An apple is not an orange but is good in its own right: A response to professional conflict between ASA and AANA
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Equating apples and oranges or nurse anesthetists and anesthesiologists simply is not plausible. Each have their own merits, and this is the point that the author makes in this article. The author examines the current AANA/ASA relationship, and the factors which have contributed to their divergent viewpoints.

The public is often confused when it comes to explaining or describing differences between types of individuals working in the same occupational field, particularly when those persons share many of the same functions and responsibilities. This confusion is further enhanced when professional in-fighting between groups leads to the publication of role differentiation or differences viewed from only one perspective—a perspective which is often biased and aimed at making the best case for the group doing the publishing while putting down or denigrating the role, capability, competence, and actual performance of others in the field. This game is played by many groups for a large variety of reasons, but often is a result of a perceived threat to the group’s social and/or financial status or to its power or control base.

This game playing is extremely notable in the health care field as a result of the fragmentation of health workers, the overlap and frequent lack of differentiation between roles, and the assumption of more difficult functions and greater responsibilities by personnel with lesser credentials, both because of need and the willingness of higher credentialed personnel to delegate these functions and responsibilities. This willingness of higher credentialed individuals to delegate functions and responsibilities stems from a host of reasons including: (1) maldistribution of personnel and a valid need; (2) the location where the service is required is insufficiently rewarding from a professional, social, cultural and/or financial standpoint for the higher credentialed individual; (3) perceived and actual overqualification leading to the lack of sufficient intellectual challenge for the routine or usual requirements for performance of the service; (4) general lack of interest, and (5) bonafide overlaps between professional groups.

It is interesting to note that while professions are often willing to give up functions and/or responsibilities, they are less frequently willing to give up or share the power, control or financial benefits that traditionally accrue to the profession or occupation doing the delegating.

This situation of public confusion is further aided and abetted by statutory law which when originally written was often applicable to the time but in effect over the course of time has not maintained its currency with social and professional change. In fact, many state
health practice acts have not been updated to incorporate the body of common law that has built up as a result of delegation and realignment of roles, functions, and responsibilities which reflect actual practice. While most of these statutes have not specifically prohibited this change, the current situation has led to the legally tenuous cliche that "practice precedes law."

A frequent ploy utilized by groups to justify delegation of function without subsequent loss to the group is to state that while one can delegate the function, responsibility for its performance cannot be delegated. Recent legal rulings would indicate that this position is rapidly changing and that the one accepting the delegation must share in the responsibility, if not assume full responsibility for its performance.

Thus, we have a situation that exists throughout society, but that is acutely manifested in the health care field, where public confusion abounds with regards to roles, qualifications, and competencies of the broad variety of health care workers. Further feeding this confusion are jurisdictional disputes, disagreements, and one-sided pronouncements between and by the professions.

The microcosm of anesthesia services

An example of this problem is typified by the situation that exists in the provision of anesthesia services to this nation. Unlike the more recent expansion of nursing roles, the broad utilization of nurses in the provision of anesthesia services in the United States began shortly after the turn of the century. Its development as a specialty within nursing predates the development of the medical specialty of anesthesiology. Therefore, nurses in the specialty have had a long history of having to work without anesthesiologist direction and/or supervision, though working under the direction and supervision of the surgeon.

The historical roots of this often tenuous relationship between nurse anesthetists and anesthesiologists as professional groups are well documented in literature.1,2,8 Efforts to improve this relationship at organizational levels have often failed for various reasons. The most recent cause for this failure has been the attempt on the part of the American Association of Nurse Anesthetists (AANA) to gain recognition for certified registered nurse anesthetists (CRNA's) within national health care legislation for services they perform, that is, as a purveyor of care to individual patients for purposes of third party reimbursement, and the objection of the American Society of Anesthesiologists (ASA) to such recognition. The thrust of these attempts by the AANA has been aimed not only toward recognition but at establishing an equitable basis for such reimbursement as compared with that allowed for anesthesiologists. It should be noted that this attempt has been based on an equitable reimbursement, not on parity or equal basis with anesthesiologists.

The efforts of the AANA in these endeavors are not unique in the health care field. It is the belief of many health care professionals outside of medicine that the failure of legislation to recognize for purposes of third party reimbursement all individuals who provide services to individual patients or clients while recognizing predominantly one group, physicians, is discriminatory in nature. Furthermore, this lack of recognition precludes innovation and establishment of alternative means of health care delivery which have the potential to benefit this nation from two standpoints—the accessibility of care and the economics of care without diminishing the quality of care.

The recent publication and insertion of a document in the Hearings Record of the Senate Finance Committee4 entitled "Differences in Services Provided By Anesthesiologists and Nurse Anesthetists" by Dr. Richard Ament, 1976-77 president of the American Society of Anesthesiologists, is an example of a one-sided interpretation of
role differentiation which for the most part cannot stand up before the facts and in the face of practice reality. The fact that the document was developed by Dr. Ament and legal counsel for ASA in and of itself indicates the lack of breadth of input necessary to accurately reflect a valid picture of anesthesia practitioners in this country.

Dr. Ament has stated in other forums that he does not work with nurse anesthetists but serves in a hospital where all-physician anesthesia is performed, either by residents in training or by staff anesthesiologists. His firsthand experience of working with nurse anesthetists or observing their education is severely limited. The publication of this distorted document, aggrandizing anesthesiologists while denigrating nurse anesthetists, ill serves the public good. The nation is dependent upon both nurse anesthetists and anesthesiologists for anesthesia services, and they both need each other if they are to effectively fulfill their national responsibility.

It is and has been the position of the AANA that the provision of anesthesia services to persons requiring those services appropriately fits into both the medical and nursing models of health care practice. This has definitely been established by history. Patients receiving anesthesia services require both, nursing and medical care. It is further the position of the AANA that patients can be afforded the most effective, economic, and concerned care when anesthesiologists and nurse anesthetists work together in a collegial relationship, thereby affording the patient the particular expertise of each profession based on individual needs or requirements. However, the maldistribution of anesthesiologists leading to shortages in many parts of the nation precludes this ideal from being realized now and in the foreseeable future. It, therefore, is necessary that nurses be initially prepared and maintain competence to function independently of anesthesiologists if all of the valid requirements for anesthesia services of this nation are to be met with competence wherever they are required.

The AANA also views nurse anesthesia as an expanded role of nursing in which the nurse anesthetist provides nursing and medically-delegated services of an anesthesia nature to patients. The nurse anesthetist is independently responsible for nursing services performed, while bearing responsibility to both the physician and the patient for medically-delegated services when functioning as the agent of a physician.

When the nurse anesthetist undertakes the anesthetic management of a patient, he (she) brings both his nursing and anesthesia competence to the patient, an anesthesia competence built on his nursing base. The anesthesiologist brings his medical and anesthesia competence to the patient, the anesthesia competence built on his medical base.

Nurse anesthetists, as part of their educational process, learn to identify and recognize patient problems which affect the plan and course of anesthetic management and utilize medical consultation from the surgeon, anesthesiologist or other medical specialist as may be required and as agreed to by the patient’s attending physician. Thus, when the nurse anesthetist administers an anesthetic, patients are not denied access to needed medical attention. Should the nurse anesthetist feel that the anesthesia risk is beyond his particular competence, or that the necessary medical consultation is not available, or the planned management is inconsistent with his personal assessment of the patient, he has the prerogative, indeed the responsibility to withdraw from the case.

In case of an emergency, the nurse anesthetist recognizes that he may be held responsible and liable for withdrawing from a case in which he cannot agree to the proposed anesthetic management when the patient does not have access to another anesthetist and suffers harm from such refusal to perform the service. However, the nurse anesthetist bears even greater liability for administering an anesthetic which, in his professional
judgment, puts the patient at jeopardy and harm results. The nurse anesthetist is independently licensed to practice nursing, of which delegated medicine constitutes a part, and as with all nurses must consider the following in accepting delegation from a physician: (1) the nurse's competence to perform that which is delegated based on education and experience; (2) the legality of the delegation; and (3) whether the patient will be placed in jeopardy by the acceptance of the delegation.

If a survey of the practice field was undertaken by an independent group, it would be quite evident that there are few anesthetics beyond the competence of most fully qualified nurse anesthetists utilizing medical consultation and that the majority of patients coming to anesthesia and surgery require minimal medical consultation beyond that of the operating surgeon and/or primary physician. This in no way negates the need for anesthesiologists nor does it equate the anesthesiologist with the nurse anesthetist—they are apples and oranges. But, for the majority of patients undergoing anesthesia, the nurse anesthetist has those qualifications which are more than adequate to provide a safe, competent anesthetic, while the anesthesiologist is often overqualified for performing such services.6,7

True, emergencies can occur in any benign situation, especially anesthesia and surgery, but again this is why the nurse anesthetist has been taught to recognize these and provide for their management, seeking confirmation and/or consultation as may be required. This potential for complications in any anesthetic or surgery is a primary reason why AANA has advocated that the ideal situation is for the nurse anesthetist and anesthesiologist to work together; but, since the ideal is not achievable at this time, the nurse anesthetist must be prepared to cope with these situations.

Types of services provided by nurse anesthetists
A survey conducted by the Health Information Services, Inc., in 1976 and reported on by Goff8 indicates the scope of practice of nurse anesthetists. (Table 1.)

Anesthesia practitioners and certification status
Today, there are approximately 10,000 active practicing anesthesiologists in this country of whom approximately 50%, or slightly less, are fully certified.

### Table 1

**Types of services provided by nurse anesthetists**

| 1. Average number of anesthetics performed by each CRNA in 1975–638. |
| 2. Percent of CRNA's who perform the following anesthetic procedures: |
| a. General Anesthesia — 100% |
| b. Regional Anesthesia (actual administration) — 61-60% |
| 3. Percent of CRNA's with responsibilities in special care areas: |
| a. Respiratory Care — 30% |
| b. Coronary Care — 43% |
| c. Recovery Room — 84% |
| d. Cardiopulmonary Resuscitation — 75% |
| 4. Percent of CRNA's involved in pre-op and post-op assessment of patients — 70% |
| (A significantly lower percentage of nurse anesthetists working in anesthesia groups composed of both anesthesiologists and nurse anesthetists are involved in pre- and post-op assessments as compared with nurse anesthetists in other types of employment settings.) |
| 5. Percent of CRNA's actively participating in quality assurance mechanisms—61% |
| a. Peer Review — 53% |
| b. Anesthesia Audit — 48% |
| c. Utilization Review, Morbidity/Mortality Surveys and Infection Reports — 33% |
There are approximately 2,100 anesthesia residents in training.\(^9\) Foreign medical graduates (FMG's) constitute approximately 50\% of the total residents in training, and between 30-35\% of practicing anesthesiologists. The full impact on anesthesia of the Health Education Assistance Law of 1976, phasing out the FMG program, is unknown. However, since there is and has been a high percentage of FMG's in anesthesiology residency programs, the impact could be severe.

Current figures for nurse anesthetists indicate that there are 14,765 active, practicing certified registered nurse anesthetists and approximately 2,900 nurse anesthesia students in accredited programs. Foreign nursing graduates have constituted only approximately 3\% of the graduates of these programs.\(^10\)

Unlike the ASA with reference to physicians, the AANA has long advocated that certification or eligibility for certification in the specialty should be the entry qualification for the practice of anesthesia by nurses. It is estimated that 95-98\% of all nurses actively involved in the practice of nurse anesthesia are currently certified in the specialty.

Controversy exists within and without anesthesiology pertaining to the preparation of anesthesiologist assistants for purposes of administering anesthesia. While two programs exist within the United States for the preparation of such assistants, it is too early to predict their future impact on the provision of anesthesia services. The American Medical Association Committee on Emerging Health Professions has been requested to recognize the anesthesiologist assistant as a new health occupation. It is conceivable that if such recognition is granted, additional programs would be instituted.

**Nurse anesthesia education**

*Prerequisites for admission to nurse anesthesia educational programs.* Prerequisites for admission to an accredited nurse anesthesia educational program includes but are not restricted to the following: (1) high school graduation or equivalency certificate; (2) graduation from a state approved school of nursing; and (3) current licensure as a registered professional nurse. In addition, most nurse anesthesia educational programs require a minimum of one year of nursing experience prior to admission. Some programs require specific college courses if the applicant has not taken them as a part of his/her nursing curriculum.

There has been recent criticism from the president of the ASA (Dr. Ament), in public forums with reference to the admission eligibility policy of the AANA Council on Accreditation which does not discriminate between the graduates of the three basic generic nursing programs. Interestingly, Dr. Ament has never voiced the same concerns directly to the Council, either orally or in writing. Unlike most professions, nursing education has three generic programs leading to the same license to practice: the associate degree, the diploma, and the baccalaureate programs. While nursing leaders have long advocated the movement of all professional nursing education into the baccalaureate frame, traditional opposition from the American Medical Association and the American Hospital Association, as well as opposition within nursing from associate degree and diploma-prepared nurses has successfully precluded such move to date.

The failure to distinguish among these graduates by licensure has led to an employment system which in general does not distinguish among graduates, on-the-job training, and non-degree granting specialization programs. It also has led to federal laws which fiscally support all three programs and discourages discrimination among graduates in the education of nurses as primary care nurse practitioners. Further, this fragmentation in nursing education creates a situation where there is an insufficient pool of graduates from any one type of nursing program to meet
the specialty needs of nursing or, for that matter, the needs of any one specialty in nursing.

It, therefore, has been the policy of the AANA and subsequently the AANA Council on Accreditation not to distinguish among these graduates but to allow each the opportunity to become CRNA’s through successful completion of a nationally accredited educational program and subsequent successful completion of a qualifying examination for certification in the specialty. While some persons question the educational validity of such a policy, it should be recognized that such validity does not merely rest with the acceptance of philosophical concepts based on theoretical constructs and assumptions, but more so on demonstrated learning through the achievement of educational objectives, that is that the education did what it proposed to do.

Thus, educational validity has been demonstrated by: (1) the acceptance of graduation from an accredited program as a basis for employment in the field of nurse anesthesia and, in some instances, as a basis for state licensure, certification or approval to practice in the field; and (2) the acceptance of transcripts from diploma, certificate and degree nurse anesthesia educational programs as a basis for evaluation for awarding college credits or admission to graduate programs by various colleges and universities. This policy has been found workable; and while it has not been subjected to validation studies with reference to why, one could postulate that small classes, self-directed study, time for individualized instruction, utilization of peer tutors, and the strong motivation of nurse anesthesia students are contributing factors to this success.

It is also noteworthy that unlike Dr. Ament’s projections that by 1977, associate degree graduates would probably constitute 40% of those nurses graduating from nurse anesthesia educational programs, their percentage has remained relatively stable for the 1975-1977 period at around 26%. Table 2 provides information about the types of nursing graduates graduating from nurse anesthesia programs and taking the qualifying examination for certification. If you add to those RN’s with baccalaureate or higher degrees, those grad-

<p>| Table 2 |
| Type of nursing graduates graduating from nurse anesthesia educational programs and writing the qualifying examination for certification: by number and percent |</p>
<table>
<thead>
<tr>
<th>Type of Graduate/Date of Exam</th>
<th>June, 1976</th>
<th>December, 1976</th>
<th>June, 1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN Diploma</td>
<td>343</td>
<td>355</td>
<td>231</td>
</tr>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent</td>
<td>56.9%</td>
<td>50.8%</td>
<td>52.9%</td>
</tr>
<tr>
<td>RN Associate Degree</td>
<td>155</td>
<td>194</td>
<td>112</td>
</tr>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent</td>
<td>25.7%</td>
<td>27.8%</td>
<td>26.6%</td>
</tr>
<tr>
<td>RN with Baccalaureate or higher degree</td>
<td>86</td>
<td>133</td>
<td>83</td>
</tr>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent</td>
<td>14.3%</td>
<td>19.1%</td>
<td>18.8%</td>
</tr>
<tr>
<td>Foreign Nursing Graduates</td>
<td>19</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent</td>
<td>3.2%</td>
<td>2.4%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total Graduates Taking Qualifying Examination for Certification</td>
<td>603</td>
<td>699</td>
<td>437*</td>
</tr>
</tbody>
</table>

*It is felt that the June, 1977 figure for total graduates is low because of a recent shift in length of nurse anesthesia programs from 18 months to 24 months. This seems borne out by the fact that 799 graduates have applied for the December, 1977 exam. (Data and extrapolations from the Psychological Corporation Statistics pertaining to the AANA-Council on Certification Qualifying Examinations, 1976-1977.)
uates who receive a baccalaureate in anesthesia upon completion of their course, the percent of graduates with a minimum of a baccalaureate degree would have increased to 17.2% in June, 1976, to 24.75% in December, 1976, and to 23.8% in June, 1977.

Basic requirements for accredited nurse anesthesia educational programs. Standards for nurse anesthesia education are set by the American Association of Nurse Anesthetists' Council on Accreditation (AANA-CA), a multidisciplinary body constituted of six nurse anesthetists, three anesthesiologists, two public members, a hospital administrator, and a nurse anesthesia student. While broad input into the formulation of these standards is provided for, their finalization and adoption is the prerogative of the council and they are not subject to ratification by any group. The AANA-CA is nationally recognized by the U.S. Office of Education (OE) as the accrediting agency for nurse anesthesia educational programs/schools.

The AANA and subsequently the AANA-CA has been on the Commissioner of Education's list of recognized agencies since 1955. It should also be noted that the awarding of three-year recognition with a mandatory progress report at the end of one year by OE to the AANA-CA in 1976 came despite challenges by Dr. Ament representing the ASA. (Anesthesiology residency approval mechanisms are not subjected to public oversight nor to OE review.)

The educational standards for nurse anesthesia educational programs are enumerated in eight categories: Educational Administration, Curriculum and Instruction, Records, Faculty, Administrative Support, Self-Study and Evaluation, Program Enrichment and Program Innovation, and Ethics. While all standards are important, the Curriculum and Instruction standard is often felt by many to be the core or the heart of the requirements. The minimum requirements cited in this standard are included in Table 3.

Many nurse anesthesia educational programs teach additional competencies beyond the minimal requirements.

Requirements for certification in the specialty

The requirements for certification in the specialty are defined by the AANA Council on Certification (AANA-CC), a multidisciplinary body composed of six certified registered nurse anesthetists, three anesthesiologists, two nurse anesthesia students, a hospital administrator, and a public member. In addition to specifying the requirements for certification, this council is responsible for developing the qualifying examination utilizing the expertise of the Psychological Corporation, Professional Testing Division, as consultants for question and test construction. The content of the examination is determined by the professional members on the AANA-CC and is derived from a pool of questions submitted by program directors. The Psychological Corporation administers the qualifying examination, grades it, and performs various statistical analyses including item analysis.

Requirements for certification in the specialty include: (1) graduation from an accredited nurse anesthesia educational program and recommendation by the program director; (2) evidence of fulfillment of minimum prescribed academic and clinical requirements with a minimum grade of a C or 75 in each academic and clinical course; (3) current licensure as a registered professional nurse in a state or territory of the U.S.; and (4) successful completion of a criteria-referenced examination in the specialty.

While the AANA Board of Directors currently confers certification status to nurse anesthetists, by bylaw it has no discretionary powers with regard to initial certification. The AANA-CC determines on the basis of its criteria those who are fully qualified for certification, submitting its list to the AANA Board of Directors for conferral of certification status.
Table 3
Curriculum and Instruction Standard of the AANA-CA

1. **Length of Program**: Minimum length is 18 months, working toward the development of a 24 month program. To date 70% of accredited programs are in a 24 month frame. Since the inception of the AANA-CA, no new programs of less than 24 months have been recognized.

2. **Minimum Didactic Program Requirements**:
   a. Orientation to Anesthesia Practice (includes history, ethics, standards of practice, medical-legal aspects, etc. (45 hours)
   b. Chemistry and Physics of Anesthesia. (45 hours)
   c. Advanced Anatomy, Physiology and Pathophysiology. (120 hours)
   d. Principles of Anesthetic Management. (60 hours)
   e. Pharmacology: Anesthetic Agents, Adjunctive and Accessory Drugs. (60 hours)
   f. Clinical Correlative Conferences. (35 hours)

3. **Textbook requirements**: Textbooks required for these courses indicating the requisite depth of study includes standard texts pertaining to anesthetic management as are used in anesthesiology residency training, medical school textbooks with reference to anatomy, physiology, pathophysiology, and pharmacology, and the standard anesthesiology texts for chemistry and physics of anesthesia or an instructor developed syllabus.

4. **Clinical Program Requirements**:
   a. A minimum of 450 cases of anesthesia must be administered. There are designated minimum requirements for types of cases, types of techniques, and variety of drug usage included within these 450 cases. The average number of cases reported by graduates in applying for the qualifying examination for certification ranges between 750-800.
   b. A minimum of 600 hours of actual anesthesia time is required. The average number of hours reported by graduates is approximately 1000 hours.
   c. Students must perform pre-op and post-op assessments on patients to whom they are assigned for anesthesia, including the development of anesthetic management plans based on the preanesthesia assessment and other patient data.
   d. Encouraged educational experiences include:
      (1) Respiratory Care, both didactic and clinical instruction.
      (2) Screening Physical Examination, both didactic and clinical instruction.
      (3) Experience in Intensive Care Settings.
      (4) Actual administration of regional anesthesia where not precluded by law or regulatory edict.
   e. Minimal Competencies Expected of New Graduates of Nurse Anesthesia Educational Programs: (Competence is defined to include knowledge, judgment, skills and attitudes appropriate to assuring patient safety in the performance of the functions.)
      (1) Perform a preanesthetic interview and physical assessment.
      (2) Evaluate patient history, physical and appropriate lab and x-ray data.
      (3) Develop an appropriate anesthetic care plan consistent with overall medical and nursing regimen.
      (4) Perform general anesthesia for all ages and all categories of patients excluding possibly open heart cases utilizing a broad variety of techniques and agents.
      (Many, but not all graduates of nurse anesthesia educational programs acquire experience with anesthesia for open-heart surgery.)
   (5) Manage regional anesthesia cases.
   (6) Use and interpret a broad variety of monitoring modalities including electronic monitors—EKG, arterial pressure, CVP, etc.
   (7) Manage fluid therapy within medical plan of care.
   (8) Recognize and take appropriate actions with reference to complications occurring during the anesthetic management, referring to a physician those beyond the nurse anesthetist's ability to manage consistent with practice standards policies and that degree of delegation accepted from the physician.
   (9) Use anesthetic ventilators effectively.
   (10) Position or supervise positioning of patients to assure physiologic function and safety.
   (11) Function as a team leader/member in cardiopulmonary resuscitation.
   (12) Interpret and take appropriate actions with reference to screening pulmonary function and blood/gas determinations.
   (13) Supervise ventilatory care in intensive care areas, including patients on ventilators.
   (14) Utilize appropriate principles of basic and behavioral sciences in protecting patients from iatrogenic complications.
   (15) Act as a crisis intervener for patients/families and to facilitate the function of the health care team.
   (16) Teach paramedical personnel in area of expertise.
   (17) Recognize personal and professional strengths and limitations and take appropriate actions consistent with valid self-awareness.
Requirements for continued certification in the specialty

A mandatory continuing education program has been adopted by the AANA as a requirement for continued certification in the specialty. It becomes effective in 1978. The AANA has had a voluntary continuing education program since the latter 1960's. Under the voluntary program, individuals were awarded, on the basis of evidence of completion of specified continuing education requirements, a Certificate of Continued Professional Excellence. A high percentage of CRNA's participated in this voluntary program. Compliance with the voluntary program or its equivalence was made mandatory for all nurse anesthetist faculty members of nurse anesthesia educational programs in 1975.

Quality of care study

The AANA Council on Practice (AANA-CP), a multidisciplinary body similarly constituted as the other two AANA councils, and charged with the responsibility to protect the public interest in matters of nurse anesthesia practice, is undertaking a study to assess the quality of care provided by CRNA's.

During the course of the AANA-CP's exploration of possible sources for grant monies to support this study, it was suggested that federal money might be made available if, working in conjunction with the ASA, the quality of care provided by anesthesiologists also was included. The ASA has been invited to participate in such a study. Their representatives have indicated recently that they are willing to explore cooperation, but at this date, it is not known whether the quality of care provided by anesthesiologists will be included.

The CRNA's contribution toward meeting the nation's anesthesia needs

In 1976, CRNA's administered approximately 9.5 million anesthetics in the United States, in addition to fulfilling other responsibilities and performing other functions in special care units and on cardiopulmonary resuscitation teams. In a study reported by Biggins, et al in 1971, it was found that CRNA's administered 48.50% of all anesthetics in the U.S., anesthesiologists 38.34%, physicians others than anesthesiologists 9.70%, registered nurses (non-CRNA's) 2.80%, with the remaining 0.66% being administered by others undesignated.

In a survey by Accardo in 1972, 60% of a random sample of CRNA's (1000 with a 66% return) reported they did not work under the direct supervision of an anesthesiologist. This is perhaps reflective of the maldistribution of anesthesiologists and the fact that CRNA's provide the bulk of anesthesia services in rural and disadvantaged areas, while also providing 42% of the anesthesia in urban and university settings according to the Biggins survey.

Accurate data as to who does what in anesthesia is becoming increasingly difficult to obtain because of the reimbursement policies of third-party payers, including the federal government. Many anesthetic records are signed by an anesthesiologist when, in fact, the case was administered by a nurse anesthetist with the anesthesiologist supervising two or more nurse anesthetists. In some instances, this supervision has been quite distant from the operating room setting, including home or other environs. To be sure, the anesthesiologist's activities as supervisor and consultant are important and worthy of reimbursement; however, future data systems should include the capability of reflecting accurately the type of workload of both nurse anesthetists and anesthesiologists.

Based on the education, capability and actual practice of nurse anesthetists, it only seems reasonable to many CRNA's and the AANA that reimbursement policies by third-party payers, including the federal government, should not discriminate against them. And, further, such reimbursement policies and legislation should reflect an equitable basis for rewarding CRNA services.
this author, this is what the AANA legislative activity with regard to Medicare-Medicaid has been all about—not equating apples and oranges, or nurse anesthetists and anesthesiologists.

REFERENCES


(7) Proposal to AMA Committee on Emerging Health Occupations; Data Supporting the Development of a New Health Occupation, The Anesthesiologist Assistant, (Tab K-17, para. 20, dtd. February, 1976).


(9) Personal Communication with AMA Liaison Committee on Post Graduate Medical Education.

(10) Data from AANA, October, 1977.

(11) AANA-CA Documents including Petitions and Responses to USDHEW (OE) and Council on Postsecondary Accreditation, 1975-1977.


(13) Actual and Extrapolated Data from Reference 8.


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