Impact of the CRNA: The specialty and its future

This guest editorial is based upon a presentation by Mrs. Fleming in December, 1985 at the AANA Assembly of States Meeting which was held in Omaha, Nebraska.

“The Impact of the CRNA: The Specialty and Its Future” is an especially relevant topic for discussion in today’s world. I believe in the specialty of nurse anesthesia and I am convinced that we have a viable future, one which may even be better than that we have experienced in the past.

Our future evolves from our past

The success that nurses have achieved in providing anesthesia services for some 100 years, as well as the success that nurse anesthetists have had in meeting repeated obstacles and challenges during most of that time, gives me the confidence that we are capable of meeting current and future challenges which may seem at first sight to be insurmountable.

Our challenges today are no more formidable than the task of providing safe anesthesia at the turn of the century, at a time when there were growing demands for investigations into the large number of deaths attributable to anesthesia. It was during this period that nurse anesthetist Alice McGaw, providing anesthesia services for the Doctors Mayo, at St. Mary’s Hospital in Rochester, Minnesota, published reports in the St. Paul Medical Journal in 1900 and 1904, and in Surgery, Gynecology and Obstetrics in 1906, of 14,000 cases utilizing ether and/or chloroform without a single death directly attributable to anesthesia. That was some record for its day, and for that matter, for any period of time since.

Just as Alice McGaw and other early nurse anesthetists were meeting the challenge of proving the capability of nurses in providing safe, competent anesthesia, newer challenges were taking shape, probably as a direct result of these early pioneers’ success. One of the first was when Lakeside Hospital School of Anesthesia for Nurses and Dr. George Crile were challenged by a group of physicians who had formed the Interstate Association of Anesthetists in 1915. The physician group filed charges before the Ohio Medical Board, citing that nurses were providing anesthesia illegally. The outcome of this complaint culminated in a hearing before the Medical Board in 1917: The Board ruled in favor of Lakeside Hospital and Dr. Crile. Dr. Crile subsequently managed to get an amendment to the Medical Practice Act passed by the Ohio Legislature in 1919. The amendment stated that nothing in the act should be construed to apply to or prohibit in any way the administration of an anesthetic by a registered nurse under the direction and in the immediate presence of a licensed physician, providing such nurse had taken a prescribed course in anesthesia at a hospital in good standing.

Yet, it is ironic that during World War I, a period that demonstrated beyond question the value of the nurse anesthetist according to one eminent surgeon, that another group of doctors challenged the nurse anesthetist. The place was Kentucky, and this particular group of physicians saw fit to rid the state of nurse anesthetists by having the Kentucky Medical Society put a statement in its ethical code denying membership in good standing to physicians who utilized nurse anesthetists or took patients to hospitals who employed nurse anesthetists. In those days, having membership in good standing in the local and state medical society was essential for obtaining hospital practice privileges, thus to defy such an ethical code could be extremely problematic to any physicians or surgeons. In defense, a surgeon, Dr. Frank, his nurse anesthetist, Margaret Hatfield, and the Kentucky State Board of Health took the matter to court. They lost at the lower court level, but on appeal, that decision was reversed. I believe that the opinion of those justices should be published year-
ly for all professionals to read. Addressing the state practice acts of medicine, nursing, pharmacy, etc., the judges stated:

"These laws have not been enacted for the peculiar benefit of the members of such professions . . . . But they have been enacted for the benefit of the people. . . . It is apparent that such a construction ought not to be given the [medical] statute, which regulates the profession, that the effect of it would be to invade the province of the professions of pharmacy, dentistry, or trained nursing, all of which are professions . . . neither should such a construction be given to it as to deprive the people from all service which could be rendered to them. . . ."

It was during this same turbulent period in 1922 that the American College of Surgeons passed a resolution without one dissenting vote. The resolution stated:

"Resolved that we express ourselves as opposed to any and all legislative enactments which would prohibit the nurses when qualified from giving anesthesia."

But, success was always followed by other challenges. Enter the 1930's and the landmark Dagmar Nelson case in California. Miss Nelson, a nurse anesthetist, was charged with the unlawful practice of medicine. The decision reached at each court level in which her case was heard was that anesthesia as she practiced it was within the scope of nursing practice and that it reflected common practice in the operating rooms within the State of California.

The decade of the forties brought World War II, where the nurse anesthetist served with distinction. The war also served as the impetus for more physicians to enter the specialty. Immediately following the war, the young American Society of Anesthesiologists (ASA) announced that anesthesia would become an all physician specialty—and one to which nurses should not be admitted. The ASA immediately started a public relations campaign which was aimed at (1) promoting anesthesia as a medical specialty, and (2) destroying the confidence of the public in the nurse anesthetists who had served that public so well for so long. This public relations ploy became so distasteful that the Boards of Directors of the American Medical Association, the American College of Surgeons, and the Southern Surgical Society passed resolutions condemning the ASA tactics. It should be noted, that at the time ASA undertook this strategy, there was less than one-third the number of qualified anesthetists (both physicians and nurses) needed within the United States.

There were other anti-nurse anesthetist campaigns in recent times, including (1) the promulgation of an ethical code by ASA precluding its members in good standing from participating in nurse anesthesia educational programs, and (2) the challenge by ASA of AANA credentialing prerogatives before the U.S. Office of Education and the Council on Postsecondary Accreditation (COPA).

These more recent challenges confronted us at a time when evolutionary and revolutionary changes were taking place in American society with which we have had to learn to adapt and cope. These included:

- Social changes that were almost unthinkable at the beginning of this century.
- An exponential escalation in knowledge and technology, once considered only dreams by early science fiction writers.
- Transportation and communication breakthroughs that made the world one community as far as geography, but which made little headway in resolving ideological or territorial conflicts among nations, or between people or groups for that matter.

But, what of nurse anesthetists? The fact that we are here today is evidence that nurse anesthetists could adapt to changing times, and that no challenge was too great for us to mount a winning strategy. Yes, we are here today because those nurse anesthetists and CRNAs who came before us did not quit, but chose to overcome obstacles, and continued to grow as professionals—a worthy example for all of us to emulate.

Someone once said, "The more that things change, the more they remain the same." And, I believe that can truly be said about the health care field and the current environment within which all health professionals find themselves today. While some of the challenges confronting CRNAs and other health professionals in the future may be of a different kind than those of past history, there will be similarities.

The present and future

There are four major areas of challenge that I believe will impact on CRNAs.

First—Cost containment and resource restriction. I believe there will be a continuation of cost containment initiatives in health care and education and an increasing competitive environment pertaining to the provision of health care. I do not believe that we will ever return to the day when there will be almost unlimited resources for health care and for the education of health professionals. The only alternative facing government, society, and individuals is to learn to get the most for the money they spend in both of these arenas.

This trend I believe is favorable to nurse anesthetists, and ultimately to their education. Why? Because CRNAs have the only potential for moderating the cost of anesthesia services in this country and they are the only proven alternative to an all physician service. I believe the health delivery system will change, placing emphasis on health maintenance. However, I also believe there will be a continuing need for both
nurse anesthetists and anesthesiologists, probably working more within groups, employed by or under fixed contracts with hospitals, HMOs, industry, or other corporate bodies. This is not only my belief, the Naisbitt group and others, are projecting that much greater reliance will be placed on nurses, including nurse anesthetists and allied health professionals in providing health care in the future.

Second — Physician glut and increased training of anesthesiologists. We are being intimidated by the constant barrage of comments pertaining to an overage of physicians and particularly the number that is entering anesthesiology. We must keep in mind that manpower requirements are a function of need, not merely a function of the number being prepared. If we look only at the number prepared, certainly we are turning out larger graduating classes of physicians, but the numbers of applicants to and enrollment in medical schools is already declining. In addition, the large number of women in medical schools, coupled with the changing values of many young physicians who desire more personal time, will keep the real increase in physician man-hours lower that the projections. These are but a few examples of the factors that will influence this moderation of hour involvement. Reimbursement mechanisms will work to some extent to decrease interest in pursuit of a medical career and the choice of anesthesiology as a specialty. The so-called physician glut will serve to change the immigration status of foreign physicians, taking them off of the priority list for work and education visas. We certainly are already seeing a decrease in the number of foreign medical graduates in anesthesiology residencies.

As reimbursement patterns moderate the income of some physicians, and place higher values on the services of other physicians, we will see changes in their career choices. For instance, at its peak the National Institutes of Health employed approximately 3,000-3,500 physicians, but due to the inability of its salary structure to compete with private or university practice, this number dropped to about 1,500. The federal services are already seeing an increase of physicians applying for appointment. And, finally, some older physicians will choose retirement rather than to have to cope with all the changes that will be made, particularly with regards to reimbursement. Thus, there will be a larger number leaving the profession for a few years, than there has in the past decade or so. After all, it has only been in the past two decades when physician income has soared.

What about the question of need? While we may be experiencing empty beds in hospitals, overall we have not seen an equal decline in surgical episodes, or the requirement for anesthesia in this country. Many cases are now being done on an outpatient basis in surgicenters, and many cases are being done in surgical offices. The increasing aging population in America and its health needs will bring about an increase in the need for anesthesia services, both for surgery and pain control. Given the multidrug use among teenagers and young adults, there is a very real potential for an increase in genetic defects in the future, necessitating surgery in the newborn and infants. The increasing complexity in surgery and sophistication in technology and anesthesia will bring about more cases requiring two qualified anesthesia providers, physician and nurse.

Where will the money come from that will pay for these increasing needs in health care? It is my belief that resource restriction will force us to resolve some of our ethical dilemmas pertaining to taking extraordinary means to preserve life beyond that time when there is no quality of life to be preserved. When we accept the fact that a major portion of health care costs is spent in the last two weeks of life, and practitioners and hospitals are not being paid to sustain an unsalvageable health problem—one which they cannot pass on to another agency—decisions will be made. Perhaps some of the pre-mortem examinations done on the operating room table since the advent of Medicare may indeed be performed as post-mortems at much lower cost. Sure, there may be some dangers in this, but in most instances, it may in reality be more humane.

Third — A decline in the number of nurse anesthesia educational programs. The number of nurse anesthesia educational programs is declining. Some losses are a result of the decision-making of anesthesiologists, and others are the result of our own lack of action. In some instances, the practice for which the nurse anesthetist is being prepared is being unduly restrained by chairmen of anesthesiology departments. Some of the decline in program numbers can be attributed to the uncertain fiscal conditions associated with the Prospective Payment System. A few closures or reductions in the number of students being accepted are a result of denial or restriction of access to clinical areas by medical chiefs of anesthesiology. Some of these result from anesthesiologists deciding they no longer want to be involved in preparing persons they perceive as competitors.

There are CRNAs among us who also seek to discourage individuals from going into this specialty, and who, while not actively pursuing closure of our programs, are neither acting in the best interest of the profession to aggressively work against such closures. Many CRNAs also are fearful of their own colleagues as competitors, a feeling shared by many anesthesiologists about the number of residents entering anesthesiology training.

While the latter problem is troublesome and must be dealt with, the denial of access to clinical depart-
ments for the education of nurse anesthetists, or undue restrictions being placed on nurse anesthetist practitioners and on the teaching of selected anesthesia techniques (for example, placement of arterial lines and catheters and the administration of regional anesthesia). I believe must be a priority for action by the AANA. Hospitals, with few exceptions, do not belong to physicians. They are public institutions and we have as much right to access to them for the education of nurse anesthetists as anesthesiologists have for preparing anesthesiologists. It may require legislation or legal action to break this stranglehold on this vital teaching resource, but are we being given a viable alternative? Recently, a nurse anesthetist with the courage of his convictions went to the Maine attorney general on a matter pertaining to the restriction of practice and education issue. The nurse anesthetist, as did the profession, won the case.

We should take heart that the justification for freezing the graduate medical education (GME) pass-through by the Health Care Financing Administration (HCFA) was predicated in part on increasing the incentives "for providers to improve the efficiency of their GME programs; . . . and to shift the emphasis of hospital medical education programs from physician to allied health (and nursing) programs." Also, as a result of the hearing and lobbying of nurses pertaining to GME funding, a bill sponsored by Senators Dole, Durenberger and Bentsen contained a provision for a study to be performed by the Department of Health and Human Services to assess the degree to which Medicare funds have supported approved nursing educational programs.

Another bright spot for us is that the AANA has gone on record promoting post-baccalaureate education of nurse anesthetists for the future. It would appear from an assessment of projected governmental educational funding that priority will be given to graduate education in the future. Even the National Governors' Conference (1985) has sent a report to the President calling for emphasis in federal spending to be placed on graduate programs and on bringing a balance between available student grants and student loans in order to lessen the loan burden of graduates. Thus, we appear prepared for this trend.

Fourth—Malpractice and liability insurance. I believe the malpractice and liability insurance crisis has the greatest potential of any to be problematic for our profession. CRNAs have never been allowed the same mistakes as anesthesiologists, nor will they ever be allowed such mistakes. Too many people are willing to testify that "this wouldn't have happened if only an anesthesiologist had been giving the anesthetic, or was in attendance". Unfortunately, so-called expert witnesses do not have to limit their testimony to facts; they can express opinions aimed at swaying insurance companies and juries in the decisions they make.

I am not concerned merely because CRNAs are not allowed the same mistakes as physicians, for in general I believe this has worked in our favor; over the years many CRNAs have been more vigilant in their practices and have provided a more conservative brand of anesthesia for the patient. This stance has paid off. Perhaps it is one of the reasons that in the few studies which have looked at outcomes of care between anesthesiologists and CRNAs, no significant differences have been found. Certainly, if there was bona fide evidence that this was not true, the American Society of Anesthesiologists (ASA) would be broadcasting such evidence across this nation. However, we must not be too satisfied with our performance, because, in general, there are too many anesthesia mishaps leading to death and disability. Furthermore, professional liability insurance has become less and less available and its rates have continually increased.

I believe that the AANA must assume responsibility for promoting our practice standards and educating members to those necessary practice and monitoring techniques, which are cost-effective in the prevention or early detection of anesthesia complications. Each individual member must assume greater responsibility for preventing anesthesia mishaps by adhering to practice standards.

The credentialing councils of nurse anesthesia must find ways of doing an even better job in credentialing or recredentialing. This may include increasing the standards of education, assuring that the Certification Examination reflects the knowledge base as well as the complexities of practice, and revising recertification criteria to have more of a potential to do a better job of assessing current competency. Let me point out that these suggestions do not imply criticism of the councils, nor their current processes, rather it is that the times are demanding more of us.

It is my belief that there would be no overage of physicians or other health providers, if the professions took their responsibility seriously of either requiring verified continuous competency of their members, or working within appropriate frameworks to withdraw practice credentials for cause. Certainly, there would be less of a malpractice crisis. Remember the words of the philosopher who admonished physicians to first, heal themselves. This admonishment applies equally to us.

Prognostications

What are my projections for CRNAs in the future? First, the future is in our hands, not the hands of the physicians. CRNAs will determine the future of nurse anesthesia, not anesthesiologists. It has ever been thus, and it will continue to be the case. We can achieve what we set out to do if we are willing to accept the costs of necessary actions.

Secondly, our potential to provide cost-effective,
quality services places us in a better position in this field for the future, than that of the anesthesiologist. I believe that the anticompetitive behaviors of physicians or physician organizations will continue, but will be the subject of increased investigation and litigation.

Thirdly, I agree with Dr. Franklin B. McKechnie, current ASA president, who stated before the Florida Association of Recovery Room Nurses that physicians will be on salary or contract with hospitals or larger corporations within the next five years. I believe this will do much to redistribute and correct the potential glut of physicians.

Fourth, competitive bidding for the provision of health services within the hospital and surgicenters, as well as the early discharge of patients from the hospital, will bring about changes in hospital staffing which will favor the utilization of professional nurses and nurse anesthetists in all appropriate health settings.

Fifth and last, there will be an increasing need for both highly qualified nurse anesthetists and anesthesiologists for the future. However, the need for CRNAs will continue strongly because of the CRNA’s potential to moderate costs while providing quality services. But, we must guard against allowing the loss of some of our educational programs to create a vacuum in manpower needs, for we can only expect that that vacuum would be filled by someone.

Collective and Individual responsibilities

Let me close with some suggestions for our organization and for ourselves as individuals. To assure a strong future for the profession of nurse anesthesia, the AANA should look to fulfill the following responsibilities:

- Provide strong, enlightened leadership for the future based on assessment and evaluation of societal trends.
- Maintain a strong government and public relations program.
- Promote the strengthening of practice standards, the credentialing mechanisms pertaining to nurse anesthesia, and quality assurance and risk management programs.
- Continue a proactive, as well as reactive, posture as needed to protect the education and practice rights of CRNAs.
- Continue its activities in support of education, continuing education, and research.
- Continue its attempt for establishing dialogue between itself and the ASA.

It must be remembered that it was not the AANA that withdrew its support of the 1972 Joint Practice Statement between the two organizations (AANA and ASA), it was the ASA. It was not the AANA that refused to agree upon agendas or send members to the liaison committee meetings between the two organizations, it was the ASA. And, it was the ASA House of Delegates that took action to prevent the liaison committee from meeting until AANA accepts ASA’s unilaterally defined statement on the anesthesia care team. Certainly, it is time that the statespersons of both professions come together and negotiate differences in a mature, responsible manner, with valid public interest taking primacy over inherent territorial conflicts that stem more from ego and economic issues than quality issues.

As individuals, each CRNA must look toward assuming the following responsibilities:

- Maintain competency and provide high quality anesthesia services to all of your patients.
- Be informed on the causes of anesthesia mishaps and exercise appropriate preventive strategies.
- Make use of your practice to market your profession and CRNAs; there is no better method of achieving such a goal than by doing an outstanding job for the patient and letting him or her know who did it.
- Avoid substance abuse, but recognize it when it happens to you or your colleague, and seek or insist on treatment and rehabilitation.
- Recognize that what you do and what happens to you reflects on your CRNA colleagues and your profession.
- Maintain an active, enlightened involvement in the AANA and its affairs; become aware, understanding the current trends and the necessity at times for hard decisions which may require unpopular action.
- Perfect your skills in government and public relations and become involved in both activities.
- Establish mature relationships with anesthesiologists and other health professionals in the institutions and communities in which you practice.
- Accept that the strength of your profession lies in the unity of its members.

There is much reason for CRNAs to be optimistic about their future. But, it will take much effort and energy on the part of both individual CRNAs and the AANA. The trends are with us, so let us make certain we are not trying to “swim against the currents.”

Conclusion

In conclusion, let me stress that change is taking place at a far faster pace than any of us have experienced in the past. Change always is an occasion for unrest, insecurity, fear, and, on occasion, unfortunately panic. In my opinion, we must hold steady upon the course which our forebears in this specialty started us on, emulating their example of courage and willingness to bear whatever costs were necessary to assure the posterity of the nurse anesthesia profession. We have reaped the benefits of our forebears’ labors, and it is now our time to “pay our dues”—shoulder the necessary burdens, pay the necessary costs to preserve our practice and our profession—not merely for ourselves nor our successors, but for the benefit of the society that we have faithfully served for more than a century.

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