MEDICAL TITLE MISAPPROPRIATION AND MISREPRESENTATION **FACTS AND BACKGROUND**

The American Society of Anesthesiologists® (ASA) is committed to ensuring all patients receive the highest quality anesthesia care and will do everything possible to uphold patient-centered, physician-led care. ASA vehemently challenges any efforts by the American Association of Nurse Anesthetists (AANA), its state society counterparts and other organizations that seek to remove the physician from that care. AANA is currently jeopardizing patient safety by:

- Advocating for nurses to practice beyond their education and training
- Misleading the public and policymakers by using confusing and blatantly inaccurate terms for nurse anesthetists

AANA misrepresents facts and misappropriates medical titles as part of its efforts to dismantle the anesthesia care team through incorrect information about patient safety in surgery, potential cost savings, education and training differences, workforce shortages, provider distribution and barriers to anesthesia care, and the requirements by state laws for physician supervision.

Medical Title Misappropriation

AANA's medical title manipulation for both the name of their profession and the name of the organization blatantly misleads the public and patients. By sanctioning and promoting the use of the medical term "anesthesiologist" for nurse anesthetists and changing the name of the organization to include "anesthesiology," AANA is artificially inflating the profession's education, licensure, certification, and expertise. AANA aggressively advocates for its members to use the titles "certified registered nurse anesthesiologist" and "nurse anesthesiologist" and encourages adoption of the same language by policymakers, insurers, organizations, employers, and health care professionals.

This falsification and overreach of the profession should not be tolerated in health care and is opposed by the American Medical Association (AMA), the American Board of Medical Specialties, and the American Board of Anesthesiology. These organizations all believe that anesthesiology is a medical specialty and that professionals who refer to themselves as "anesthesiologists" must hold a license to practice medicine. The New Hampshire Supreme Court upheld a ruling by the New Hampshire Board of Medicine to limit the use of the term "anesthesiologist" to individuals licensed to practice medicine. The Board of Medicine's review included studies, surveys, and licensure requirements highlighting similarities and differences between nurse anesthetists and physician anesthesiologists and the public's understanding of that distinction – information that was likely the basis for their decision.

According to a recent AMA Truth in Advertising survey, 70% of patients recognized an anesthesiologist as a physician and 71% knew that a nurse anesthetist is not a physician. That means nearly a third of patients are not aware of the facts. Allowing nurse anesthetists to call themselves "nurse anesthesiologists" confuses medical titles and will confuse patients who should fully understand the credentials of their health care provider.

This will become even more obscured as some nurses are now pursuing doctorate degrees or Doctor of Nursing Practice degrees (DNPs), which will be required for entry-level nurse anesthetist programs by 2025. The DNP is not equivalent to a Doctor of Medicine degree or Doctor of Osteopathic Medicine degree and the DNP "will not alter the current scope of practice for APRNs (advanced practice registered nurses)," according to the American Association of Colleges of Nursing. However, this will further confuse the public and patients if nurse anesthetists refer to themselves as "doctors."

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Patient Safety in Surgery

There are no independent studies that show nurse anesthetists can ensure the same safety and outcomes in surgery as physician anesthesiologists. Yet, AANA consistently misrepresents data, asserting there is no difference in patient safety outcomes between nurse anesthetists and physician anesthesiologists.

Independent research shows that the presence of a physician anesthesiologist in surgery prevented 6.9 excess deaths per 1,000 cases in which an anesthesia-related or surgical complication occurred. Other independent research reviewing over 2.4 million surgeries over 10 years also found that patients having outpatient surgery are far more likely to have an unexpected disposition – an admission to the hospital or death – if their anesthesia was solely provided by a nurse anesthetist rather than a physician anesthesiologist.

AANA's data on patient safety comes only from self-funded studies. These studies also typically evaluate nurse-only practice with low-risk patients undergoing low-risk procedures and do not reflect an accurate benchmark for removing physician supervision of anesthesia care.

Physician anesthesiologists' expertise in preventing patient complications and responding to emergencies in surgery can mean the difference between life and death. As leaders of the anesthesia care team, physician anesthesiologists ensure the highest-quality patient care and best patient outcomes. In addition to highlighting the importance of physician-led anesthesia care and how it ensures patient safety, research also shows how its elimination does not improve access to care or save medical costs.

Team-based anesthesia care is also the standard of the World Health Organization (WHO). The WHO's 2018 "International Standards for a Safe Practice of Anesthesia" recommends: "Wherever and whenever possible, anesthesia should be provided, led or overseen by a physician anesthesiologist."

Cost Savings

Allowing nurses to administer anesthesia without physician supervision does not save patients or taxpayers money. Medicare, Medicaid, and most third-party insurers pay the same fees for anesthesia whether it is administered by a nurse anesthetist or physician anesthesiologist.

AANA's self-funded advocacy studies erroneously try to position nurse anesthetists as the most cost-effective anesthesia providers, but independent studies show that eliminating physician anesthesiologists can actually cost more. Other physicians may be needed to consult or provide services a physician anesthesiologist would, such as assessing pre-existing conditions or handling emergencies and other medical issues before, during, and after medical procedures that could jeopardize a patient's life and safety.

A 2017 study of "opt-out" states, which allow nurse-led anesthesia care for Medicare patients, found a consistent pattern of increased costs when compared to states that did not opt out of the physician-led anesthesia requirement, with inpatient surgical care costs 8.7% higher in the opt-out states.

AANA's self-funded studies are coupled with its audacious statements about overcompensation for physician anesthesiologists and falsified accusations of billing fraud.

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Education and Training

Physician anesthesiologists are medical doctors who specialize in anesthesia care, pain management, and critical care medicine, bringing the knowledge required to treat the entire body. Their education and training include 12 to 14 years of education, including medical school, and 12,000 to 16,000 hours of clinical training to specialize in anesthesia care and pain control.

Nurse anesthetists are qualified members of the anesthesia care team, but they can't replace a physician. They have about half the education of a physician anesthesiologist and only 2,500 hours of clinical training — hours cited on the AANA's own website for the profession's training in 2016.

While the amount of clinical training hours has not changed for nurse anesthetists since then, AANA now embellishes those hours and presents distorted comparisons in a deliberate attempt to position nurse anesthetists' education and training as equivalent to that of physician anesthesiologists. These comparisons dismiss the undergraduate training of physician anesthesiologists and inflate the training of nurse anesthetists, which covers anesthesia administration, but not a physician's medical education or clinical training to treat the entire body and make critical decisions during surgery.

By continually advocating that nurse anesthetists replace physician anesthesiologists, AANA is condoning nurse anesthetists to practice beyond their scope and outside of their education, training, and certification. Nurses who have completed their nursing education are still nurses, not physicians. Nurse anesthetists should not pretend to be physicians or mislead patients into thinking that physician anesthesiologist's and anesthetist's education and training are the same.

ASA has nearly 100 member physician anesthesiologists who formerly were educated, trained, and practiced as nurse anesthetists. Recognizing that they had not fully completed their anesthesia education, they went to medical school for four years and anesthesiology residency for an additional four years to become practicing physician anesthesiologists. There are no physician anesthesiologists who at the completion of their medical school and residency programs went to nurse anesthesia school.

Workforce Shortages, Provider Distribution, and Barriers to Care

All patients deserve access to physician-led anesthesia care – the highest quality and safest medical care. AANA repeatedly fabricates workforce shortages, issues related to provider distribution, and barriers to care to position the need for nurse-only practice. The AANA increasingly implied this throughout the COVID-19 pandemic.

Throughout this public health emergency, there have not been any shortage of anesthesia providers that would necessitate this change in the U.S. Department of Veterans Affairs (VA) or in hospitals across the country.

AANA also misconstrues provider distribution and falsely represents their profession as being more likely to work in areas with lower median incomes and a larger population of those who are unemployed, uninsured, and/or Medicaid beneficiaries. This misleading information is presented without the context of the anesthesia rural pass through, a taxpayer-funded incentive program that discourages small rural hospitals from using physician anesthesiologists and actively denies rural citizens access to medically trained anesthesia care.

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Physician supervision in no way impedes access to anesthesia care or increases costs. Studies of states that "opted out" of the Medicare requirement for physician-led anesthesia care have found no evidence that opting out of the safety standard increases access to care. For example, an analysis of more than 1.1 million Medicare patients who underwent one of five common elective procedures found that patients in opt-out states traveled the same distance for care as those in non-opt-out states.

Physician Supervision State Laws

The laws and regulations in 45 states and the District of Columbia require physician ***supervision, collaboration, direction, consultation, agreement, accountability, or discretion over nurse anesthetists providing anesthesia services*** to ensure patient safety. AANA state chapters misconstrue these laws stating 42 states do not require supervision. While there are states that do not use the term "supervision," AANA does not explain that all but a handful of states use another term requiring physician involvement or oversight.

The AANA and state chapters often further confuse and misrepresent the law by combining the opt-out states with states that, by legislation or regulation, have no physician involvement requirements. An opt-out is activated exclusively and only through a governor's action – and any governor can just as easily reverse that action. The state legislature may or may not pass corresponding legislation. To date, only five of the 19 opt-out states have completely removed physician involvement requirements.

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