November 17, 2015

To the Honorable Chairs and Members
Joint Committee on Public Health:

Re: H.1996/S.1207 – An Act to remove the restrictions on the licenses of nurse practitioners and certified registered nurse anesthetists as recommended by the Institute of Medicine and the Federal Trade Commission

My name is Sheila Barnett, M.D. I am a physician anesthesiologist and the Director of Preoperative Testing at Beth Israel Deaconess Medical Center and I am the President of the Massachusetts Society of Anesthesiology (MSA). Our Society represents over 1,500 physician anesthesiologists practicing in the Commonwealth and includes board certified attending anesthesiologists, specialists in Pain Management and Critical Care as well as over 400 physician residents and fellows pursuing careers in Anesthesiology and our specialty areas.

The MSA is submitting this testimony in support of the team approach to the delivery of anesthesia services and in strong opposition to H.1996 and S.1207. We also strongly support and wish to be recorded in favor of S.1169 (Truth in Advertising) which will require an accurate presentation of one’s professional skills/training to the public. Many different types of health care providers including nurses identify themselves as “doctor”. S. 1169 would require health care providers to identify themselves to patients in a health care facility by their license: for example, M.D.—physician, Doctorate of Physical Therapy—physical therapist, Doctorate of Nurse Practice—nurse, etc.

**Anesthesia is the practice of medicine.** Anesthesia is a field of medicine often oversimplified by the public and even by other health care providers. There may be simple procedures to be performed on a patient, yet making that individual ready is never a “simple” task.

In its simplest form, (and depending on what needs to be done for the patient) “anesthesia” may necessitate providing a continuum of sedation medications ranging from minimal loss of consciousness to inducing a state of medically induced, yet reversible, coma by blocking all of the patient’s protective reflexes. Anesthetics, no matter how “simple” they may seem, carry substantial risks and these risks are compounded by pre-existing medical conditions many surgical patients may have. This practice of critical care medicine necessitates physician supervision and availability, and serves the patient’s best interest. In my hospital, as well as most every other hospital in the Commonwealth, we practice in the model known as the Anesthesia...
Care Team, where physicians delegate appropriate tasks to nurse anesthetists for administration of anesthesia. The remaining hospitals have physician anesthesiologist-only services. In the Care Team model the leadership, authority and responsibility for the anesthetic care delivered remains with the supervising physician. This helps to assure that the timing and appropriateness of a given procedure is in the patient’s best interest and is done in collaboration with the surgeon. This role is far beyond the training and scope of practice of a nurse anesthetist. In practice settings where an anesthesiologist is not available, typically outside a hospital setting, a nurse anesthetist works under the medical direction of the operating surgeon.

Since the advent of modern anesthesia more than 150 years ago (a Massachusetts event in 1846), the Anesthesia Care Team has safely and effectively delivered anesthesia care with the nurse anesthetist as the non-physician member of the team. In fact, this is the model for delivery for the vast majority of anesthetics in the United States. Anesthesia, as practiced today under the current collaborative care team model, is incredibly safe.

Nurse anesthetists are a valued member of the healthcare team, but under no circumstance would it be in the public’s best interest to have physician oversight of anesthesia care removed or reduced. The education and clinical training of anesthesiologists and nurse anesthetists are quantitatively and qualitatively markedly different.

**Education**

Physician anesthesiologists have at least 12 years of education and medical training. Nurse anesthetists have as little as two (2) years post-graduate training in anesthesia. A physician anesthesiologist has at least 12,000 to 16,000 hours of supervised clinical patient care during training, while a nurse anesthetist has a median of 1,650 hours of supervised clinical experience often times not directly done by a physician but another nurse who is part of the Anesthesia Care Team. If H.1996 and S.1207 were to pass, a nurse anesthetist just out of training with only 1,650 hours of training would be able to practice independently without any physician supervision or oversight. There are many who compare our specialty to the aviation industry and this disparity in training would not fly in the eye of the FAA. They would not consider it safe, so why should we?

**Skills and responses**

Nurse anesthetists are an important member of the anesthesia team who are technically sufficient, but their nurse education and limited clinical training does not equal the medical education and training of a physician as mentioned above. They are not trained in medical decision making, differential diagnoses, medical diagnostic interpretations or medical interventions outside of the operating room. Removing physician supervision of anesthesia care makes no more sense than removing it from any other critical care location. Moreover, this legislation fails to place any statutory limitations on scope of practice, and could dramatically expand nurse anesthetists’ scope of practice into other areas of medicine, such as chronic pain, cancer pain, and interventional pain medicine. The expansion of nurse practice into these areas has been a source of great concern in other areas of the nation, all the more so considering the implications of new
prescribers of opioid pain medications. Nurse anesthetist education and clinical training does not include any significant time studying and training in these specialty areas.

The safe administration of anesthesia requires a collaborative team approach between a nurse anesthetist and supervising anesthesiologist or surgeon. Unforeseen and unpredictable complications can and do arise during the course of any anesthetic, even with the most healthy appearing patient whereby rapid medical intervention and decisions are required. This may include having difficulty in establishing a proper airway leading to a state of severe oxygen deprivation and retention of carbon dioxide. Vital signs may become unstable and cardiac arrest may rapidly ensue due to the development of an allergic reaction without any prior exposure to the causative agent (for example, latex anaphylaxis). Effective management of time critical emergencies demands that the lines of authority in the operating room be clear; independent nurse practice can give rise to conflict and confusion. When seconds count, having a physician anesthesiologist or qualified physician immediately available, working with and overseeing the nurse anesthetist reduces risk and ensures the safe delivery of quality anesthesia care.

No Difference in Outcome?
It has been claimed by the proponents that there are no differences in patient outcomes when anesthesia services are provided by independently practicing nurse anesthetists. The FACT is there are NO credible studies that demonstrate anesthesia administered by nurse anesthetists without physician involvement is as safe as that administered in a team model. The "literature" to which advocates of H.1996 and S.1207 point are scientifically and statistically flawed and biased by their source of funding: the American Association of Nurse Anesthetists. You should not be swayed by such non-science literature.

In fact, an independently-funded 2000 study on anesthesia outcomes that used robust risk adjustment found that for every 10,000 Medicare patients who had general or orthopedic surgery, there were 25 more deaths when an anesthesiologist did not direct the anesthesia care. In addition, for every 10,000 patients suffering a complication, the absence of a supervising anesthesiologist resulted in 69 additional patients not surviving the 30-day period after hospital admission.\(^1\) Furthermore, an independently-funded analysis of more than 2.4 million patients published in 2012 found the odds of an adverse outcome, after ambulatory surgery, were 80 percent higher when anesthesia was provided by a nurse anesthetist as opposed to a physician anesthesiologist.\(^2\) This was the case even if the original procedure was low risk. Adverse outcomes are more likely when a physician isn't involved in anesthesia care from the beginning, and these complications are not only costly in a monetary sense, but in physical costs for the patients involved.

Nurse anesthetist scope of practice is UN-related to nurse practitioner primary care scope issues

The management of anesthesia differs markedly from primary care. In primary care decisions may be made in hours or days; in the operating rooms and recovery rooms, where anesthesia is provided, potentially life-threatening conditions abruptly appear that require life-saving decisions be made in minutes or seconds. Anesthesia care is critical care medicine, and physician oversight is needed.

While there may be general consensus that access to primary care may be limited in some areas of Massachusetts, there is no demonstrated access problem for anesthesia and surgery.

No Issues of Access to Surgical and Anesthesia Services

You may hear that H.1996 and S.1207 would increase access to surgical and anesthesia services. There are no issues of access in Massachusetts. Surgeries are not being cancelled or delayed because of a shortage of anesthesiologists. Every hospital in the state provides anesthesia services either by anesthesiologists practicing alone or with anesthesiologists and nurse anesthetists workings together as the anesthesia care team. The only exception is Nantucket Hospital, where nurse anesthetists work under the medical direction of a surgeon and difficult or complex cases are moved to hospitals on the mainland. You may hear that the legislation will bring Massachusetts in line with other states: that there are 17 states which have opted out of Medicare supervision rules, but in those instances state laws governing scope of practice of nurse anesthetists still control. In fact, there are only 4 states (Montana, New Hampshire, Oregon and Utah) that have legislation or regulations that eliminates physician oversight of nurse anesthetists. The majority of those states are rural states where there is a shortage of anesthesiologists. That is not the case in Massachusetts.

The Legislation will not lower Health Care Costs.

You may hear that this legislation will lower the cost of health care. That is not true at all. Charges and payments for anesthesia services are the same whether delivered by an anesthesiologist, a physician/nurse anesthetist care team or a nurse anesthetist who bills independently for services. There will be no cost savings if nurse anesthetists are granted independent practice, but there could be a cost to quality and safety.

MSA Response to FTC letter

The Federal Trade Commission (FTC) letter as noted in the bill title was a letter from the FTC staff and not an official determination by the FTC itself as to the legislation. The staff research regarding anesthesia appears to have relied in large part to information provided by nursing advocacy groups. The FTC staff did not reach out to MSA and to our knowledge did not contact any other medical association in the state. The letter chiefly concerns itself with primary care and not specialty care such as surgery and anesthesia. The confusion around the skill and training needed for primary care with that needed for surgical anesthesia places patient welfare and safety at risk.
The letter claims that independent practice would reduce costs and increase access. This is simply not the case. As we have indicated, there is no evidence to support the cost proposition here in Massachusetts for anesthesia services. Medicare, Medicaid, and most third party insurers pay the same fees for anesthesia services, regardless of the health care provider.

Nurse anesthetist independent practice will not increase access to surgical or anesthesia care in Massachusetts. Each hospital in the Commonwealth currently provides anesthesia services under the supervision of anesthesiologists, except Nantucket where supervision is provided by non-anesthesiologist physicians. Surgical procedures are not being delayed because of a lack of board certified anesthesiologists. The FTC staff alleges that some counties in western Massachusetts have fewer board certified anesthesiologists as compared to Suffolk and Middlesex counties. This appears to reflect some ignorance of the health care system in the state and the concentration of our hospitals. In western Massachusetts as in the east, every hospital has a sufficient number of board certified anesthesiologists to provide anesthesia services, mostly by an anesthesia care team, without any reported delays or interruptions in surgical scheduling due to lack of anesthesia services. The fact that outside of Springfield there are fewer hospitals in general than one would find in eastern Massachusetts was unfortunately missed by FTC staff.

**Voters in Massachusetts Want Physician Anesthesiologists to Supervise or Personally Administer Anesthesia to Patients in Surgery and Respond to an Emergency. They oppose independent practice by NAs.**

A July 2015 survey of 800 Massachusetts voters found:

- **87%** of residents want a physician to administer their anesthesia or respond to an emergency during surgery. Only 9% said a nurse.
- **86%** of residents trust a physician anesthesiologist to deal with a medical complication or emergency during surgery. Only 8% would trust a nurse anesthetist.
- **78%** of residents oppose permitting NA's to administer anesthesia and address medical emergencies for patients in surgery without the supervision of a physician.
- **62%** of residents found it unacceptable for a NA to administer anesthesia independently without physician supervision.³

The current physician led Anesthesia Care Team plays a pivotal role in ensuring that patients receive the highest-quality and safest care in the operating room. 87% of Massachusetts residents indicated that they want a physician to administer anesthesia or respond to an emergency during surgery.

**Expansion of Nurse Anesthetist Prescribing Authority Beyond the Operating Room**

The legislation would not only allow nurse anesthetists to practice independently, but would repeal the current statutory provision governing their prescribing authority, which limits the ordering of tests and therapeutics and prescribing to the immediate peri-operative period (beginning the day prior to surgery and ending upon discharge from post anesthesia). That statute,

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³ Poll conducted by TelOpinion Research on behalf of the Massachusetts Society of Anesthesiologists and was conducted July 27-July 30, 2015 among 800 registered voters in the State of Massachusetts. Margin of error ±3.2%.
Chapter 191 of 2010, was negotiated among the parties by the former House chairman of this committee and accepted by both MSA and the Massachusetts Association of Nurse Anesthetists (MANA). The law was predicated on the principle that a collaborative team approach requiring physician supervision of a nurse anesthetist was required.

You may hear that not many nurse anesthetists have prescribing authority. The simple fact is that nurse anesthetists don’t need prescriptive authority to administer anesthesia. Most administer anesthesia or other drugs during the perioperative period under a “standing order” of a physician. Indeed, for this very reason, MANA requested that the 2010 law make it quite clear that the administration of anesthesia to a patient does not require a prescription. Any assertion by MANA that nurse anesthetists are unable to care for patients because they do not have prescriptive authority is not true. How do they currently care for patients if it is “impossible” to do so without prescriptive authority?

We would also note that the unlimited nature of H.1996 and S.1207 in granting nurse anesthetists the ability to prescribe in an unrestricted manner (beyond the immediate peri-operative period under current law) may increase access to dangerous pain-killing opioids by authorizing another approximately 1,000 nurse anesthetist prescribers to write these prescriptions without any physician oversight and beyond the scope of the administration of anesthesia and the nurse’s training to other areas of medicine, such as, chronic pain. If one does a simple internet search for “Massachusetts opioid abuse,” countless articles come up describing the current epidemic facing our state. Adding more prescribers to this problem is NOT the solution.

The MSA would urge the committee to retain the collaborative team approach to the delivery of anesthesia services that has ensured quality and safety through the dynamic interaction among physicians and nurse anesthetists working together on behalf of our patients. We respectfully urge you to reject H.1996 and S.1207

Respectfully submitted,

Sheila Barnett, M.D.
President
H.1996/S.1207 – An Act to remove the restrictions on the licenses of nurse practitioners and certified registered nurse anesthetists as recommended by the Institute of Medicine and the Federal Trade Commission - will allow all Advanced Practice Nurses (APNs), including nurse anesthetists to practice independently. The bill would allow APNs to order and interpret tests, and to prescribe, dispense, distribute and conduct research on controlled substances – without any physician supervision.

Key Facts

- **Legislation Grants Independent Practice**
  - The legislation would eliminate the statutory provisions requiring nurse anesthetists practice under the supervision of a physician.
  - Nurse anesthetists would be able to order and interpret tests, order treatments and therapeutics and prescribe medications independently in accordance with regulations adopted solely by the Board of Registration in Nursing.

- **Education and Training**
  - Physician anesthesiologists have at least 12 years of education and medical training. Nurse anesthetists have as little as two years post-graduate training in anesthesia.
  - Physician anesthesiologists have at least 12,000 – 16,000 hours of supervised clinical patient care during training, while nurse anesthetists have a median of 1,650 hours of supervised clinical experience. Under this legislation a nurse anesthetist with only 1,650 hours of clinical training would be able to practice independently without any physician supervision or oversight.
  - Anesthesia is the practice of medicine. It is often the patient’s medical problems that convey greatest risk during even routine surgery, and proper recognition and treatment of these medical conditions are even more important in complex surgeries. The legislation fails to place any statutory limitations on scope of practice; and could dramatically expand nurse anesthetists’ scope of practice into other areas of medicine, such as, chronic pain and cancer pain. Nurse anesthetist’s education and clinical training does not include any significant time studying and training in the diagnosis and treatment of these conditions.

- **Patient Safety**
  - No longer would a nurse anesthetist be required to ensure a physician is immediately available to assist them in case of emergency such as cardiac standstill or cardiac arrhythmia.
  - The legislation eliminates the physician-led, team-based model of care, which ensures quality anesthesia care and patient safety.
  - In an emergency, where seconds count, having a physician anesthesiologist or other qualified physician immediately available, working with and overseeing the nurse anesthetist reduces risk and ensures the safe delivery of quality anesthesia care.
• **Health Care Access and Cost**
  o Nurse anesthetist's independent practice will not increase access to surgical or anesthesia care. There are no issues of access in Massachusetts. Every hospital currently provides anesthesia services under the supervision of a physician.
  o Nurse anesthetist's independent practice will not lower the cost of health care. Charges and payments for anesthesia services are the same whether delivered by an anesthesiologist, a physician/nurse anesthetist care team or nurse anesthetists who bills independently for services.
  o There will be no cost savings if nurse anesthetists are granted independent practice, but there could be a cost to quality and safety.

• **Response to Federal Trade Commission**
  o The Federal Trade Commission (FTC) recommendation letter as noted in the bill title was a letter from the FTC staff and not an official determination by the FTC itself as to the legislation.
  o The letter primarily concerns itself with primary care and not specialty care such as surgery and anesthesia. The confusion around the skill and training needed for primary care with that needed for surgical anesthesia place patient welfare and safety at risk.
  o The letter notes that independent practice would increase access and reduce costs. This is simply not the case. There is no evidence to support that proposition here in Massachusetts for anesthesia services. Medicare, Medicaid, and most third party insurers pay the same fees for anesthesia services, regardless of the health care provider.
  o The FTC letter acknowledges...“patient health and safety concerns are of critical importance when states regulate the scope of practice of health care professionals, and FTC staff defers to Massachusetts on the ultimate health and safety standards that the Commonwealth may choose to establish.”
  o Granting nurse anesthetists independent practice without any physician oversight will not ensure the delivery of safe, quality anesthesia services to Massachusetts patients.

For more information regarding the importance of a physician led Anesthesia Care Team and the role physician anesthesiologists play in making sure you receive the highest-quality and safest care, please visit www.asahq.org/whensecondscount/.

The Massachusetts Society of Anesthesiologists represents over 1,000 physician anesthesiologists providing anesthesia, pain management and critical care medicine in the Commonwealth.
The Risks of Independent Practice by Nurse Anesthetists

Scope of practice legislation (H.1996/S.1207) would eliminate the statutory provisions requiring nurse anesthetists to work under the supervision of a physician. Nurse anesthetists would care for patients in the critical care environment of the Operating Room without physician oversight or consultation.

Patients trust their doctors knowing that they have undergone extensive medical education and clinical training. Physician anesthesiologists have at least 12 years of medical education and medical training with 12,000-16,000 hours of supervised clinical patient care. Nurse anesthetists have only two years of post-graduate nursing education with only a median of 1,650 hours of supervised clinical experience.

An important July 2015 survey of 800 Massachusetts voters found:

- 87% of residents want a physician to administer their anesthesia or respond to an emergency during surgery. Only 9% said a nurse.
- 86% of residents trust a physician anesthesiologist to deal with a medical complication or emergency during surgery. Only 8% would trust a nurse anesthetist.
- 78% of residents oppose permitting nurse anesthetists to administer anesthesia and address medical emergencies for patients in surgery without the supervision of a physician.
- 62% of residents found it unacceptable for a nurse anesthetist to administer anesthesia independently without physician supervision.

The administration of anesthesia is the practice of medicine. It is often the patient’s underlying medical issues that cause the greatest risks during even routine surgery, and proper recognition and prompt treatment of these medical conditions are even more important in complex surgeries. The current physician-led Anesthesia Care Team plays a pivotal role in ensuring that patients receive the highest-quality and safest care in the operating room. 87% of Massachusetts residents indicated that they want a physician to administer anesthesia or respond to an emergency during surgery.

It is clear that voters in Massachusetts want physician anesthesiologists to supervise or personally administer anesthesia to patients in surgery and during an emergency. They oppose independent practice by nurse anesthetists.

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