

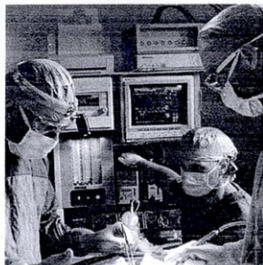
The Right Thing to Do

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I applaud the President's actions in preserving the Medicare Supervision Rule for CRNAs. I've learned from and worked with CRNAs for the better part of my anesthesia practice, and I believe that CRNAs are an integral part of the fabric of American medicine. When anesthesiologists and CRNAs work together in a care team, both clinicians, as well as the patient, benefit. But once you take the physician out of the equation, the potential for a bad outcome increases tremendously.

Upon first entering private practice, I encountered two very different behaviors amongst the nurse anesthetists I supervised. In my surgery center, there were clinically prudent CRNAs who sought the advice and guidance of anesthesiologists, and there were also some CRNAs who felt they had the expertise to practice independently. These CRNAs were open about their desire to achieve equal pay for their work, and they had no desire to consult with or even work with the physicians charged with supervising their clinical duties. Over the course of five years, I had no medical mishaps with the first group of nurses. Unfortunately, I cannot say the same for those who wished to practice independently.

One example I will share was, regretfully, not at all uncommon.



The incident involved a CRNA who had been practicing for about ten years. Clearly he had the experience and knowledge to know what he could do safely—and what would have been out of his scope of safe practice. He had always been talking about going to one of the smaller towns in a nearby state where CRNAs “worked alone and made fifty thousand more a year.” One day he started an anesthetic on a ten-year-old boy for a simple ENT procedure. His attending anesthesiologist had seen the patient and family, but the nurse had chosen to start the case alone. When I was called back “STAT” to the operating room, I found the patient blue and motionless on the operating room table. Apparently, during induction of general anesthesia, the boy had gone into laryngospasm. The nurse anesthetist panicked and was unsure how to manage the situation. Fortunately, I was able to quickly secure the boy's airway, and he recovered nicely. He

was discharged home from the recovery room several hours later with no adverse sequelae. The CRNA never boasted of wanting to work independently after that experience.

Just as that CRNA was too aggressive, others may not have the expertise to know when they're being too cautious.

Faced with a patient with abnormal laboratory values, for example, a CRNA may elect to simply cancel the case. An anesthesiologist would be more likely to understand that the patient might be in chronic renal failure and subsist daily with abnormal “paper values.” He is more likely to (correctly) deem the surgery absolutely safe and absolutely necessary.

Anesthesiology is much more than administering a concoction of drugs, cookbook style, to render a patient numb or unconscious. It is the practice of medicine. Only medical school and residency training can teach the nuances of practicing medicine, and only doctors have the expertise to do so.

Regardless of the results of the much-needed national outcomes study on anesthesia (recommended to assess the data on patient morbidity and mortality under physician vs. CRNA vs. care team practice), I want a physician involved in my anesthetics. It makes good sense, and it makes for good medicine! ■