How recent legislation will affect the future of CRNA professionalism

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The author explains how recent state and federal government actions are likely to induce a variety of professional "identity crises" for nurse anesthetists in the future. As Dr. Brown views it, at stake will be essential professional rights to control nurse anesthetist training, conduct peer review, help define client needs, and secure an acceptable level of reimbursement. He highlights the 1974 Taft-Hartley amendments, PSRO's, HMO's, and HSA's, emphasizing how CRNA's can use them to further their professional growth.

Until recently, your profession of nurse anesthesia had been doing quite well. Your relations with staff RN's steadily had been improving. You also (in 1972) had become charter members of the Federation of Nursing Specialty Practice Organizations and the American Nurses' Association. Your friendship with surgeons had helped give you an informal voice in many hospital medical staff meetings.

You and your anesthesiologist colleagues had established a national liaison committee to help settle misunderstandings. Hospital administrators had granted you liberal personnel policies, often allowing you educational leaves and other benefits in excess of that allowed RN's. Finally, by 1972, even the federal bureaucrats had noticed you and decided that Medicare should pay for anesthetist services though not directly.

Yet, 1972 also was the year that things started mishappening on a local level, with New York state being a prime example. That year, you failed to convince the First Deputy Commissioner of Health that he should recommend your getting fee-for-service reimbursement under Medicaid. His denying your request specifically because of his belief that "the administration of anesthesia is not recognized as a nursing service" under the New York State Hospital Code probably was particularly galling.

Furthermore, 1973 was not such a good year either. For then, the New York State Society of Anesthesiologists took the position that you were not qualified to administer regional anesthesia regardless of how you were paid.

Along came 1974, at which time the New York State Nurses Association joined you in trying to convince the New York State Legislature's Select Committee on Insurance Rates and Recodification to require insurance companies to pay all CRNA's and RN's directly. But, this effort failed.

Unfortunately, 1975 brought you even more worries. All of you helped finance an expensive legal campaign to fight the American Society of Anesthesiologists' (ASA) challenge to the American Association of Nurse Anesthetists' right to continue accrediting nurse anesthesia schools and certifying graduates. You won, but another challenge may be
made this year. Moreover, the ASA is not the only body looking at your training programs and practices.

Many of you are aware of the New York State Education Department's proposal in 1975 to create the title "Clinical Nursing Specialist" and, thereby, regulate the training programs and practice limitations of all "expanded role" nurses. Many of you may be even more alarmed by the New York State Department of Health's still vague wish to regulate all nurses in "expanded roles" under the 1971 Physician's Associate—Specialist's Assistant law. Whatever becomes of these issues could set a precedent for the rest of the nation.

Your rights to control anesthetist training, conduct peer review, help define client needs, and secure what you consider to be an acceptable level of reimbursement are no mean rights. They are the foundation of your professional autonomy, your right to control your work. The ability to exercise this right is what some sociologists say is really what makes professionals different from nonprofessionals. It, therefore, is very understandable why some of you worry about the future of nurse anesthesia as a profession.

The future indeed is likely to bring with it a host of "identity crises" for your profession. But, like the crises that punctuate individual development, your crises need not bring disaster with them. They also can provide exciting opportunities for further growth. Whether or not yours do may depend largely on how you deal with the pain they will cause you.

Effects of the amended National Labor Relations Act

Some of the most painful crises will be those resulting from recent federal health legislation. You may surprisingly be most affected by the amendment Congress made on July 26, 1974 to the National Labor Relations Act. This amendment granted collective bargaining rights to all not-for-profit health facility work-ers. You might expect that you would be better able to protect yourselves after being given federal collective bargaining rights. But, unfortunately, the interest taken by Congress initially in granting you these rights may not have been accompanied by a corresponding interest in safeguarding your professional needs.

Consider the position of Congress on bargaining unit size. Nowhere has Congress or the National Labor Relations Board (NLRB) said that nurse anesthetists or any other group of specialized health professionals will be allowed to bargain as a separate unit. Indeed, many of those voting for the amendments believed that the NLRB would prevent "proliferation of bargaining units in the health care industry."

The main hope for separate bargaining comes from the NLRB's "community of interest" doctrine. It states that the NLRB's "primary concern is to group together only employees who have substantial mutual interests in wages, hours, and other conditions of employment."

But, this doctrine is rather vague. Is the NLRB likely to say that all of you possess a "community of interest" and, therefore, allow you to bargain separately just because you belong to the same profession? Or, is the NLRB going to ask for more?

One regional director indicated last year that more may be required. Although he based his decision on allowing nurse anesthetists working for the Group Health Cooperative of Puget Sound to bargain separately from an RN unit on narrow technical grounds, he also made a point of emphasizing the long history of bargaining independence enjoyed by the anesthetists. He noted that: (1) the anesthetists had bargained with Group Health for the previous 10 years, and (2) the anesthetists had not been included in bargaining between Group Health and the RN's for the previous 25 years.
To prevent "bargaining unit proliferation," the NLRB so far has seemed willing to permit only five hospital employee groups to bargain independently. These are: (1) RNs, (2) salaried non-RN professionals, (3) technical employees, (4) clerical employees, and (5) service and technical employees. Unless you are able to prove you have been bargaining separately with your employers for what the NLRB arbitrarily considers to be a "long enough period," your only choice may be that of choosing which of these five groups to join.

Perhaps, you will choose to join RN units. Your growing friendship with RN's might seem to make this the most natural choice. Yet, I need not remind you that perhaps the most violent arguments over money and politics are those between friends! Moreover, because most bargaining units are governed by majority rule, you may end up losing most of these arguments in large RN-dominated units. For example, CRNA Lawrence Todd, who served as a director of the New York Association of Nurse Anesthetists, joined an RN-dominated unit. It secured a 20% raise for RN's but only a 9% raise for anesthetists. In fact, the actual dollar amounts of the anesthetists' raises represented only 25-50% of those of the RN's!

Some of you understandably might prefer to gamble on joining bargaining units dominated by house staff and other salaried MDs who provide anesthesia. After all, since the National Association of Nurse Anesthetists (as it was then called) and the ANA parted ways in the 1930's, many of you have come to identify yourselves more with the medical than the nursing staffs of the places where you work.

But, your economic and political interests may conflict with those of anesthesiologists even more than they might with RN's. For example, the AANA executive director Bernice Baum asked Senator Herman Talmadge, this past August, to take steps to see that Medicare pays hospitals using CRNA's with graduate training at 85% the rate received by board certified anesthesiologists. A simple enough proposal. However, its admitted intended effect was to reduce the amount anesthesiologists would collect under Part B of Medicare. Anesthesiologists—salaried or not—have not taken kindly to this attempt to restrict their income. Many may view it as an infringement of their professional autonomy. Whether caused by the 85% rate or the possible effect on professional autonomy, it is clear that the letter "upset many ASA members."

Even anesthesiologists who like you do not seem disposed to recommend that third-party payors pay you more than half of what anesthesiologists receive. Thus, even if you figure out a way to reassure salaried anesthesiologists that you have no designs on their paychecks, it is unlikely that they often would be disposed to let you bargain for a salary that approaches theirs. If you join units composed of post-residency salaried MDs in particular, you may be greatly disappointed by the results.

Perhaps, the most complex question raised by the new labor amendments is this: will professional employees be allowed to bargain about patient care issues? Hospital administrators, like factory managers, consistently have taken the position that any decisions affecting budgets are core "management rights" about which unions should not be allowed to bargain. Although the United States Supreme Court has indicated that unions cannot destroy an employer's "freedom to manage his business," the nature of this freedom in health facilities still is far from settled.

It certainly is clear that bargaining about patient care issues often does take place. Indeed, the recent strikes by New York City and Chicago interns and residents largely were fought over these issues. If the federal mediators in Chicago objected, they did not do so loudly.

It also is clear that bargaining about patient care issues often takes the form of bargaining about being given more managerial power. Both the New
York City and Chicago settlements provided house staffs with seats on hospital committees making important patient care decisions. Furthermore, RN's also have used collective bargaining tactics to press for similar rights to serve as patient advocates and secure places on institutional governing bodies.

Yet, if being able to speak for the patient is an important professional right, one wonders how warmly professionals now sitting on these patient care committees will welcome yet other groups. As time passes, it may become more and more difficult for you to be given an independent voice in deciding patient care policy.

Unless you organize quickly into aggressive independent unions—or can outnumber non-CRNA's in your bargaining units—your only long-term hopes of determining your pay level and patient care policies may be joining bargaining units dominated by RN's, MD's, or nonprofessionals. Of these alternatives, the most promising may well be your joining large RN units and then trying to negotiate an independent anesthetist role within them.

One predictor of your success may be the willingness of nursing associations to make statements respecting your professional and bargaining autonomy. "Joint resolution agreements on jurisdiction and mutual assistance", as they are called, already have been announced by both the state nurses' associations and nurse anesthetists' associations of Michigan and New Mexico. Agreements like these clearly can set a tone of mutual respect which, hopefully, would last even if CRNA's and RN's later decide to bargain together.

Effects of PSRO's

The 1972 Professional Standards Review Organization (PSRO) law may precipitate a CRNA "identity crisis" at least as painful as that fostered by the bargaining law. The reason is that the law clearly was written with the physician in mind. The PSRO's have the duty of reviewing all "health care practi-
should have in the review of your services and what role you should have.

The second step is to realize that, despite Prof. Miller's beliefs, the PSRO law does leave the door open to substantial non-MD involvement. The PSRO's are authorized to make "arrangements to utilize the services of persons who are practitioners of or specialists in . . . [non-MD] types of health care . . . ." Moreover, "advisory groups" of non-MD health care practitioners and health facility representatives soon will be established to assist statewide Professional Standards Review Councils.

Further steps, thus, immediately come to mind. It certainly would not hurt to let those physicians sitting on your local PSRO boards know that you are interested and available to set standards of nurse anesthesia practice. Many physicians already may have read the Standards of Practice published by the AANA and may be very receptive to any offers to help implement these standards.

Most important, it should be stressed that the law permits non-MD's to sit on local PSRO boards. Indeed, as an example, the PSRO in the Albany area has bylaws allowing for 49% non-MD board membership. But, no non-MD's have been appointed! It is true that opportunities do exist for you to prevent PSRO's from destroying your professional autonomy. But, it also may be true that these opportunities will have to be seized, not waited for.

Effects of HMO's

The Health Maintenance Organization (HMO) Act of 1973, unlike the PSRO law, obviously was written with the non-MD care provider in mind. It mandates, for example, that HMO-affiliated medical groups must "utilize such additional . . . allied health personnel . . . as are available and appropriate for the effective and efficient delivery of [the group's services]."

The law also specifies that HMO's must provide procedures for settling disputes between MD and non-MD providers, and requires non-MD's to join physicians in reviewing "the process followed in the provision of health services." Moreover, the law makes no statement specifying the proportion of physicians or other health professional group that must sit on the HMO governing body.

At first glance, however, HMO's may not hold much appeal for you despite their emphasis on non-MD professionals. Few if any HMO's exist, for example, in New York state which employs CRNA's to administer anesthesia. Moreover, as Dr. Nicholas Greene, professor of anesthesiology at Yale, has noted, it is very unlikely that HMO anesthesia ever would be given except under anesthesiologist supervision.

Finally, some of you may have noticed that the fixed nature of the HMO annual income can stimulate bitter struggles among health professional groups over the right to get or spend this income.

Yet, HMO's also may provide you with unique "expanded role" opportunities. Many nurses already have written how outpatient-oriented HMO's have enabled them to cast off the role of being the "doctor's handmaiden" by becoming "nurse clinician coordinators" and taking on some administrative responsibilities.

No a priori reason exists why you also could not respond to the clinical and administrative challenges HMO's will provide. For example, your technical expertise might qualify you to direct outpatient units providing thorough preoperative patient assessment.

Inpatient-oriented HMO's also will be the source of many opportunities. Dr. Greene has noted that the current trend in anesthesiology is for anesthesiologists to move out of the operating room and into directorships of intensive care units. Part of your future might lie in an analogous trend for some of you to move out of the operating room and into directorships of HMO inpatient units providing post-operative respiratory and psychological care.

Effects of HSA's

Perhaps, the most long-range chal-

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Challenges to and opportunities for increased CRNA professionalism will come from the National Health Planning and Resources Development Act of 1974. This law provides for the creation of “health systems agencies” (HSAs) to replace all previously existing federal health planning bodies. Each HSA must have a governing body composed of 50-60% consumers. The rest must include representatives of five groups, including: “physicians (primarily practicing physicians), dentists, nurses, and other health professionals.”

Please note that the law does not specify what the proportions should be of these particular health professionals.

The new HSAs, at least on paper, have been given very ambitious goals. They are to devise means of providing primary care for “medically underserved” populations, develop plans for the “training and increased utilization of... especially nurse clinicians,” promote activities designed to improve health care service quality, and devise means for controlling health care costs. The HSAs also have been given considerable powers to help achieve these goals. Perhaps the most controversial of these powers is the HSA obligation to review all ongoing institutional health care services every five years “respecting the appropriateness in the area of such services.” In addition, the agencies must make recommendations to a state planning body before any “substantial expenditures” are made for expansion or new development of institutional health services.

It should be expected that a facility’s right to federal funding and national health insurance will depend on HSA willingness to make these determinations of need. Finally, HSAs will have the right to “coordinate” their activities with those of PSRO’s and “other appropriate general or special purpose regional planning or administrative agencies.”

Clearly, the right to plan for anesthesia services will carry with it the right to affect the nature and distribution of anesthetist man- and woman-power. If HSA’s decide that all new surgery units must be built in university hospitals rather than in small rural hospitals, one would predict an accompanying rise in the numbers and, therefore, power of the university anesthesiologists.

If, on the other hand, HSA’s decide that high quality anesthesia services best can be guaranteed by encouraging the rapid expansion of nurse anesthesia training programs or by encouraging the AANA to define all CRNA practice standards, quite a different picture comes into focus.

One even can argue that such matters as, whether or not third-party fee-for-service reimbursement would affect the nature and distribution of CRNA’s in the future and, therefore, should come under HSA purview. In any event, it seems likely that HSA’s probably future ability to affect health facility reimbursement will give them enormous power over health facility affairs.

In sum, one would not be surprised to see HSA’s gaining a strong voice in managing health facility affairs both directly and by setting policies which hitherto had been the exclusive preserve of other health agencies and organizations. Indeed, securing membership on local and state planning bodies perhaps will become the most important avenue for health professionals to protect their autonomy in the future.

Conclusion

Overall, your future seems far from bleak. By participating actively on local planning bodies, you can secure an unprecedented ability to help define your clients’ needs and ensure that you will be able to satisfy them. By aggressively seeking—and helping to create—“expanded role” CRNA positions in new HMO’s, you can redefine your work in many creative ways.

By taking advantage of the “loop-holes” in the doctor-oriented PSRO law, you more than ever can gain the right to be responsible for peer review in your profession. By forming independent bargaining units or at least getting RN’s...
in combined units to recognize your professional rights—you can gain more power to set patient care policies, as well as get the pay you want.

It may be true that the struggle to convert your legislatively induced "identity crises" into opportunities for further professional growth will be painful at times. Simultaneously, convincing the National Labor Relations Board, federal bureaucrats, state agencies, and other professional groups to grant you increased autonomy will be no easy task. However, based on my personal observations, I'm convinced that you will deal with your future crises sensitively and successfully.

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EDITOR’S NOTE: Dr. Brown will be a guest speaker at the American Association of Nurse Anesthetists 43rd Annual Meeting, Clinical Session, and Graduate Course which will be held in San Francisco on August 22-26, 1976.