would anyone want someone with just 2500 hours of training (and no one for backup) when you could have someone with 11000 hours of training? It's one thing if patients had a choice. But 1) most patients aren't savvy enough to ask about the training discrepancy. 2) patients coming through the ED have no choice in this preference and 3) let's say this billing issue is worked out

Unsupervised anesthesia care by a nurse anesthetist is a threat to patient safety
 no choice in this preference and so let's say this billing issue is worked out
 - and CRNAs could bill without having an MDA "supervise"... can I look
 forward to my ACO employing only CRNAs from now on... or my
 insurance provider (i.e. Medicare) only paying for CRNAs and not for an
 MDA? Where is the choice in that?

1 ^ | v Share >



[stanley kristiansen](#) → Close Call · 2 years ago

you are correct sir in your understanding as it relates to CMS. States have determine the supervision issue, some states just say supervision some use the word direction and some use the word colaberattion. Really it is about who signs the chart insofar the concern over CMS decisions. In all states it can be the surgeon who sign, tell me how does this make you safer? How does signing a chart make anyone safer?

2 ^ | v Share >



Guest → stanleykristiansen · 2 years ago

Signing the chart makes nobody any safer. Having an anesthesiologist available to manage the case is the lifesaving part. Signing, billing, who cares? I want an anesthesiologist performing my case (and that's what I get, I don't thing that supervising 4 CRNA is safe at all).

3 ^ | v Share >



[Margalit Gur-Arie](#) → Mike MacKinnon · 2 years ago

Yes, the real issue is billing, because first will be Medicaid, which will only pay for CRNA and not MDA. Next, those "affordable, consumer-driven" insurance plans will also only pay for CRNA for their members. Medicare will follow, perhaps with carve outs for complex cases, just to make administration even more burdensome than it already is. Before long, the only folks able to choose an MDA will be those that are wealthy enough. And this is what is at stake with midwife vs. OB and MD vs. NP in PC and probably more and more medical care, which will become "separate but equal", according to studies, of course.

1 ^ | v Share >



[Stephen Ferrara](#) · 2 years ago

You are changing your attitude based on a few posts on a blog? This seems incredibly short-sided and I only hope thats not how you objectively evaluate all evidence.

1 ^ | v Share >



[RJ](#) → Stephen Ferrara · 2 years ago

No evidence need to be 'evaluated' here. This is not a crime scene or science

NO EVIDENCE NEED TO BE EVALUATED HERE. THIS IS NOT A CRIME SCENE OR SCIENCE experiment. Blog or not, my attitude is what it is because the FACTS can no longer be ignored.

Fact: There are nurses out there who want to play doctor

Fact: They are represented by a NATIONAL association that lobbies endlessly to this end

Fact: The recent CMS rule change initiative spells out how urgent this issue has become.

Fact: I will do my part (however small) to oppose this trend and convince others to do so as well. I will start by minimizing my involvement with SRNAs.

6 ^ | v Share >



[Earl Mueller](#) → RJ · 2 years ago

RJ... Here, Here!! You said it, minimize you're involvement with SRNA's. Not only will that "show 'em" you mean business, but you will also get to sit on your own stool, do your own case, and bill for that one case at a time to medicare or whoever. Good to know that your financial plan is willing to take that reduction in salary. I commend you for stepping up to the plate and make exactly what work you put in. Too bad that strategy will back fire if more of your colleagues would do the same.... not enough MDA's to do all the cases in America to fill the shortage that will incur. Perhaps ASA can lobby for increased federal funds to increase MDA training slots in medical centers to fill the gap. Either way, I commend you for getting those pesky SRNA's and CRNA's out of your way... after all, what the hell do they know.... their just a nurse. ;-)

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[RJ](#) → [Earl Mueller](#) · 2 years ago

Earl, I appreciate your concern for my financial well being but you're grossly missing my point. I have nothing against working with nurses, as I had previously stated I embrace the ACT model. Nurses proclaiming equivalence that's another matter. When a srna is assigned to me they will receive just enough medical knowledge to be safe in the surgical environment and little technical training beyond putting in an IV. I suspect most of my partners at work will feel the same way once they read some of the comments here. Unfortunately many are in the dark with regard to this issue... especially in the big city environment I work in. However, the word will spread. If only a fraction of my colleagues out there follow my suggestions, the notion of

Unsupervised anesthesia care by a nurse anesthetist is a threat to patient safety

colleagues but there follow my suggestions, the notion of equivalence will be even more ludicrous than they are now regardless of how many phony studies the AANA comes out with. Sure there are well trained military crnas or the rural crnas that 'does it all' but they will be the exception. Again, just to be clear: to me this is not about working harder or making less; what I do object to is the absurd assertions of equivalence by people who only have a fraction of my training.

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[lauramitchellrn](#) → RJ • 2 years ago

"Doctor" is a TITLE, not an OCCUPATION. Your occupation is physician. You rebel at addressing doctorally prepared nurses as "doctor," but I bet you have NO problem addressing a PhD in chemistry or literature as "doctor."

6 ^ | 1 v Share ›



[stanley kristiansen](#) → RJ • 2 years ago

Fact anesthesia has been a nursing specialty for over 100 years, therefore using your "logic"

1. doctors are attempting to be nurses, fact
2. fact there is a national and state associations who wish to promote the medical takeover of a nursing specialty.
3. fact the CMS change threatens the income of these nurse wannabes
4. fact your part will be small.

Wow it is weird looking through the world out of ignorant hostility, how do you do it?

5 ^ | v Share ›



[RJ](#) → stanley kristiansen • 2 years ago

Wannabe nurses?? Let's get real here. How many kids aspire to be nurses when they grow up? I am not knocking the profession... it is what it is. By your twisted logic, I would then reason since barbers performed surgery hundreds of years ago... somehow surgeons are trying to be barbers! How ridiculous is that?

Stanley, you are so darn transparent.

Look, it's not my fault you couldn't cut it as a pre-med. I understand your frustration as it will probably hunt you for the rest of your life.

Make the most of the "do it all" nurse anesthetist threat to patient safety. Q M

May I suggest non-traditional medical school application? No wait... of course you wouldn't dare selling out. That would mean you'd have to ace a legit basic science curriculum and actually score well on the

[see more](#)

2 ^ | v Share >



[lauramitchellrn](#) → RJ • 2 years ago

Just because some of us realize that pre-med/medical school isn't for him/her (including myself) and opt for nursing (or another health care discipline) doesn't make us failures, so there's no need for rudeness. We became nurses because we wanted to, NOT because we couldn't get into medical school. As far as CRNA/SRNA education and declining to assist in their education, now you're just being petty.

4 ^ | v Share >



[RJ](#) → lauramitchellrn • 2 years ago

laura, i don't mean to be rude but judging from his posts stanley apparently has a knack for bringing out the worst in people. hard to imagine he is any different in real life. fwiw, would you please answer me this question: why would anyone choose to become a nurse if all they aspire to do is practice independent medicine? and do spare me the sob stories. i had to overcome many hurdles to achieve my dream. my parents were blue collar folk who never went to college. was told i had a learning disability in grade school. my family survived many years on my mom's meager 25k salary. i put myself through college working 2 jobs. mac and cheese was my staple up until recently. if someone wants to practice medicine, go to medical school. too much school/ training/ sacrifice you say? not for everyone? you're absolutely right. i'm sorry but refusing to train what i consider ungrateful/ backstabbing so called colleagues is not petty but plain common sense. why help train today's CRNAs when tomorrow all they want to do is fight to legislate your obsolescence!? trust me, i appreciate the current ACT model but can no longer continue in the current environment. wish you and your family a happy thanksgiving.

2 ^ | v Share >



[stanley kristiansen](#) → RJ • 2 years ago

Well RJ my mother was a nurse and my father a CRNA, sort of a tradition I do not want to practice medicine independently, just nursing. Remember anesthesia has long ben recognized as a field of nursing

I do not desire the elimination of anesthesiologists, I have found my interactions with most quite pleasant, I have learned much and taught much (mostly regional and practical tidbits you know). I could not teach them medicine but they have taught me a fair amount. Really the status quo has been independent practice for CRNA's the ones who really want to change things are the ASA. BTW most people find me pleasant, but most do not talk down to me or call me a wanna be doctor. I feel no need to protect the ego of those who throw stones and when it is thrown back cry mommie mommie the nurse was mean to me.

2 ^ | 1 v Share >



[lauramitchellrn](#) → RJ • 2 years ago

I strongly suggest that you read the Nurse Practice act in the state where you. There are aspects of nursing practice that are interdependent with medicine, but there are other aspects that are independent. I too worked my way through school: as an LVN to complete a community college RN program, then a working RN as I completed an RN-BSN program, both while supporting a family. While I understand your antipathy towards advanced practice nurses, how many of them do you really know as individuals and how much of this antipathy has been created by your professional organizations vs personal experience?

2 ^ | v Share >



[Ailan Medici](#) → stanley kristiansen • 2 years ago

Stanley, your responses to posters whom you disagree with are so silly, that you are doing a disservice to the profession you are trying to defend. Presenting your point of view with sarcasm or snarkiness will not win over anybody (i.e. laypeople, patients) who read this blog to be better informed.

5 ^ | v Share >



[stanley kristiansen](#) → Ailan Medici • 2 years ago

oh I am sorry I will just note the MD snarkiness, please allow me to apologize if my pointing out the inanity and ignorance of the aforementioned statements upset you.

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