“Never let the truth get in the way of a good story.” - Mark Twain

By Laura L Roberts

Heeding Twain’s admonition, the SC Association of Nurse Anesthetists (SCANA) has embarked on a campaign to disrupt the most common, efficient and safe model of practice in anesthesia care known as the Anesthesia Care Team. Many physicians work with advanced practice providers and value their contribution to the healthcare team. Physicians focus on high quality outcomes for patients with the hope that legislators and the public will understand that the best patient care is achieved when we work together in a team of individuals with different yet important roles.

The leadership of the nurse anesthetists have asked the General Assembly to change existing law so that they would no longer be required to work under the direction, supervision, oversight, or any other arrangement with a physician. Their bill would not only remove the physician as the leader of the team but would remove the nurse from the team. The nurse anesthetists would be independent, alone in this most critical of medical situations. There would be no physician, anesthesiologist or surgeon, leading the medical care of the patient.

Why would the patients of South Carolina want this reckless change in the law? Is it because we can’t get doctors and nurses to go to rural areas and this change would help? The answer is simply, no. While there are anesthesiologists in every hospital, ambulatory surgery center and most office-based surgery facilities, current SC laws and regulations require a supervising physician, which can be the anesthesiologist or the surgeon. There are in fact no “access gaps” in South Carolina for anesthesia care.

The SCANA also claims that money will be saved if they didn’t have a physician supervisor. Once again, that story fails to reconcile with the truth behind the reimbursement for anesthesia services. Anesthesia services are reimbursed based on a unit cost. That unit cost does not increase or decrease based on the type of anesthesia provider or team. Eliminating any given provider from the scenario does not alter the billing and reimbursement system and therefore the charge for anesthesia service would not be decreased if we didn’t have the physician supervisor.

Perhaps the most troublesome position taken by the SCANA leadership is that the education and training of a nurse anesthetist is ‘about the same’ as a physician, or ‘good enough.’ In addition to the stark difference in education and training between nurses and physicians, scientifically legitimate and rigorous studies demonstrate a lower rate of complications and death when an anesthesiologist is involved compared to a nurse anesthetist practicing without physician supervision.

So, who should we believe in a “he said/she said” scenario? Aside from scientific studies or international standards, is there another way to gain some understanding about the

qualifications and safety outcomes by members of the Anesthesia Care Team? Indeed there is. Several former nurse anesthetists and registered nurses, myself included, went to medical school and became anesthesiologists after careers in nursing. As explained by Dr. Jane Fitch, a former CRNA and Past President of the ASA, “Nursing skills are important, and nurses are trained to administer anesthesia, but their education does not come close to the advanced medical education, training and clinical experience of physicians”.

The leadership of the nurse anesthetists is expending a tremendous amount of energy and resources in pursuit of obtaining legislatively what should be earned through education. This effort is neither wise nor appropriate for the public good.

Our patients deserve the best and safest anesthesia care – care that is provided in a physician-led care team model. We, as physicians, will continue to foster communication and team building with our nursing colleagues. As physicians, we remain dedicated to providing the highest quality of care to our patients.

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