COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HOUSE PROFESSIONAL LICENSURE COMMITTEE HEARING

STATE CAPITOL
IRVIS OFFICE BUILDING
ROOM G-50
HARRISBURG, PENNSYLVANIA

TUESDAY, JANUARY 26, 2010
3:12 P.M.

PRESENTATION ON HOUSE BILL 1866

BEFORE:

HONORABLE MICHAEL P. MCGEEHAN, MAJORITY CHAIRMAN
HONORABLE WILLIAM F. ADOLPH, JR.
HONORABLE MATTHEW E. BAKER
HONORABLE JAMES E. CASORIO, JR.
HONORABLE GARY DAY
HONORABLE MARC J. GERGELY
HONORABLE JARET GIBBONS
HONORABLE KEITH GILLESPIE
HONORABLE NEAL P. GOODMAN
HONORABLE SUSAN C. HELM
HONORABLE NICK KOTIK
HONORABLE DEBERAH KULA
HONORABLE JOHN MAHER
HONORABLE MARK T. MUSTIO
HONORABLE BERNIE O'NEILL
HONORABLE CHERELLE L. PARKER
HONORABLE JOSEPH A. PETRARCA
HONORABLE HARRY READSHAW
HONORABLE DOUGLAS G. REICHLEY
HONORABLE JOHN P. SABATINA, JR.

JEAN DAVIS REPORTING
7786 Hanoverdale Drive ~ Harrisburg, PA 17112
Phone (717)503-6568 ~ Fax (717)566-7760

BEFORE (cont.'d):

HONORABLE MARIO M. SCAVELLO
HONORABLE TIMOTHY J. SOLOBAY
HONORABLE RICHARD R. STEVENSON, MINORITY CHAIRMAN
HONORABLE JAMES WANSACZ
HONORABLE RONALD G. WATERS

JENNIFER L. SIROIS, REPORTER
NOTARY PUBLIC

I N D E X

TESTIFIERS

P R O C E E D I N G S

CHAIRMAN MCGEEHAN: Just a reminder that this is a, will be an official hearing of the House Professional Licensure Committee. There is a stenographer, and it will be part of the official record which will be distributed among the entire membership of this committee and will be available to you upon request from the Committee. And while we're -- just bear with us and have a little patience for a little while longer while the members arrive from the House floor.

(Off the record.)

Good afternoon, the hour of 3:00 having arrived, I want to call this hearing of the House Professional Licensure Committee to order. Normally, the first point of business is to conduct the roll, but we'll deviate from that today because I want to give my personal congratulations to our chairman. Bill Adolph has been the Chairman of the House Professional Licensure Committee for some years now.

He's somebody -- and I'll speak on behalf of my membership since we didn't have a vote today -- that every one of the democratic members not only likes, but respects. I'm the new chairman beginning this year, and I have many times turned to Mike, who has become my good friend and really the political advisor about how to conduct yourself

as a chairman of the committee. I want to congratulate him by being selected from his membership, the Republican members of this committee and the House, as the new Appropriations Chairman in Pennsylvania House.

It's not certainly an easy job, and there will be a lot of difficult days ahead. And although we may not always agree -- many times we did in this committee, but in his new role in the Appropriations Committee. Because of budget shortfalls that exist here and around the country, there will be many difficult decisions to be made. And as I said, although we may not always agree, we'll never be disagreeable.

And I wanted to personally thank you, Chairman Adolph, for the guidance you've given me and really establishing the standards of how to chair a committee, how to conduct yourselves. And I give nothing but praise, and I thank you for allowing me to serve with you in a fraternal way in this committee. And I wish you nothing but the best, and not just from myself, but for the entire contingent Democratic members of the House Professional Licensure Committee.

REPRESENTATIVE ADOLPH: Thank you, Mr. Chairman. We're already cutting expenses. Every other mike is working. But first of all, I want to thank Chairman McGeehan for those kind words. Chairman McGeehan's a real

gentleman and a real statesman, and he's been very fair to me and the Republican Committee. I'm going to miss this committee. I have enjoyed working with the professional associations throughout the Commonwealth. I'd like to thank Michael and his staff, first-class staff. I'm going to miss Wayne and Marty's staff.

They worked tremendously for the Committee here to work together in a bipartisan fashion in order to get the proper legislation passed regarding the 27 boards that we have here in Pennsylvania. And this committee has accomplished an awful lot over the last several years, and hopefully the Appropriations Committee will be able to work in the same manner and we get the balanced budget passed by June 30th this year.

And that's one of our goals. I'm certainly glad you didn't make that announcement that all these Democrats were supporting me prior to the Republican caucus because it might have cost me a couple votes. I surely appreciate our friendship, and that will continue once I leave this committee. Thank you.

CHAIRMAN MCGEEHAN: Thank you very much, Chairman Adolph.

Will the clerk conduct the roll, please?

(The clerk conducted roll call.)

We're here today to conduct a hearing on House

Bill 1866. The prime sponsor is Representative Mark Gergely, and at this time, I'll recognize Representative Gergely for a few remarks.

REPRESENTATIVE GERGELY: Thank you, Mr. Chairman.

And I've been a member of the Licensure Committee since I've been elected to the State House in 2002, and some of you members that have served on this committee with me since then can appreciate two things: This is a large crowd.

We appreciate the interest in this issue, and another one that I rattled was another one of my bills for interior designers that was out in Philadelphia. At that time, they actually had buttons made against me, so I'm used to some controversy. This is what we're about in the State House. I appreciate the members' attendance greatly as we move forward. We're a little bit late on time, so thank you both chairmen for having the hearing, and let's begin.

CHAIRMAN MCGEEHAN: Thank you very much, Representative Gergely.

I do want to recognize Vice Chairman Dick Stevenson. Chairman Adolph is pulled away for other duties, and he'll be chairing this meeting. I want to also recognize Representative Gary Day. He's not a member of

the Committee, but asked the indulgence of the Committee to give a few brief remarks.

Representative Day?

REPRESENTATIVE DAY: Thank you, Mr. Chairman. Should I stay here, or would you prefer me to --

CHAIRMAN MCGEEHAN: You're fine there.

REPRESENTATIVE DAY: Okay. Thank you, Mr. Chairman.

To both chairmen, I'd like to say thank you, first of all, for giving me a few moments to make comments about this issue. I also want to thank the members of the Committee here for allowing me to testify and considering my comments. I have the unique distinction of having both the 2009 Presidents of the Pennsylvania Society of anesthesiologists, the doctors, and PANA, the president for 2009. They both are residents in the 187th Legislative District.

Now, I know that this issue or components of this issue or pieces has been back and forth before the Legislature many times, but having both of these individuals in my district puts me in a unique position, a position of having to directly represent the needs of both doctors and nurses. Although, I believe as legislators, we all try to balance the concerns on both sides of any issue. This one uniquely hits home for me.

I am pleased that this committee is set to listen today to what nurses have to say, to what doctors have to say as well as getting input from the hospitals in which they work. This bill asks us to decide where a line should be drawn between anesthesiologist practitioners or doctors and our nurses. The issue could be reduced to let's just keep it as safe as possible, but the easy decision to stop right there and be done with the issue is probably not the best way to go or the best reason to go that way.

We need to be better than that. Also, some people might think it's better to be safe, safe, safe safer than sorry. However, I believe we need to do our homework a little bit more on this issue, and we need to examine further. We need to figure out what is the law and is the practice that's happening now reflecting that. We need to ask is the current practice safe and even financially efficient the way it's done.

The bill states that a certified registered nurse shall administer anesthesia under the overall direction of a physician. That seems to be key language in this bill. Whether spelled out in the State Board of Nursing regulations in hospital policies or codified in state law and whether we use the word directs, supervises or cooperates, the key factor is the relationships between

the doctors and nurse. And that relationship will probably remain the same. I hope it will remain the same.

While the administrative procedures, if we would choose to go this way or some variant of this way, if there's a better way decided, might be a more efficient way to go. We may have an opportunity to maintain the patient safety while possibly reducing overall healthcare costs. This reduction may not change what either doctors or nurses are compensated, but it may streamline procedures, administrative procedures.

I know this committee will work together with these healthcare providers to craft a plan which I hope both doctors and nurses may be proud. My hope is for a plan which will maintain the safety and possibly improve administrative efficiencies, a plan that will reflect the best way for doctors and nurses to work together. It's these types of opportunities that we must examine and adopt if we are truly serious about doing what we can to reduce healthcare costs.

As it stands, I will testify that the professionalism of both doctors and nurses in this field is, as I have here, unparalleled. I really believe that. With proper credentialing and monitoring, doctors and nurses who may administer anesthesia will do so with the utmost care and efficiency no matter what is written in the

law, and they will work together to ensure that patient care is the preeminent concern. That's what I've heard from both groups that have talked to me over this past year.

As I stated earlier, both 2009 presidents live in my district. We go to the same church together, as a matter of fact. I see one in church, and then I see one at the pizza parlor right after church. But these presidents as well as the organizations and the memberships they represent and the other testifiers here today are all speaking on behalf of highly competent people who put the needs of their patient first.

I really appreciate the opportunity to testify here today, and I'm very pleased that this committee has taken up this issue and ask all committee members to please look into this issue and take time to examine subtle, but important differences in perception and language so that we can establish the proper policy for the citizens of the Commonwealth.

Thank you, Mr. Chairman, for this time -- I appreciate it -- and members of this committee.

CHAIRMAN MCGEEHAN: Thank you, Representative.

We've been joined by Representative O'Neill. I just wanted to, as a reminder to the audience and to the members present, that these proceedings are being recorded

for broadcast on PCN. I'd also, just some remarks I'd ask, because the session ran late and the lateness of the day -- I know you've all taken time out of your busy schedules to be here, but I'd urge you to be as brief as possible and not to be hamstrung by your written remarks, that you may present your written remarks and then speak extemporaneously.

The remarks and everything you submit to the Committee will be part of the official record. The first panel that we'll hear from today are the Pennsylvania Association of Nurse Anesthetists. They're represented by Joe D'Amico. He is a CRNA. He's a member and past President of the Pennsylvania Association of Nurse Anesthetists; and K. Stephen Anderson, also a CRNA. He's a former member of the Pennsylvania State Board of Nursing, and he's a member of the Pennsylvania Association of Nurse Anesthetists.

Are those gentlemen here?

Would you take a microphone? While you're setting up, I also want to recognize Representative Steve Barrar, who's also the co-sponsor with Representative Gergely on this bill.

Steve, do you want to join us? You're certainly welcome.

And Representative Christiana is there too. I

didn't see him. Okay. He's certainly welcome to join.

Mr. D'Amico, Mr. Anderson, begin when you are ready, and as I said, just as brief as you can. And if you have written remarks, don't feel you have to adhere to them. They will be part of these official proceedings.

MR. D'AMICO: Okay. Thank you.

Mr. Chairman and members of the Professional Licensure Committee, on behalf of the 3,200 members of the Pennsylvania Association of Nurse Anesthetists, I want to thank you for this opportunity to speak with you today. House Bill 1866 as legislation has been a topic of discussion within this committee for several sessions. This bill amends professional nursing law.

This is a CRNA scope of practice bill which defines certification requirements and defines how a CRNA practices in settings within the Commonwealth. This includes healthcare facilities such as hospitals, ambulatory surgery centers and other offices. The scope of practice for a CRNA varies within these different settings and often is defined by the employer.

House Bill 1866 will provide clarity to the different regulations because each one of those different regulations has different language in it, and also presents a problem with misunderstanding of what their regulation is saying what their scope of practice might be. As I walked

through the hallways last year visiting legislators from various districts and committee members to discuss title protection, I had with me four students. Three of the students had come to the State of Pennsylvania for their education; one was born, raised and educated in the State of Pennsylvania, and yet, out of those four students, none of them were planning on staying postgraduation.

There are two primary reasons; one was title protection, and the other one was being able to practice within their scope of education. House Bill 1866 will clear up an ongoing problem with the State Department of Welfare. The only insurance carrier in the State of Pennsylvania that does not recognize CRNAs is the Department of Public Welfare, and the reason is because we don't have the scope of practice that defines our ability to practice in the state.

We have regulations, but we don't have statute. And until we are able to acquire statute, DPW will not be able to recognize us. We have been told that. Members of the Committee, in a state that represents the largest board-certified nurse anesthetists in the United States, the most nurse anesthesia schools in our country and a state that produces the greatest number of students, over 500, Pennsylvania continues to represent one of the largest shortages of anesthesia care providers in our country.

It is time that we stop and, as a state, recoup the efforts and resources that we expend to educate our youth, and let us stop this revolving door process of having our youth postgraduation move and not return. House Bill 1866 will also ensure the Governor's vision for healthcare reform by securing access to care of all citizens of our Commonwealth, not just for those in our major cities, but to our rural counties as well.

As previous sessions have passed, a common concern I have heard is that CRNAs are looking to advance their scope of practice. This is not the intention of this bill. In fact, CRNAs work cooperatively with other healthcare professionals regardless of the specific language used in state law or regulations. There's not a healthcare professional, including a physician, surgeon or anesthesiologist, who works independently in the sense of not communicating with other healthcare professionals as necessary.

In other words, a CRNA has an ethical and legal duty to communicate with surgeons regardless of whether state law requires such communication. The nature of anesthesia services is that they complement other services such as surgery. Again, let me state that the Pennsylvania Association of Nurse Anesthetists has no intentions in this bill to seek independent practice.

Let me also point out that there is nothing in this bill that will impact or affect the practice of anesthesiology in any way. To take this one step further, when Representative Gergely introduced House Bill 1866, he took the language from the Pennsylvania nursing regulations to be placed into statute. This means that the current healthcare practices that occur in hospitals and ambulatory surgery centers and office space practices will be maintained the same. It will not change.

Basically what we're asking of this House Bill is the State Board of Nursing recognize who we are. We are grouped in with 2 hundred thousand other nurses. They don't know that Joe D'Amico's a CRNA because they can't certify me and they can't credential me. So when you look at a nurse midwife, a clinical nurse practitioner and a certified nurse specialist, they have statute.

The State Board of Nursing can clearly make sure that the way they practice is safe, and if they don't practice safely, they can yank their certification. Because I'm grouped in with the other RNs, they have no idea to find who I am or can control my practice. They don't set the requirements of how I practice safely in the state, and that's what this House Bill is going to do.

It's not going to change our scope of practice. It's not going to advance it. It's not going to do

anything to what we're doing today except to give to the State Board of Nursing the ability to recognize who we are and make sure that we are practicing safely in our state. If you and I have had the opportunity to speak before, you have probably heard me say that the first recorded anesthetic given in this country was right here in the State of Pennsylvania. It was given by Sister Mary Bernard. It was given in Erie, Pennsylvania at St. Vincent's Hospital, and it was given in 1877.

That's the first recorded anesthetic in our entire country. That was given by a CRNA, and she was not working with an anesthesiologist. She was working with a surgeon. Not until 1931, the American Society of Anesthesiologists was formed, so some 50 years had gone by with nurse anesthetists working without anesthesias.

And to this day, there has never been a credible study to state or show that the anesthesia services provided by a nurse anesthetists is any different in the quality given by an anesthesiologist. On behalf of the Nurse Anesthetists Association, thank you for giving us the opportunity to speak with you today, and I'd like to turn it over to my colleague, Steve Anderson.

MR. ANDERSON: My name is Steven Anderson. I just would like to add the fact that I'm a former member of the State Board of Nursing. I was the Vice Chair for one

year, Chair for three years and I spent five years as Chair of the Regulations Committee. Mr. Chairman and members of the Committee, I just want to add a few comments or remarks to Mr. D'Amico to help make sure -- to make our point, we have prepared a briefing book that addresses the issues related to this bill and rebuts many of the erroneous statements that have been made by the anesthesiologists.

The answer to the question is there a need for a greater access of anesthesia care, is there a greater need for access of anesthesia care, the answer is, yes, there is. Consider the following: Pennsylvania faces a significant shortage of physicians. Specialties that may experience the greatest shortage within five years are obstetrics and gynecology, general surgery, anesthesiology, urology, radiology and neurosurgery. 24.5 percent of the anesthesiologists indicate they will stop practicing within the next five years or less.

86.5 percent are practicing in the urban counties. 13.5 percent are practicing in the rural counties. There are 7 counties with ambulatory surgery facilities that do not have any anesthesiologists with clinical medical privileges; Adams, Bradford, Cambria, Carbon, Jefferson, Lawrence and Venango Counties. And there are 26 counties with 5 or less anesthesiologists with clinical or medical privileges and 4 counties with 0

anesthesiologists.

Given this information, it is prudent for the Legislature to take action now to assure full access to anesthesia care in all settings. House Bill 1866 does not alter the present cooperation between the CRNAs and the anesthesiologists in any way, nor does it seek to allow independent practice for CRNAs to perform up to their level of their scope of practice. The bill codifies current nursing regulations and, in many settings, allows the CRNAs to provide services efficiently where anesthesiologists may not be present.

I would also like to address the issue of jurisdiction. This is a nursing bill. I'd like to repeat, this is a nursing bill. It affects nurses. I served as a member of the State Board of Nursing for 13 years. In that role, I saw the administrative activities and the interaction between the related boards. The reality is that all the healthcare professionals are governed by their respective boards.

The legislation codifies the nursing regulations and has no relation whatsoever to the anesthesiologists or their procedures under the Pennsylvania State Board of Medicine. Just as we would not presume to inject ourselves into the Board of Medicine our relationship among doctors, hospitals and patients, we would hope and expect that

doctors would respect our efforts to clarify and function under our own scope of practice. This is our scope of practice bill. It is a nursing bill.

It doesn't affect anesthesiologists in any way. Moreover, it is time for Pennsylvania to establish a law protecting the profession of CRNAs. As you can see from the chart, 45 other states have adopted similar strategies, 45, and have adopted statutory language towards CRNAs. At this time, Mr. D'Amico and I would be pleased to answer questions that you may have.

CHAIRMAN MCGEEHAN: Thank you very much, Mr. Anderson and Mr. D'Amico, for your testimony. I'll entertain questions from the Committee if there are any.

Representative O'Neill?

REPRESENTATIVE O'NEILL: Thank you, Mr. Chairman.

You said that 25 percent of anesthesiologists indicate they're going to be leaving practice within five years or less. Why is that? Is it just reaching the age of retirement or getting out of town or state, what?

MR. D'AMICO: It's retirement, people leaving practice, changes in practice setting.

REPRESENTATIVE O'NEILL: The other question is you had mentioned anesthesiologists that do not have clinical medical privileges. Can -- excuse my ignorance,

but what is clinical medical privileges?

MR. ANDERSON: Privileges that would be given by the institution by a credentialing process within the institution.

MR. D'AMICO: In order to work in any healthcare facility, that facility has to make sure that you are who you are. So you go through a credentialing process making sure that you are an anesthesiologist, you are a nurse anesthetist, that you do have an adequate license and that you are able to practice in the state.

REPRESENTATIVE O'NEILL: Great. Thank you.

MR. D'AMICO: That's a requirement by the Department of Health.

CHAIRMAN MCGEEHAN: Thank you, Representative O'Neill.

Representative Mustio?

REPRESENTATIVE MUSTIO: Thank you, Mr. Chairman.

And I want to thank you for your testimony, and I also want to thank you for getting me a copy of the study. I had sent an e-mail to your website the other night. And I've seen it referenced in several e-mails that I've received and also from the website, but not a complete copy of the study. So you were able to get that to me, and I was able to digest that somewhat last night.

A quick question as it relates to the

legislation itself. The House Bill on page 3 talks a little bit about electronic communication, when the operating or anesthesia team consists entirely of nonphysicians, an anesthesiologist or consulting physician of the Certified Registered Nurse Anesthetist's choice shall be available to the Certified Registered Nurse Anesthetist by physical presence or electronic communication. Can you tell me currently how that electronic communication and supervision takes place?

MR. D'AMICO: Sure. There are practice models, and there are various practice models in our state. There's an anesthesiologist who worked with a CRNA, and that's under the care team model. There's an anesthesiologist who may work by himself, and there's a CRNA who may work by himself. Electronic communication, for example, is when there is a care model where you have an anesthesiologist who's working with the CRNA.

In our state, the anesthesiologist has the ability to quote/unquote supervise four rooms. So theoretically, that one person is overlooking four rooms. Now, in the event -- let's say something happens in those four rooms simultaneously and the anesthesiologist is not able to get to their rooms, then you have the ability to get someone as quickly as you can.

And so something like picking up the telephone,

calling the office or calling for help, paging system, over a hospital paging system, requires your help in a room or whatever the case may be, whether it's a message that we have on the telephone or a message that we have on our beepers, to get that person who's quote/unquote supervising our room. And that's what the term electronic communication means.

REPRESENTATIVE MUSTIO: But I don't see that defined and described that way in the legislation, and I guess that's the purpose of this hearing is really to kind of work through some of the verbiage and get this cleaned up if necessary.

MR. D'AMICO: Absolutely. There's a misconception of many of the regulations, especially with the various facilities, as to what the language means.

REPRESENTATIVE MUSTIO: One of the areas that's of concern to me -- and let me just digress for one second. When I started receiving those early on in this bill, I feared they would become a battle of the studies, and that's what has happened in my own mind. Some of the comments that your testimony made -- you know, I'm sitting here reading another study that said the number of anesthesiologists has increased significantly.

So it's a totally contradictory study that may have been done a few years ago, so I just wanted to throw

that out. That's the trouble personally I've had in trying to get through this issue. Let's -- under current relations and under this legislation, if there is an unanticipated difficult airway that develops as a result of administering the anesthesia, how would an emergency situation be handled via electronic communication?

When I see electronic communication, I'm thinking there's not an anesthesiologist on the premises, as is identified by some of these counties that you're saying there aren't any. My concern from a patient safety standpoint would be that you're reaching out in an emergency scenario to someone, an anesthesiologist, and bringing them in after the fact to resolve a significant problem.

MR. D'AMICO: Sure. That electronic communication is the care team approach, that model. There has been -- and I can quote you from the Federal Registrar, where the Federal Government had actually looked at all these various studies and did their own study amongst themselves, and clearly they say within this registrar that there has never been no studies published in the last ten years demonstrating any need for federal intervention in state professional practice laws governing CRNAs.

Currently, there's no reason to acquire a federal rule on these conditions of participation,

mandating that a physician supervise practice to another state license or professional where there's no statutory provision authorizing direct medication -- or I'm sorry -- Medicare payment for the service of that health professional. It goes on to say that various studies has shown that because of the education that's required for a nurse anesthetist and, of course, not only the education, but the safety record -- for example, our malpractice insurance has gone down.

Back in 1984, there was 1 in 10 thousand deaths related to anesthesia. Currently today, there's 1 in 203 thousand deaths that are related to anesthesia. And certainly, the nurse anesthetists are certainly qualified to provide anesthesia in all capacities, whether it's something that's emergent or something that's not emergent.

MR. ANDERSON: Presently, the regulations address electronic communications, and they were promulgated in October of 1976. And they were promulgated because of the fact that there were hospitals, there were a lot of hospitals that did not have anesthesiologists or did not have Directors of Anesthesia.

Also, they were promulgated, within the discussion of this, if the physician is with a case on the floor, then he would not be able to be available to help the CRNA if there was an issue. So this is why this was

moved into regulation, to assure that there would be someone available for the CRNA if the CRNA needed to talk or to consult with the physician. This has worked well since 1976. The Board of Nursing has had very little, if not any issues with that part of the regulation.

REPRESENTATIVE MUSTIO: So my -- this is my last comment, Mr. Chairman.

Are you telling me then that in that situation where there was the airway difficulty, that you're confident that the CRNA would not need an anesthesiologist's assistance?

MR. D'AMICO: What I am saying is that nurse anesthetists are capable providers. In any emergent situation, nurse anesthetists are not only skilled, but educated to take care of that emergency.

CHAIRMAN MCGEEHAN: Thank you, Representative Mustio.

Representative Maher?

REPRESENTATIVE MAHER: Thank you, Mr. Chairman.

It seems to me that a couple of years ago, we had a similar hearing, and at that time, it was perception that there was a pretty wide agreement on the notion of having statutory recognition of CRNAs as distinct from RNs. And I hear today that you're not able to bill Medicaid. If the CRNA's involved with provision of care provided and

it's a Medicaid patient, how does compensation occur?

MR. D'AMICO: Currently in the State of Pennsylvania, it does not.

REPRESENTATIVE MAHER: Well, certainly CRNAs aren't in there working for free, so how is compensation accomplished?

MR. D'AMICO: If I'm taking care of a Medicaid patient without an anesthesiologist supervising me and I'm the only anesthesia care provider, then I am not able to bill for my services.

REPRESENTATIVE MAHER: All right.

MR. D'AMICO: If I am working for an anesthesiologist, then the bill will be reimbursed using the anesthesiologist's credentialing.

REPRESENTATIVE MAHER: Okay. And in terms of the statutory recognition, I also seem to remember about two years ago that there seemed to be a consensus for me between CRNAs and physicians who practice anesthesia as to how a scope of practice might be defined. Where is the rub now from the CRNA perspective? What is really the sticking point from your perspective?

MR. D'AMICO: House Bill 1866, for me, means nothing more than to give the ability of our State Board of Nursing to --

REPRESENTATIVE MAHER: Well, I heard you

testify, but I'm just saying, where's the rub? What's the problem? What's the issue? Obviously, there must be an issue. There's an awful lot of people here. So I'm just -- I haven't really had clarity on what the issue is. What was it about the consensus that seemed to be forming two years ago that doesn't seem to be present in 1866?

MR. ANDERSON: There should not be a rub in this bill.

REPRESENTATIVE MAHER: Okay.

MR. ANDERSON: And that's the issue.

REPRESENTATIVE MAHER: So you're not aware that there's any disagreement at this point with 1866 from anybody? If that's your testimony, I'll accept it, but I'm surprised by that.

MR. D'AMICO: I'm very surprised that we are having opposition of being able to put in statute what we do every day.

REPRESENTATIVE MAHER: Well, I'm trying to seek your opportunity to explain to me what you think the sticking point is and what your point of view is on that, whatever the sticking point is, but you're saying you don't perceive that there's any disagreement?

MR. D'AMICO: No.

MR. ANDERSON: I perceive it as a nursing bill. This deals with nursing. This will eliminate some of the

confusion that presently occurs.

REPRESENTATIVE MAHER: But you're not aware of any point of view that's different than yours?

MR. ANDERSON: No.

REPRESENTATIVE MAHER: Okay.

CHAIRMAN MCGEEHAN: It will be a lengthy meeting, Representative Maher. I'm sure you'll hear opposing view points.

Representative Kotik, please?

Thank you, Representative Maher.

REPRESENTATIVE KOTIK: Thank you, Mr. Chairman.

Doing some of my due diligence on this legislation, I was just trying to see what some of the other states that surround us do. Are you familiar with some of the other states and what they do in terms of the position that's called an anesthesia assistant?

MR. D'AMICO: I'm not aware of any states around us that are using anesthesia assistants, no.

MR. ANDERSON: This really is not about anesthesia assistants. This is about nursing. I keep --

REPRESENTATIVE KOTIK: I'm talking in terms of the shortage. We were talking about as far as the shortage of anesthesiologists. I mean, we've expanded the scope of practice in other areas with physicians and physician assistants, and I'm just trying to get an idea in my mind

as to whether there are other alteratives as far as what other states have done. That's the only question I'm asking.

MR. D'AMICO: Well, what other states have done is they've given statute for their nurse anesthetists, and by giving them statute, that cleared up a lot of understandings of how nurse anesthetists work. And by governing that statute, it has allowed the access to more care, especially in our environment.

What's difficult for us as nurse anesthetists in our state to work is that there's a misconception of the languages, and because of that misconception, unless you're employed in a hospital environment versus an ambulatory surgery center where there is no anesthesiologist, because of that misconception, it's difficult to get employment and provide that access of care.

REPRESENTATIVE KOTIK: So you're still of the contention that we're still facing a shortage in the near and long term here in Pennsylvania relative to people leaving the state after they're educated here?

MR. D'AMICO: Yes. We still have the shortage in our state because of not being able to provide that access of care by giving --

REPRESENTATIVE KOTIK: And you feel that if this legislation is passed, that will change that?

MR. D'AMICO: It will help it.

MR. ANDERSON: It will help it.

REPRESENTATIVE KOTIK: Thank you, Mr. Chairman.

CHAIRMAN MCGEEHAN: Thank you, Representative Kotik.

We've been joined by Representative Wansacz. I'd like to acknowledge that.

Representative Reichley?

REPRESENTATIVE REICHLEY: Thank you, Mr. Chairman.

Gentlemen, I guess some of the confusion up here is that you currently have CRNAs out there. Is that correct? Based upon your map, you have a number of counties in which CRNAs are performing services. Is that correct?

MR. D'AMICO: Yes. So getting back to Representative Maher's question, if you're out there working and you already have regulations about the conduct of the performance of your duties, why is it necessary to have this additional step? Is it for purposes of being able to be compensated by medical assistance? If you get certified, do you then get to bill for that?

MR. D'AMICO: Well, that's part of it, but the other part is to raise the bar of our profession. By allowing the State Board of Nursing to regulate and,

therefore, ensure that we are practicing, that's really what we're looking for in this legislation, is to give that ability to the State Board of Nursing to say, you're Joe D'Amico and you practice as a nurse anesthetist; if you want to do this in this state, then I, as the State Board of Nursing, am required to meet these standards of care. And currently in our State of Pennsylvania for nurse anesthetists, that is not recognized because there is no standard of care.

MR. ANDERSON: One of the things I note, it will help provide access and relieve the Board some of the confusion that goes on. Right now, the Board has no authority over CRNAs. As we said, the CRNAs practice under their nursing license. The Board has no idea who's practicing in nurse anesthesia in the Commonwealth of Pennsylvania unless they go to the -- unless it's placed on the Department of Health questionnaire that comes with their licensure.

They don't know who the CRNAs are. They do know who the nurse specialists are. They do know who their nurse midwives are. Another thing that kind of codifies this whole thing is to practice anesthesia in the Commonwealth of Pennsylvania, you need to meet the requirements of 2117. However, there's a loophole. What happens is, a person comes in from another state with a

license from that state, and they want to come over to work temporarily or locum tenens in the Commonwealth of Pennsylvania.

They come in to the state, they practice for six months and leave. They do not have a license. The State has no idea when they leave if anything happens. Now, if something happens or there's a misadventure during that time, the State has no statutory authority over that CRMP -- or that CRNA. And so, therefore, it kind of is a patient safety issue by having the State Board of Nursing issue the certificate so that they'll know who's practicing.

And when someone comes in to do a locum tenens anesthetic, they would have to have the certificate; they would have to go through the background check, and they would be able to be issued prior to them practicing in the Commonwealth. That's the same that happens with CRMPs. It's the thing that happens with the CNS's. It's the same thing that happens with the nurse midwifes. And there has to be some clarity across the lines.

REPRESENTATIVE REICHLEY: Under current law, if the anesthesiologist is in the operating room, does that individual have supervision responsibility over a nurse anesthetist in the same room, in a separate operating room? What's the circumstances on that?

MR. D'AMICO: A nurse anesthetist, as an anesthesiologist, is independently responsible for their own actions. So if I cause harm to someone, then I am responsible for the actions I have taken, whether I'm supervised by an anesthesiologist or whether I'm supervised by a surgeon or whether I'm supervised by another physician. I am independently responsible for my own actions, so the liability falls on me.

REPRESENTATIVE REICHLEY: I guess that's not really my question though. Is it common practice that a nurse anesthetist is in the room with the anesthesiologist at all times, or does an anesthesiologist supervise five different operating rooms, or are there nurse anesthetists in each operating room?

MR. D'AMICO: And that depends on your practice model. In some ambulatory surgery centers in our state, there is no anesthesiologist. It's just nurse anesthetists. So you are working in cooperation with the physician, such as a gastroenterologist in a GI center.

REPRESENTATIVE REICHLEY: So the --

MR. D'AMICO: In a hospital environment, the practice model of having anesthesiologists and nurse anesthetists is a much more common thing.

REPRESENTATIVE REICHLEY: Well, maybe that's part of my confusion because I believe Ms. Tremmel has

provided us with the department regulations of the Department of Health, which says that you're supposed to be under the supervision of the operating physician or anesthesiologist; but then the bill utilizes language from, I think the regulation, as Joe mentioned, about being under overall direction.

So I'm just curious if you're going to have a conflict between this regulation and another regulation because you got this statute, and what you're implying is that an anesthesiologist may not even be on the premises when your nurse anesthetist is applying anesthesia.

MR. D'AMICO: In an ambulatory surgery center such as a GI center, that is often the case. That is correct. An anesthesiologist is not part of that anesthesia care team. It's the nurse anesthetist.

REPRESENTATIVE REICHLEY: So apparently you're still going to have that conflict between regulation of 1.2.5 (ph)?

MR. D'AMICO: Well, that's a hospital regulation. That's not an ambulatory surgery regulation. Ambulatory surgery rights are in the 5.5.5's (ph), and the hospital regulations are in the 100's(ph), so there's two different regulations that are governing two different entities, and that's a lot of the confusion because the language is different in most cases for the different

regulations. So there's a misunderstanding of how a nurse anesthetist should be practicing nursing in our state.

REPRESENTATIVE REICHLEY: But does the bill reconcile those differing standards?

MR. D'AMICO: This bill isn't going to change that. Again, this bill is going to give the State Department of Nursing the ability to credential us so we can practice safely.

It's not changing the scope of practice how anesthesiologists and nurse anesthetists work in our Commonwealth each and every day. It's not going to change that. It's giving to the State Department of Nursing the ability to say, Joe D'Amico, you are safe to practice in this state.

REPRESENTATIVE REICHLEY: Well, I guess I'll just beg to differ because on page 3, it sort of lays out what exactly your performance would be, but --

MR. ANDERSON: Under the nursing regulations, it's cooperation with the physician, or it is cooperation under 2117.

CHAIRMAN MCGEEHAN: Thank you, Representative Reichley.

Representative Gergely?

REPRESENTATIVE GERGELY: Thank you, Mr. Chairman.

Thank you, gentlemen, for coming today and testifying.

Mr. Chairman, there's a lot of questions relative to so many issues in this bill, and obviously I always have an open room in my office to make such changes, as Representative Mustio had mentioned about the electronic communication provision. What we need to do is realize that following the testimony of these two gentlemen will be additional testimony which will probably be very contrary similar to very many things that occur in this committee.

And we should ask that you be prepared to answer many of those issues that arise so that we get a full scope of this because I think we're finally starting to delineate what is and what isn't true in terms of substance in relationship with this bill. Explain to me quickly in layman's terms what the chart represents with the state.

MR. ANDERSON: Well, the chart shows the distribution of anesthesia professionals in the Commonwealth of Pennsylvania. Where you see the light red, that is the counties in which there are only CRNAs practicing.

Where you see the darker red, what it shows is there's more CRNAs than there are doctors. White counties are even. If you see a blue, light blue color, there are more M.D.s than there are CRNAs; and in the darker blue,

there are only anesthesiologists. In black, there are no providers whatsoever, anesthesia providers. Is that what you wanted to know?

REPRESENTATIVE GERGELY: I was actually referring to the other chart.

MR. ANDERSON: Oh, I'm sorry. The other chart talks about the statutory jurisdiction. In the first line where it says licenses, those are the states that provide licensure above and beyond the RN license to CRNAs.

MR. D'AMICO: And currently that number's 45 -- 21.

MR. ANDERSON: 21. The next one is a certificate, which there are 13 states that issue a certificate. Pennsylvania issues a certificate for CRMPs and CNS's, so 13 of them. Five of them give authorization in their statutory language for nurses to provide anesthesia. There is a registration in 5 of the states, and that registration is kind of tied into their licensure.

They have a license like a driver's license tied into that. Again, and then recognition, again, 6 states recognize CRNAs in their statutes as advanced practice nurses. I'm not sure what this notification in Arizona does. They probably just notify everybody that they can practice. I don't know. And there is nothing in five of the states; Indiana, New York, Pennsylvania, West Virginia,

Wisconsin. We just -- they weren't under the regulatory, the regulations within the Board of Nursing.

MR. D'AMICO: And I think what we're trying to say there, Representative, is that 45 states already have statutes that recognize nurse anesthetists. We in Pennsylvania among New York and Indiana do not.

REPRESENTATIVE GERGELY: If this bill would pass in its current form, where would you fall in that chart?

MR. ANDERSON: I would believe, in my experience on the Board of Nursing, they would put them in, certify them, give them a certificate as a CRNA.

REPRESENTATIVE GERGELY: Not licensure?

MR. ANDERSON: Historically, they've given certificates. The Board of Nursing has done certificates for CRMPs, CNS's, nurse midwives.

REPRESENTATIVE GERGELY: As we go on and the other testifiers come up, there will be questions that I want to verify. When is the last time the Federal Government has issued any clarity on administration of CRNAs? Is -- I have in my hands something from the Federal Registry from January 18th of 2001. Is that the most recent and updated clarification for this administration?

MR. D'AMICO: December 9, 2009 --

REPRESENTATIVE GERGELY: Thursday, January 18th, 2001, rules and regulations that are concerning a lot of

the administration of anesthesia.

MR. D'AMICO: Actually, in December of 2009 of this past year, the Federal Government has put out a regulation that stated that nurse anesthetists no longer need to be supervised by an anesthesiologist or a physician during administration of the epidural management as well as monitoring conscious sedation.

REPRESENTATIVE GERGELY: So that was the only significant change?

MR. D'AMICO: That's been the most recent change from our Federal Government.

REPRESENTATIVE GERGELY: As we go on with the questioning obviously, this study, or this statement from the Federal Government needs to be further discussed. And we'll go with the other testifiers. One more thing, we want to focus on patient safety. We want to focus on delivery of care as one of the reasons you want the licensure in and of itself.

And the question was asked once by Representative Kotik. Do you support some kind of amendment to this bill or a new bill that will eliminate the ability to have anesthesia assistants become a part of the medical field in this state?

MR. D'AMICO: No, we do not.

REPRESENTATIVE GERGELY: Why would that be?

MR. D'AMICO: Because an anesthesia assistant has no true formal education in anesthesia.

REPRESENTATIVE GERGELY: So, yes, you would support a bill that would eliminate the opportunity for --

MR. D'AMICO: I'm sorry. I misunderstood what you said. Yes.

REPRESENTATIVE GERGELY: Wouldn't there be others that would support that position of bringing them in? Have you saw anything yet that others in the medical field would support adding anesthesia assistants into the operating room?

MR. D'AMICO: I would certainly hope not. I haven't seen anything.

REPRESENTATIVE GERGELY: Would this bill help clarify who should be performing anesthesia?

MR. D'AMICO: I think what this bill will help to clarify is that CRNAs should have the right to practice in the state as well as anesthesiologists do. Yet, more importantly, it's going to raise the bar of who we are as professionals because now we're going to become accountable to our state.

REPRESENTATIVE GERGELY: I think what I'm saying really here is that for the anesthesiologist, the anesthetist, patient safety is such a core part of this issue that that discussion has to go along with all members

that are going to testify to see where everybody falls. Much of the testimony I read says patients may -- again, morbidity, a lot of good words that I want to see a commitment to not letting anyone else administer anesthesia. And my problem is, anesthesiologists and anesthetists aren't participating in the state.

They're getting educated here, they're leaving or they're retiring. As my mom -- very simply, she's 62. Like any baby boomer, they're not get any younger, and they're not replacing them. At some point, you folks out here are going to have to get together no matter what because there just isn't enough of you. And it shouldn't be our job to do that, as I guess Representative Maher said earlier. I would wish that this would get resolved without legislative process, but here we are today. Thank you.

MR. D'AMICO: Thank you.

CHAIRMAN MCGEEHAN: Thank you, Representative Gergely.

Thank you, Mr. D'Amico and Mr. Anderson, for your testimony.

I'd invite Representative Parker or anyone else who'd like to occupy the chair that's now vacant, or anyone on the floor is certainly welcome to take a microphone there.

Our next panel of testifiers is representing the

Pennsylvania Society of Anesthesiologists. Joseph Answine is the past President of the PA Association of Anesthesiologists; and Carol Rose, M.D., she's the past President of the Pennsylvania Society of Anesthesiologists. Good afternoon. Make yourself comfortable. As I indicated, don't feel you need to read your written testimony. You may speak extemporaneously and then field questions from the members of the Committee. Begin when you're comfortable.

DR. ANSWINE: Good morning, and thank you.

Good morning, Chairman McGeehan, and members of the House Professional Licensure Committee. Thank you for allowing me to explain the position of the Pennsylvania Society of Anesthesiologists on House Bill 1866. Although similar legislation received a hearing last session, this is a great opportunity for the PSA to inform new and returning members of the Society's reasons for our objections to the proposed legislation.

I'm Dr. Joseph Answine. I'm a physician and an anesthesiologist. I'm a past President of the Pennsylvania Society of Anesthesiologists and currently a specialty trustee for the Pennsylvania Medical Society. I work with CRNAs. I respect the role of CRNAs. The PSA and I oppose 1866 because it will degrade patient safety without any corresponding benefit. It will change a system for

delivering anesthesia care that works very well in achieving its core mission, protecting surgical patients.

A June 2007 article in Scientific American contained two quotes that are both true and eyebrow-raising. First, the powerful neurodepressive effects of anesthetic drugs make them more likely to cause death during an operation than the surgical procedure itself. Second, the drugs have a fairly narrow margin of safety, which is the difference between the therapeutic dose and a dose that is toxic, even lethal.

In fact, the same powerful agents, paralytics and electrolytes that anesthesia providers use daily, in high doses, are what we use to execute prisoners by lethal injection. General anesthesia takes away the patient's ability to communicate, swallow and breathe. The anesthesia provider takes over control of breathing by hand with a ventilation mask or an anesthesia machine.

Commonly, the patient's blood pressure and heart rate change dramatically secondary to the effects of the anesthetic medications, and any abnormalities of either are closely monitored and, when necessary, treated with another set of drugs. If a breathing tube is used, a neuromuscular blocking drug is administered which paralyzes the muscle required to breathe. All this happens within a matter of seconds, before the surgeon's first incision.

Every anesthesiologist can provide examples of unexpected complications and of bad outcomes averted. We're not talking about sub acute or chronic illnesses that take hours, days or months to progress, but acute situations that develop and progress in seconds with lethal consequences if not handled immediately and correctly.

Anesthesiologists treat patients before and after surgery. They make the final decision as to whether surgery should be performed at all or delayed for further workup or for the patient to be optimized. They develop an anesthesia care plan, including post-operative care. They decide based on the view of a patient's condition whether a case warrants the full attention of an anesthesiologist or whether tasks can be split between an anesthesiologist and a CRNA.

All of these are important medical judgments that rely on medical knowledge to make properly. Why, we ask, would an experiment to determine the impact of replacing a physician with a less fully-trained provider involve anesthesia? There are aspects of medicine in which tasks can be appropriately delegated to lesser-trained nonphysician personnel, such as CRNPs, PAs and nurse midwives.

There are aspects of anesthesia care that can be delegated as well, but anesthesia care is one area in which

the maintaining medical control and direction and expertise is absolutely critical. Imagine asking your heart surgeon to stay at home by the phone while his or her very competent nurse practitioner performs your heart surgery. This is no different.

Every day throughout Pennsylvania, infants and children undergo tonsillectomies, adenoidectomies and other routine procedures. But a common occurrence during these surgical procedures laryngospasm. Laryngospasm is an intense uncontrolled contraction of the larynx that causes a complete closure of the vocal cords, which seals off the airway passages.

Much more quickly than adults, children use up their remaining oxygen and turn blue from cyanosis. Within a few seconds, their heart will slow down and eventually stop until oxygen levels are restored. Anesthesiologists in Pennsylvania deal with this situation every day. When a difficult situation arises in a nonmedical setting, most of us take 60 seconds or so to collect our thoughts. In this situation, there isn't time for that.

Instead, our thoughts have been collected in advance, through years of intense training and education, so that we do what needs to be done to save the patient. We can ponder the situation later at leisure. When an anesthesiologist is providing the anesthesia care,

treatment likely begins even before the oxygen level begins to drop and before the child's heart stops, as the anesthesiologist recognizes the earliest signs of the developing problem.

When the CRNA is providing care, he or she too begins care promptly, but they do one other thing, they call for the supervising anesthesiologist ASAP. The anesthesiologist arrives, assumes command, makes any necessary adjustments; and 99-plus percent of the time, the laryngospasm is broken, the oxygen levels and the heart rate return to normal and the patient's recovery is uneventful.

We look up at the slightly stressed surgeon and say, just a little laryngospasm; everything's fine. A very small percentage of laryngospasms are not so uneventfully resolved. In those instances, the anesthesiologist's presence may even more clearly make the difference in the outcome between a timely discharge versus an extended hospital stay or even worse. As we say again, anesthesia's a serious and potentially risky endeavor.

Currently, there is no statutory description of the role of a certified registered nurse anesthetist in Pennsylvania law. A CRNA's role is described in the Board of Nursing regulations only. However, the regulations governing all anesthesia performed in hospitals and

surgical centers are those of the Department of Health. The Department of Health regulations state that CRNAs must be supervised by an anesthesiologist or the operating physician in the hospital setting.

This last scenario is not ideal as compared to the involvement of an anesthesiologist. And we strongly believe that it should be the exception, not the rule; and it should be discouraged, not encouraged. But even in that situation, a physician is present to provide medical oversight to the CRNA. In July of 2008, the PSA and the PANA formed a joint committee to try to reach agreement on the issues of statutory recognition and scope of practice of CRNAs in Pennsylvania.

We, the two society presidents, Joe D'Amico and I, met along with other representatives of our organizations including our legal counsel. We agreed in theory to legislation that would grant CRNAs statutory recognition and provide a scope of practice modeled on medical supervision and the current anesthesia care team. We drafted legislative language and thought that we were in agreement with this language.

Eventually, PANA rejected the agreed-upon language and the discussions ended. I want to stress that this is, above all else, a patient safety issue. Although I am surprised we are here again fighting to keep

physicians, especially anesthesiologists, involved with the care of patients undergoing the risky and potentially life-threatening administration of anesthesia, we're here and we're willing again to fight for the citizens of this state.

In closing, we ask the Committee to, again, reject efforts to remove physician involvement in the provision of anesthesia care in Pennsylvania. There's nothing to gain and a great deal to lose. At this time, I'd like to introduce Dr. Carol Rose, who is truly one of my mentors in anesthesia and, as of today, the new Chairman of the Board of Medicine.

DR. ROSE: Thank you.

Thank you, Chairman McGeehan, and the members of the Committee. You know my name already. I am a practicing anesthesiologist from Pittsburgh, a former president of the PSA, a past President of the Pennsylvania Medical Society; and as Joe just said, I am on the Pennsylvania State Board of Medicine. And I am very, very honored to be on the Board of Medicine.

I would like to cover some of the quality of care issues that this legislation would jeopardize and will also reinforce my colleague's testimony. There is no wasted education. However, an education curriculum determines your area of expertise. Like my colleague, I

attended pre-med undergraduate classes, took the Med Cat exam and sweated acceptance into medical school, then followed four years of medical school and three years of residency training, which was required at that time. Currently, four years of residency is a minimum to be a board certified anesthesiologist.

Many of my colleagues trained even one or two years longer than that before starting their practice in order to subspecialize in a particular area of anesthesiology, such as cardiac, pain management, pediatrics and obstetric anesthesia and intensive care. The education of a CRNA involves four years of undergraduate training and two to three years of CRNA training, which is half the usual time required for a physician to become an anesthesiologist.

CRNAs are not trained and certified by the state as advanced practice nurses as are nurse practitioners. However, many CRNA programs are moving toward adding a degree in Doctor of Nurse Practice. For most DNP programs, the advanced curriculum does not provide advanced training in diagnosis, treatment, physiology or pathology of human disease, which is a large part of medical school and residency training.

Again, I stress that no education is wasted, but we have to appreciate that our educations are vastly

different in order for us to contribute appropriately to the team concept in which we work. Many CRNAs have gone on to attend medical school, and only afterward, they state that during their education and practice as a CRNA, they didn't know what they didn't know about the true role of an anesthesiologist.

House Bill 1866 uses some different wording when compared to previous House and Senate bills. Instead of cooperation or collaboration, this bill uses overall direction to describe the oversight of CRNAs. Although it sounds like there is a level of supervision involved, there really isn't. Overall direction has not been previously defined, and is not defined in this bill. Therefore, it will be left for the future determination by the Board of Nursing.

There is little doubt, in my mind anyway, that if left to the Board of Nursing, the final definition would be far less than the current supervision or medical direction. These two terms, supervision and medical direction, already include the understanding of oversight provided by a physician who is qualified and either present in the room or immediately available. Immediately available is mighty quick.

Furthermore, in this bill, there is the use of the term electronic communication. A CRNA, if in trouble,

will only be required to have a physician available to call, e-mail or text. Is that what we want for our patients, in a life or death situation, the doctor is being texted for help? It's just not possible to be safely caring for a compromised patient and holding a phone to your ear or texting to get advice from an anesthesiologist who is not physically available to come immediately to help.

This sounds horrible, but it would be acceptable if House Bill 1866 became law. I, for one, would not be willing to be involved in such an arrangement by being the anesthesiologist being contacted electronically and not being immediately available. Will House Bill 1866 decrease costs? The answer is no. If CRNAs practice without the medical direction of an anesthesiologist, the pre-operative and post-operative evaluation and treatment will have to be provided by another physician consultant, and that would be at additional cost.

Remember that many pre-operative medical needs or complications that may occur post-operatively are currently handled by the anesthesiologist. We do have extensive training in cardiology, intensive care, pulmonary medicine as well as many other specialties. We can evaluate and treat many conditions that would otherwise require multiple consultants with their resultant extra

costs. Therefore, anesthesia care given by CRNAs working without an anesthesiologist's direction would likely increase rather than decrease overall costs. Will House Bill 1866 improve access to anesthesia care? I think not.

Here are the facts: Currently in Pennsylvania, anesthesiologists are available in greater than 98 percent of Pennsylvania hospitals. The care is provided either by anesthesiologists directly or by medically-directed CRNAs. The few remaining anesthetics in Pennsylvania are performed by CRNAs under the supervision of the operating physician. Again, this is not ideal as compared to the involvement of an anesthesiologist, but it stresses the fact that a physician must always be present and knowingly responsible to supervise the CRNA.

Therefore, access to quality, medically-provided or medically-directed anesthesia is currently available to all Pennsylvanians, and it should stay so. Severe complications during routine anesthetics do happen. This is not an uncommon occurrence. It can happen to healthy people, and they can become quite ill during anesthesia. It can happen regardless of the training of the anesthesia provider.

The central point is that you have to have extensive training to correctly diagnose and take action and to treat in a rapid fashion. This is not the time to

take the physician away from the patient. Although sicker patients are more likely to die from anesthesia, even healthy patients during routine procedures are not immune to the dangerous effects of the agent that we use.

Almost every anesthesiologist has been involved in a case of unexpected and serious complications, even cardiac arrest and death during what should have been a really simple procedure such as colonoscopy or cataract surgery. It may seem that I'm trying to frighten you, and truthfully, I am. But everything that I am describing is accurate and real. Nothing of what I have said is meant in any way to denigrate the value that CRNAs add to the care of patients.

They are wonderful, well-trained and caring professionals whose value to the patient is not to be belittled. I work with CRNAs, and on a regular basis, I am delighted to send highly complimentary messages to their superiors about the great care that they have given to the patient. However, please note that this care is being given in what I consider to be the best case scenario, and that is in the anesthesia care team method.

That is the kind of care that I want when I have surgery, and that is the kind of care that you should make sure your constituents receive when they have surgery. We are strongly opposed to House Bill 1866 because we know

that the people who trust you want you, their legislators, to keep anesthesia care in Pennsylvania as safe as it can be. Thank you very much for this opportunity to testify.

CHAIRMAN MCGEEHAN: Thank you, Dr. Rose, and Dr. Answine.

There are a number of questions from the Committee.

Representative Petrarca?

REPRESENTATIVE PETRARCA: Thank you, Mr. Chairman.

A few quick questions. I guess I understand the role of the nurse anesthetist is not defined specifically under Pennsylvania law. I believe that's what you said. And you also made reference, I guess in Addendum A, to different regulations that control what is supposed to happen, what the nurse anesthetist, I guess, can and cannot do regarding supervision. Are those the only two regulations that deal with this relationship at this point, and do you find any conflict between those regulations?

DR. ANSWINE: You have the Board of Nursing regulations in there. It uses the word supervision. I think it even mentions something about electronic communication, but then you have to understand though, it can say whatever it wants because in this state, it's the Department of Health regulations that are the rule of the

land. Healthcare facilities have gave them that, that ruling. So, yes, they're in conflict because the Department of Health regulations, which are truly how we operate under, how we operate under hospitals and surgery centers, state that they're to be supervised by anesthesiologists or the operating physician.

So, yes, as far as I know, it's the Board of Nursing regulations that say one thing and the Department of Health regulations which states something entirely different.

REPRESENTATIVE PETRARCA: And when we talk about, I guess under this legislation, an anesthesiologist being able to be contacted electronically or what have you, what happens now in a situation where potentially an anesthesiologist is not available?

DR. ROSE: I'd like to answer that question. I work at the University of Pittsburgh Medical Center Presbyterian Hospital. And on occasion, there is an anesthesiologist -- let's say for the sake of argument, supervising two rooms -- and may be very, very busy in Room 1; and Room 2 has a situation where they need that anesthesiologist, but that anesthesiologist may be tied up with something going on in Room 1.

Our situation is where the circulating nurse, who is the person physically available to push a button and

use an intercom or something like that will call out, help in Room 2, please. And I have been involved in this situation where you see dozens of people going and running to Room 2 and as many as six or eight of them may be anesthesiologists going there.

So in my situation and probably in most hospitals where there's more than one anesthesiologist, people go running. The nurse anesthetist is not flying on her own or his own. There's always help to be had, so we're not jeopardizing patient care. And as a matter of fact, nurse anesthetists -- I mean, anesthesiologists, at least in the circumstance where I work, will always say, you know what, I've got a big case going on in Room 1; things aren't going well; would so and so -- Dr. Answine, would you take my Room 2 now because things aren't going well in Room 1.

So we're very aware of the status of what's going on in our rooms, and we want to be kept informed. In a situation that I was in early in my career, there was a nurse anesthetist whose habit it was to call the anesthesiologist whenever anything happened, anything at all. And quite honestly, I loved working with that nurse anesthetist.

One of my colleagues wasn't too thrilled because he was getting called all the time, and I loved it. That

was a really good nurse anesthetist because she kept me informed of what was going on. I like working with nurse anesthetists. I value what they do, and together as a team, we take very good care of our patients.

REPRESENTATIVE PETRARCA: Well, one more question. I know that we're worried about, in Pennsylvania and nationally, we're worried about access to healthcare. Also part of that is the question of cost. If this bill were to become law, would that save any money, or would there be any money savings for anyone under this legislation?

DR. ROSE: Not the way I see it. Not the way I see it because of the -- like I said in my testimony, I do pre-operative care. I may say, I'm not sure whether this patient's quite ready; let's get some lab work; let's do an additional EKG; let's do this or that.

Or in the recovery room, I may do some medical care for that patient. If I, as an anesthesiologist, were not there and if the surgeon were not comfortable with that care, that surgeon might have to call a cardiologist or a nephrologist or a diabetologist or something like that. So that's additional costs.

REPRESENTATIVE PETRARCA: Thank you.

CHAIRMAN MCGEEHAN: Thank you, Representative Petrarca.

Chairman Stevenson?

REPRESENTATIVE STEVENSON: Thank you, Mr. Chairman.

Just a couple follow-up questions relative to the testimony we've all heard earlier. We've heard about situations, I believe, in ambulatory surgical centers where no anesthesiologist was present and the CRNAs were able to handle it there by themselves. Would you comment on that?

DR. ANSWINE: Absolutely. Like I said, in hospital settings, 99.9 percent of those anesthetics have either anesthesiologist supervision in the state or an anesthesiologist supervising the CRNA. The ambulatory surgery centers, anesthesiologists are present in about a little over 80 percent. In this state, when we look at ambulatory surgery centers, we take all comers. We take all -- like, ours where we're doing laparoscopic cholecystectomies, knee arthroscopies, ACL reconstructions, etcetera.

Also, we include gastroenterology suites, so the majority of those situations where there is no anesthesiologists, those are the gastroenterology centers. So you're talking about colonoscopies and relatively benign procedures. Now, we would love to be in all those centers. The gastroenterologists choose not to have us, and they oversee. They actually oversee the CRNAs in those

situations.

The CRNAs in this state never practice independently. They can't. The Department of Health says they can't. In those situations when there's no anesthesiologist, you have the operating physician taking on the responsibility, if they choose to do so, as the supervisor. And if the CRNA makes a mistake, it's not just them. It's the supervising anesthesiologist or physician that has the liability. They are not practicing independently in this state, never did.

REPRESENTATIVE STEVENSON: Secondly, just to follow up again to the remarks we heard earlier, if I understood Mr. D'Amico properly, he said that this legislation does not expand responsibilities or the scope of practice of CRNAs. Would you comment on that?

DR. ANSWINE: Absolutely. In this situation, if you look at this bill, it says a couple of things. It uses the term overall direction. Overall direction doesn't have a definition. Who gets to define overall direction? Well, whoever you give the power to in the bill. So you give the power to the Board of Nursing to define what overall direction means.

Overall direction sounds more administrative than anything else. Supervision has a understandable definition as what it means. Medical direction seems

understandable, and actually that is actually defined by CMS. Overall direction doesn't seem like much, and you're going to give the power to the Board of Nursing to define what that term is. And my guess is they're going to define it very, very liberally, meaning that there's going to be very little oversight, very little supervision, very little medical direction.

So two things about the bill we have a problem, that you have an undefined term, that you're basically taking a practice of medicine which is anesthesiology and you're giving it to the Board of Nursing. Really, that's the role of Department of Health or even the Board of Medicine to decide, so this bill has many problems.

REPRESENTATIVE STEVENSON: Finally, along that same line, you indicate in your testimony that you felt you were very close to working out the issues on this issue a year or so again, but that the CRNAs withdrew from the negotiations. Is that accurate?

DR. ANSWINE: That is accurate.

REPRESENTATIVE STEVENSON: And where does that stand, or what was the idea with that?

DR. ANSWINE: The idea was they wanted statutory recognition because, as I said in my testimony, they don't have it. It's true that they're only defined in the State of Pennsylvania in the Board of Nursing regulations.

There's no statute that says anything about CRNAs. That's absolutely true. So we sat down and they said, we'd like statutory recognition. We said, we understand. We like supervision. We like the anesthesia care team. We like anesthesiologists and physicians being involved in the care of all patients receiving anesthesia.

So let's put together legislation that says the CRNA has statutory recognition and they are supervised by an anesthesiologist or an operating physician if the anesthesiologist can't be there. It seems reasonable. They stepped away.

REPRESENTATIVE STEVENSON: Thank you. Thank you, Doctor. Thanks for your testimony.

CHAIRMAN MCGEEHAN: Thank you, Chairman Stevenson.

Representative Casorio?

REPRESENTATIVE CASORIO: Thank you, Mr. Chairman.

Drs. Answine and Rose, I just want to do a little bit of follow-up if I could from your testimony, Dr. Rose, and from the questioning from my colleague, Representative Petrarca, on cost. I guess we're all acutely aware of the financial impact of everything that we do here in the Capitol, and those of you probably are facing some of the same shortfalls and financial

difficulties that we are here as well.

So trying to zero in on, again, Representative Petrarca's questions, and Dr. Rose alluded to the answer of decreasing cost. That's where I'd like to go, if I could, in brief, Mr. Chairman.

Two prong question about House Bill 1866; saving money, the overall financial aspect, not only to the physicians, but I guess more broadly, if you will, to facilities, patients, insurers, the Commonwealth of Pennsylvania as we're all keenly aware of; and if you could, tying in, I know with some latitude, Mr. Chairman, House Bill 2883 -- it's not before us today, but it addresses some of the same issues about pay level for physicians and for CRNAs, so I guess it's a generally broad question, but zeroing in on the overall cost and some cost containment, please.

DR. ANSWINE: The situation is exactly as you described. Right now, if an anesthesia service is rendered, regardless if it's a CRNA who's being supervised by the operating physician, an anesthesiologist alone or an anesthesiologist and a CRNA, there's one fee. If it's an anesthesiologist and a CRNA, that fee is split between the two of them. If it's an anesthesiologist alone, etcetera, but it's the same fee.

There are a couple very rare circumstances where

the CRNA is reimbursed at a lower rate, and they actually introduced House Bill 2883 to correct that problem because they wanted equal reimbursement. So if you would pass any type of legislation that's going to give them independent practice, the next thing that's going to come out is another House Bill 2883 to make sure that all the fees are equal and understandable.

So not only do you basically pay the same fee whether it's a CRNA working without an anesthesiologist or an anesthesiologist alone or a care team, but if a CRNA is working independently, then you're going to have consultants doing jobs that we already do. We do the preoperative evaluation and workup. We do the ordering because CRNAs do not have prescriptive authority. They can't order things.

We do the post-operative care. If there's a cardiac abnormality, for the most part, we can treat it. We can address it. We can order the appropriate studies. If there's a glucose abnormality in a diabetic, we take care of it. If there's a pulmonary problem, we take care of it.

If we're not there, then you're going to get a pulmonologist for the pulmonary problem; you're going to need a endocrinologist for the sugar problem; you're going to need a cardiologist for the cardiac problem. So not

only are we saying that this isn't going to make things less expensive, we really strongly feel that it's going to increase costs because of all the necessary additional costs with consultants that you're going to need to accrue or take on.

REPRESENTATIVE CASORIO: Mr. Chairman and Doctor, thank you. You -- and I won't take any more of the Committee's time. You talk about studies. We've heard you basically say the same thing Dr. Rose did about increasing costs overall. Some of those studies, I think, would be -- with the Chairman's permission, if you could maybe, in the next few weeks in a timely fashion, maybe get some of that information to us as we digest all of this information today. It would be very helpful.

DR. ANSWINE: Absolutely.

REPRESENTATIVE CASORIO: Thank you, Doctor.

Thank you, Mr. Chairman.

CHAIRMAN MCGEEHAN: Thank you, Representative Casorio.

Representative Maher?

REPRESENTATIVE MAHER: Thank you, Mr. Chairman.

If I understand correctly then from the physician perspective, you are in accord with statutory recognition of CRNAs. Where the rub is is the nature of the scope of practice?

DR. ANSWINE: Absolutely, sir.

REPRESENTATIVE MAHER: Now, I'm a little bit confused because I had thought I understood Dr. D'Amico and Mr. Anderson to express that this legislation was simply elevating to statute what already exists in regulation. But from your testimony, it sounds as though this legislation is at odds with existing arrangements, in particular with respect to supervision, immediate availability and so forth. So is it correct or is it not correct that this legislation is simply elevating to statute what already exists in regulation?

DR. ANSWINE: It's elevating to statute what already exists in the Board of Nursing regulations. It would dramatically change what it says in the Department of Health regulations.

REPRESENTATIVE MAHER: Very good. And this issue about overall direction, is that already in the Board of Nursing regulation, or do they use the other phrasing?

DR. ANSWINE: They use cooperation, and I think also at some point they do, in collaboration, they do mention overall direction.

REPRESENTATIVE MAHER: Okay. So the wording here is somewhat different then to your recollection?

DR. ANSWINE: Yes.

REPRESENTATIVE MAHER: Okay. Well, that's easy

enough for us to establish. But I do appreciate, at least now, I think the members now have some clarity on what the rubbing point is, and I thank you for that.

DR. ROSE: One thing I would like to add now is that if the anesthetists are saying that they want the recognition of the state, recognizing them as certified registered nurse anesthetists, I think that's a fair request, but don't think that at the current time they are not, indeed, acknowledged as certificated registered nurse anesthetists. They go through rigorous training. It's not the same as medical training.

It's rigorous training though. And then they take an exam that's not an easy exam. It's not a slam dunk that they're going to pass it. And then they become certified registered nurse anesthetists, and they must maintain that certification by getting educational credits and maintaining their practice as certified registered nurse anesthetists. So it's not like they lack recognition.

If the state has not at this moment acknowledged them as certified registered nurse anesthetists as a separate certification, which they're saying they want certification, don't think that they're not certified. They are certified. They happen not to be certified in Pennsylvania as a separate entity, but they are certified

and they maintain their certification.

REPRESENTATIVE MAHER: And just to quickly follow up, you would have no objection to statutorily establishing the certification per se? It's a question of the scope of practice it's associated with?

DR. ANSWINE: Exactly.

REPRESENTATIVE MAHER: Thank you.

DR. ANSWINE: I mean, what the situation is, I mean, we can call it whatever you want. We can call it statutory recognition. We can call it -- you name it. It's about scope of practice. This is purely scope of practice. This is independent practice for a nonphysician. It's nothing more. We have to be serious about this. I mean, we can talk about it and call it what we want, but we know what it is. That's why we're here.

CHAIRMAN MCGEEHAN: Thank you, Representative Maher.

Representative Waters?

REPRESENTATIVE WATERS: Yes. Thank you, Mr. Chairman.

I want to thank you for being here. I look at this as part of the, what we did with the Prescription for Pennsylvania where we were trying to expand quality healthcare throughout the Commonwealth. And I'm proud to say that during this period, that I was able to be the

prime sponsor of the nurse midwives, where the nurse midwives now can practice within their scope of practice, what they know. They seem to have been very excited about the ability to do so, and I know that they have a role that they play in term of healthy deliveries.

And so this particular bill right here, this bill has been around for a while for people who are nervous about this in terms of not having a position or with the anesthesiologist or physician when the drug is administered.

And I wanted to say that my concerns about it is -- the CRNAs, it seems like we have an abundance of them in the state in places according to this chart. There are a lot of -- there are more of them then there are doctors. What are they doing in those locations?

DR. ANSWINE: Well, in those situations, there are doctors as well, just more CRNAs. And that makes sense because you can cover up to four CRNAs at one time in the operating setting, anywhere from one to two to three to four. Anesthesiologists have the ability to practice in the operating room by themselves doing the cases themselves, or they can cover one or two or three or four CRNAs or two residents.

So in those situations, 99.9 percent of the time, there are anesthesiologists there as well, except

we're just outnumbered by the CRNAs. Interestingly though, the current numbers, we looked at the manpower issue, and we are making headway. Between 2005 and 2008, the number of anesthesiologists in hospitals increased by 486, CRNAs by 256. In the ambulatory surgery facilities in that same time period, there's been an increase of 338 anesthesiologists and 273 CRNAs, so we are making headway.

We're putting more providers out there. We're going to continue to do so. If we keep making Pennsylvania a good place to practice medicine, we'll get the physicians. We'll get the people in here to take care of these patients. I promise you.

REPRESENTATIVE WATERS: Yeah. The issue of reciprocity, does that factor in this at all?

DR. ANSWINE: I'm not sure I understand your question, sir.

REPRESENTATIVE WATERS: Pretty much, I know that there are -- some had where they were allowed to practice in three, maybe a tri-state area or their license is recognized in different states.

DR. ANSWINE: Well, really accepting there are -- President Clinton and then eventually it was President Bush, they said states, when it comes to Medicare, that they can opt out, that they can allow CRNAs to practice without supervision under Medicare rules, if

that's the question you're asking. There are about 18 states out there, most of them very rural areas. If I'm missing the question -- go ahead.

You answer.

DR. ROSE: Are you talking about where, one of the gentlemen before was talking about coming into the state and nobody knowing that they were here or something as CRNAs?

REPRESENTATIVE WATERS: Well, I know that happens.

DR. ROSE: Well, if a CRNA comes to the state to do a locum case, that is working temporarily, they would be working under a nursing license, and one would expect that they would have a nursing license. A CRNA, I wouldn't think -- now, maybe somebody's got to awaken me to reality or something, but a CRNA is not going to be able to come into this state and work as a CRNA if they have no licensure at all in the state.

They're probably licensed as a nurse, if that's what you're alluding to with reciprocity. Licensed professionals don't cross borders without having a license where they're going. I mean, we saw this in Katrina, that many doctors wanted to go down to Louisiana and help out and couldn't because they didn't have a license to practice in Louisiana, and I would venture to say that nurses

couldn't do it either.

And by the same token, doctors and nurses who were licensed in Louisiana and maybe wanted to come to Pennsylvania because they had a sister or a brother and they could live with them here, but if they're not already licensed here, they can't practice here. So that's what reciprocity means, and I don't know what else you mean by the reciprocity issue.

REPRESENTATIVE WATERS: Okay. Well, thank you. This is a concern that I had. (Inaudible) grandfather in Wilkes-Barre had someone who came in from, I believe Florida, and caused harm to him.

DR. ROSE: Then wherever that person was working if they were not licensed to practice in this state --

REPRESENTATIVE WATERS: They weren't.

DR. ROSE: Well, then they had no business, and whoever allowed them to do that, if it was a hospital or a surgery center, that was not permitted. Yeah, it's not permitted in any specialty. My husband's an architect, and he wasn't permitted to practice as an architect when we moved here from Florida until he became a licensed architect here.

REPRESENTATIVE WATERS: Yeah, Pennsylvania has good laws.

DR. ROSE: Yeah.

REPRESENTATIVE WATERS: Thank you. And a lot of them came out of this committee.

CHAIRMAN MCGEEHAN: Thank you, Representative Waters, and if there is a particular problem, I'd encourage you to share it with my staff so they can follow through with that. Thank you.

Our last questioner is Representative O'Neill.

REPRESENTATIVE O'NEILL: Thank you, Mr. Chairman. And I apologize for -- the hour's getting late, and this may be redundant. I'm trying to get all this organized by thought here. What you were saying is if House Bill 1866 is enacted, it would change the scope of practice and allow CRNAs to work independently without supervision. Is that what you were telling the Board?

DR. ROSE: That's what we feel.

REPRESENTATIVE O'NEILL: Okay. And you're also saying that one of your major problems with this piece of legislation is the definitions of supervision and who would be making those definitions.

DR. ANSWINE: Overall direction.

REPRESENTATIVE O'NEILL: Pardon me?

DR. ANSWINE: Overall direction.

DR. ROSE: The words overall direction.

REPRESENTATIVE O'NEILL: Yes. And you're advocating that the Board of Health or the Medical Society

should be making these definitions and not the Board of Nursing?

DR. ANSWINE: Yeah. It's true. I mean, this is anesthesia. There's no doubt that this is a purview of physicians. This is medicine at its finest. These decisions should be made by the Department of Health and/or the Board of Medicine.

REPRESENTATIVE O'NEILL: And then lastly, does the PSA oppose what the CRNAs are trying to do by being recognized and see this accreditation of advanced nursing from the Board of Nursing as long as the proper definitions are in there and who's making those definitions and so forth?

DR. ANSWINE: We don't have a problem with them being recognized statutorily. We have a problem with them wanting to practice without a physician's supervision.

REPRESENTATIVE O'NEILL: Okay. I just wanted to make sure. Okay. Great. Thank you.

CHAIRMAN MCGEEHAN: You've raised additional questions.

Representative Baker?

REPRESENTATIVE BAKER: Thank you very much, Mr. Chairman.

Doctors, you've indicated that this should be falling under the Board of Nursing or the Department of

Health. Has there been any discussion transpiring with either one of them about modifying or changing the regulations?

DR. ANSWINE: Not that I know of, sir.

REPRESENTATIVE BAKER: And the record reflects that 45 states have, in fact, have adopted similar statutes according to the nurse anesthetists. That clearly is not under the Board for the Department of Health. Is there a model there out of 45 states that you could live with?

DR. ANSWINE: Well, yeah. I couldn't give you a state, per se. If you look at New York and New Jersey, they have, I'm pretty sure in statute, they have a description of CRNAs; but they also have in statute, at least in New Jersey if I remember correctly, supervision.

So it would be nice to have in statute supervision and the requirement for the appropriate medical direction or supervision of the CRNA by a physician as well as having their recognition of CRNAs in statute.

REPRESENTATIVE BAKER: Okay. So if you were to identify one of those models --

DR. ANSWINE: Jersey would be the one that comes to mind.

REPRESENTATIVE BAKER: Which one comes to mind?

DR. ANSWINE: New Jersey.

REPRESENTATIVE BAKER: Okay.

DR. ANSWINE: And I can get you that information with no problem.

REPRESENTATIVE BAKER: There definitely is a conflict here in terms of opinion. The record also reflects that CRNAs, and I quote, this does not seek to allow independent practice for CRNAs to perform up the level of their scope of practice training. You're of the mind that it does, in fact, lead to independent practice?

DR. ANSWINE: Yes, I am, but I think there's enough history to prove that there one goal is independent practice. If you remember the testimonies from 2007, you were told, the Insurance Committee was told that they thought anesthesiologists weren't necessary. Let's be honest. This is about independent practice.

REPRESENTATIVE BAKER: And one last question is, if -- let's say the New Jersey model is not agreed to between the two parties. Does the 2008 agreed-to language still stand on the table? Is it still on the table?

DR. ANSWINE: We would sit down with them today if they wanted to sit down and talk this through again. We were happy to do it 2008, July of 2008. We'd be happy to do it again. We've never turned our backs on CRNAs, never.

REPRESENTATIVE BAKER: Thank you very much, Doctors.

Mr. Chairman?

CHAIRMAN MCGEEHAN: Thank you. Excellent questions, Representative Baker. Thank you very much.

And positively the last question is from the prime sponsor of the bill, Representative Gergely.

REPRESENTATIVE GERGELY: Thank you, Doctors. I appreciate your time. Let's start off with some simple questions. Of the states that have licensure, how many CRNAs practice, independent practice in any of those states? Does that exist in this country?

DR. ANSWINE: It may. I'm trying to think. There's probably a few of the rural states -- Montana comes to mind and Wyoming -- that they have the ability to have independent practice. You know, it's an interesting situation because if you look at CNS, even those states that have opted out, it said that, according to CNS, they can practice independently, even if our state would opt out today. Guess what?

They can't practice independently because the Department of Health says they can't, and as long as the Department of Health is in control, they can't. So I don't know, per se -- I know there's 18 or 14 states that have opted out, but I'd be hard-pressed to say that many of those, even those that have independent practice, maybe a couple.

REPRESENTATIVE GERGELY: And honestly, I'm not

for that definition, so I want to make -- for the record, that's not the objective of this bill. This is a discussion about where we should be with recognizing this.

And, Representative Waters, maybe I can make some clarity with reciprocity because I have dealt with reciprocity with other professional licensure groups. It's a national standard for anesthetists -- is that correct -- so they can go from state to state to practice; if they've met the standard in PA, they could go to Ohio or Illinois based on what they've accomplished or met in Pennsylvania?

Maybe it's a question to the anesthetists, but we need to know that because if you are licensed and that helps them with reciprocity, that's important for us to know.

DR. ROSE: I'd like to answer since I'm on the Board of Medicine. Reciprocity would imply you can go from one state to another, one defined state to another defined state without any problem at all, just hop right over there and you can work there. But I know being a member of the Board of Medicine, that each state, because they are separate and there's no federal licensing law, each state has its own little quirks in some states. How about if I speak as a physician --

REPRESENTATIVE GERGELY: How's physician

reciprocity?

DR. ROSE: Right. Physician reciprocity doesn't truly exist because each state has its own requirements for the number of continuing medical education credits, what kind of credits. Some states require -- like, we require patient safety credits. In some states, they require pain management credits. So you can't just say, I'm going to go here and tomorrow I'm going to work there and I have reciprocity.

REPRESENTATIVE GERGELY: Okay. So I guess the question is --

DR. ROSE: Yes. They are certified; they have a national certification that is generally accepted, but I don't know what it would take for a CRNA to go from one state to another, just hop over there.

REPRESENTATIVE GERGELY: This certification --

DR. ROSE: It's a nationally acknowledged certification.

REPRESENTATIVE GERGELY: Right. And with this certification from the state though, someone obtaining a position in another state, do you think they are hindered or handicapped by not having certification?

DR. ANSWINE: No.

DR. ROSE: Here, no, not at all. It's only related to Pennsylvania that they don't have a

certification that comes from --

REPRESENTATIVE GERGELY: Right. So what I'm saying, if they leave this state without a certification, go to a licensed state, like Alabama or Arkansas --

DR. ROSE: No.

REPRESENTATIVE GERGELY: -- it doesn't affect them?

DR. ROSE: It doesn't.

REPRESENTATIVE GERGELY: And, of course, I hope, if that is debatable, we should get, both entities should submit information on that. Okay? I think we have to understand that. We want to protect our residents for job opportunities in other places.

DR. ANSWINE: I don't understand. Why would you think that because they're recognized statutorily in the State of Pennsylvania, why would that make a difference in California?

REPRESENTATIVE GERGELY: I'm not --

DR. ANSWINE: That's what I'm saying. And I'm not being sarcastic.

REPRESENTATIVE GERGELY: I'm not either, but then there's licensure in other states. They're not licensed here, so there may, in fact, there may not be reciprocity.

DR. ROSE: It's just a difference in state laws.

That's all. But nationally, they have taken and passed their exam.

REPRESENTATIVE GERGELY: And I said that right off the bat. It's a national standard, and I believe that. I don't disagree. What I'm saying is, in Connecticut and Delaware, they both have licensure, have reciprocity that still we don't have in Pennsylvania.

DR. ROSE: I cannot imagine that. I mean, I cannot see where it would keep a CRNA who's a CRNA in Pennsylvania from going to -- it can't keep them from going to another --

REPRESENTATIVE GERGELY: It's just never been discussed.

DR. ROSE: Certification as they have it, certified registered nurse anesthetists, is that they're certified by their national board.

REPRESENTATIVE GERGELY: Right.

DR. ROSE: That is not the same definition as certification here in Pennsylvania that they're talking about. It's a different term.

REPRESENTATIVE GERGELY: Right. And I won't belabor this.

I think, Mr. Chairman, we should identify differing requirements to perform for an anesthetist in different states as much as we do -- if this is a -- only

in the scope if this is, if we did this, it would be positive to help them with reciprocity.

DR. ANSWINE: And I think what you need to do then is separate out that issue of scope of practice because that's the -- we have to separate this.

REPRESENTATIVE GERGELY: I think it's interesting. I would like to hear the two doctors' opinions. In the nursing board regulations -- you guys, I don't know if you're familiar with them or not -- in Section 21.17 --

DR. ANSWINE: They describe the CRNA's role.

REPRESENTATIVE GERGELY: -- they describe the CRNA's role, correct, and it says -- and I'll paraphrase where the comma is -- the CRNA shall have available to her by -- her, we should change that, by the way, to male or female -- physical presence or electronic communication, an anesthesiologist or consulting physician of her choice. So in this state, we already have this electronic communication.

DR. ANSWINE: No, you don't.

REPRESENTATIVE GERGELY: That's what I want to clarify because the Department of Health --

DR. ANSWINE: Doesn't state that.

REPRESENTATIVE GERGELY: Right. That's what we have to -- that's what I was trying to clarify. So we have

a problem with our own code, codifying this -- so as you stated earlier, it could be in the nursing code, right, but it actually isn't implemented. Even within this bill, as Representative Mustio said earlier, that doesn't necessarily mean it would occur because the Department of Health regs.

DR. ANSWINE: Right. But, you know, please help me with this because this is your role and not mine, but if something becomes statute, don't all regulations have to be altered no matter what they are to correspond to the statute?

Because it's my understanding that you can't have a regulation that go against statutes, so I'm assuming that if we make this a law, that not only does the Board of Nursing regulations have to be changed, but the Department of Health regulations would have to be changed as well because they would then go against statute. So that's the problem. Am I correct on that or not?

MS. TREMMEL: It's been my understanding with our drafting of legislation, if we have a bill here in the House and we want to amend one of our licensing statutes and we also have to correct something in the Department of Health for their regulations, then we have to also have that in our statute when it passes, or their regulations do not have to correspond.

DR. ANSWINE: So the next step would be a bill that puts this in the Department of Health regulations, and then we have to back here and do this again?

MS. TREMMEL: Or we could add to this bill right now to have that corresponding change.

DR. ANSWINE: Thank you. I appreciate that. That's why I was asking because, take my word for it, I belong in an operating room.

CHAIRMAN MCGEEHAN: Does that complete your question, Representative Gergely?

REPRESENTATIVE GERGELY: I probably won't have any questions for any additional testifiers, but the two entities that are most important to this issue, one's already testified and the other's at this table. So I appreciate your patience, Mr. Chairman.

To the members, I think if you took the bill and you took page 3, line 4 through 20, that's the essence of this issue, pretty standard. It's about overall direction. I don't believe, and I disagree respectfully about what independent -- I don't want, and I already told you, I don't want, of the 90 percent, 98, 99 percent of surgical procedures being performed in a hospital, I'd want an anesthesiologist present.

That's the bottom line. And we perform that. It's patient safety in this state. But overall direction

isn't going to give my anesthetist the ability to not have that happen. I don't understand why that wording is so problematic for you as well. What would you say instead?

DR. ANSWINE: I would do two things. I would take it out of the hands of the Board of Nursing. I would put it in the Department of Health's hands, and I would change it to medical direction. Take out electronic communication. Get rid of it because it's only going to hurt somebody. Put medical direction.

If you want to put supervision, that's fine, but put it in the hands of the Department of Health and the Board of Medicine. We don't want our roles and our patients' care to be defined by the Board of Nursing. I mean, and it's nothing against the Board of Nursing, but we're talking about medicine here. So if you can put in medical direction, take out electronic communication and give the power to the Department of Health to do the defining, we're okay with it.

REPRESENTATIVE GERGELY: Because I don't want the members to believe that if this were to pass, that anesthesiologists wouldn't be unnecessary and, all of a sudden, every hospital would eliminate you and have anesthetists with the surgeons. That's not going to occur, correct?

DR. ANSWINE: It would take our power away

dramatically.

REPRESENTATIVE GERGELY: In what sense -- is my theory correct then? That's what you think would happen? You think hospitals would institute that?

DR. ANSWINE: Take my word for it. It would -- what would happen, overall direction would be loosely defined. It's already happened. If you look back in the nurse practitioner scope of practice, that was watered down. There was some gray areas there. It would be a very, very loosely defined term, which would mean some direction from afar.

And that's truly our opinion, and I haven't heard anything yet that would change my mind. I really think that this bill, as it's worded -- and I'm sure you meant the best, and I'm not knocking you. But we have to defend anesthesiologists and our patients. It would dramatically change the way we practice.

REPRESENTATIVE GERGELY: So if we were to just kind of revisit this in more specifics to performing general to actually add surgical -- which we've done with other bills -- surgical procedures, where an anesthesiologist has to be present, you wouldn't have such a problem; it wouldn't be so problematic for you?

DR. ANSWINE: I'm not sure I --

REPRESENTATIVE GERGELY: Instead of overall

direction, we could actually identify what surgical procedures are performed in hospitals?

DR. ANSWINE: No. That wouldn't be good. We need to talk about anesthesia being delivered, so it doesn't matter what surgical procedure. I've seen patients die from colonoscopies. I've seen patients die from appendectomies. It has nothing to do with the surgical procedure. We have to talk about, if an anesthesia is delivered, an anesthetic, there has to be medical direction.

There has to be an anesthesiologist and/or an operating physician, if he chooses to take on that responsibility, present to take over control when necessary and be there and be responsible for that patient. Because as I said right now, there is no independent practice currently in Pennsylvania for CRNAs. If a CRNA does something that hurts the patient, yes, they are responsible, but so is that supervising anesthesiologist or physician.

They don't go it alone, and we don't want that to happen. We don't want to put them in that situation. To be honest with you, if you talk to the majority of CRNAs in this state, they like those anesthesia care team models. I'm sure your mother liked it too, and it sounds like she was great at it. That model is the way she practiced her

old career. That model's the way the majority of CRNAs like to practice in the state currently. The vast majority of them don't want things to change, but there's a few that do.

REPRESENTATIVE GERGELY: Okay. So back to the bill, where in the bill does it provide for them to be independent, have independent -- outside of overall direction is where you're debating me, on whether or not they're independent. You're saying overall -- so we know this. You're saying overall direction provides for them to be independent of oversight?

DR. ANSWINE: We're saying that when overall direction is finally defined, that's what it's going to say.

REPRESENTATIVE GERGELY: Finally defined, so --

DR. ROSE: By the Board of Nursing.

REPRESENTATIVE GERGELY: By the Board of Nursing.

DR. ROSE: So if you want something, put it in your law. Don't wait for someone to write the regulations.

REPRESENTATIVE GERGELY: That's what I was getting at. You want it --

DR. ROSE: You want it in the law. What you want is to put it in the law.

REPRESENTATIVE GERGELY: But if I were to ask

from yourselves what you would -- you said medical --

DR. ROSE: Medical direction.

REPRESENTATIVE GERGELY: -- medical direction, and that would be the two words you would use as opposed to overall direction?

DR. ANSWINE: And also, like I said, we want a couple things. We want medical direction, and we want the appropriate governing body to be in charge of defining these terms and in charge of these terms. We would sit there -- like I said, we were willing to talk. We've done this before.

To Joe D'Amico's credit and his organization and my organization, we sat down and had a couple meetings and we really discussed this, and we thought we came somewhere. Now, I don't know what happened, but they stepped away. We were willing to talk to make this work, to get them their statutory recognition, but we will not give up the role of the physicians who provide all the anesthetics delivered in the state.

REPRESENTATIVE GERGELY: And I don't want to belabor it, but as you said, the states that have independent anesthetists, we have rural areas and we do have ambulatory care where there is a doctor providing the oversight for the anesthetists, correct?

DR. ANSWINE: Right.

REPRESENTATIVE GERGELY: That's still necessary because we have to provide care in those areas. But this also -- oh, I know where I was going. Your position on anesthesia aides is what?

DR. ANSWINE: Excuse me?

REPRESENTATIVE GERGELY: Anesthesia aids.

DR. ANSWINE: Anesthesiologist assistants?

REPRESENTATIVE GERGELY: Is that it? Well, there's --

DR. ANSWINE: If you're talking about who can actually directly provide anesthesia care, there's anesthesiologist residents in anesthesiology, CRNAs and anesthesiologist assistants in about 14 or 15 states.

DR. ROSE: And Ohio is the closest state where anesthesiology assistants are being trained and are employed.

REPRESENTATIVE GERGELY: Are we for them from your position, or are we against them?

DR. ANSWINE: We would love to see, if every patient in this state was having an anesthetic, that there was an anesthesiologist and a CRNA involved in their care. If it gets to the situation where we don't have enough CRNAs to provide care -- and they claim that their numbers are -- we're working hard.

If we can keep anesthesiologists, we'll keep

them here. I would rather see an anesthesiologist overseeing or directly supervising an anesthesiologist assistant rather than have no anesthesiologist present in that care. I'm not necessarily -- I would love to see anesthesiologists and CRNAs always working together. I would love to see the anesthesia care team model that's been around for decades, for centuries, to continue.

But if the situation arises that we have to bring in anesthesiologist assistants because there's not enough CRNAs, it's not what we want. It's not ideal, but at least there's an anesthesiologist who provides them that care. Let's hope it doesn't come to that.

REPRESENTATIVE GERGELY: And I guess that's the line of questioning. I appreciate that. I have no idea what their level of education is in terms of medical practice. Are they nurses?

AUDIENCE MEMBER: No.

DR. ANSWINE: It's not the same as a CRNA, and we would never say it is.

REPRESENTATIVE GERGELY: Okay.

DR. ANSWINE: But, again, most importantly, we just want anesthesiologists involved with the care of these patients. That's what we want because that's what we do. We would love to see the anesthesia care team as it exists in the state and be the way it is always.

REPRESENTATIVE GERGELY: And two years ago, this did occur. And I put it on my own personal responsibility to follow through with all this.

DR. ANSWINE: I appreciate that.

REPRESENTATIVE GERGELY: There's one thing, Mr. Chairman, being on this board, we've always forced issues in compromise, and it's getting time to force the compromise with respect to both parties on this. This battle can't last forever. And one thing I don't want to see is regulatory change because then it could happen in the next process through the Legislature. You don't want someone else just making --

DR. ANSWINE: Absolutely.

REPRESENTATIVE GERGELY: And you realize that, and I realize that. It's in your best interest, I think.

DR. ANSWINE: And we understand that, and we do understand that. And we appreciate the process. We're just, we just have to defend the patients and the anesthesiologists and even the CRNAs in this situation that like the anesthesia care team model. That's why we're here.

Now, you have to understand when we talk about compromise though, we can't compromise when we're talking about what type of cases will have an anesthesiologist, what type of cases would have a CRNA without an

anesthesiologist, etcetera. The compromises occur, and then we can work on their statutory recognition, but keeping the anesthesia care team models strong and powerful in the state as it is. We've been providing safe anesthesia here for a long time. Why change it?

REPRESENTATIVE GERGELY: And I agree. And I remember when -- Representative Waters, was it nurse midwives?

REPRESENTATIVE WATERS: Yeah.

REPRESENTATIVE GERGELY: I can remember, I was -- it wasn't Chairman McGeehan. It was Chairman Sturla. I was in his office suite. I can remember, at 2:00 in the morning, both entities sat in that room until they hammered out agreements. That's my expectation on this. That's where I think this needs to go.

DR. ANSWINE: Our door is always open.

CHAIRMAN MCGEEHAN: Thank you, Representative Gergely, for your commitment to continuing to work on this matter.

Dr. Rose, Dr. Answine, thank you for taking time out of your very important work to be here and adding your expertise to this testimony. Thank you very much.

Representative Petrarca has reminded me that last session, we changed the House rules that we not go beyond 11:00, so we don't want to even attempt that today.

Our next testifier is James Goodyear, Doctor. He's the President of the Pennsylvania Medical Society.

Dr. Goodyear, thank you for being with us today, and begin when you're prepared.

DR. GOODYEAR: Good afternoon, Chairman McGeehan, members of the House Professional Licensure Committee. I am Dr. James Goodyear, President of the Pennsylvania Medical Society. As many of you already know, our organization is the largest statewide professional organization of approximately 20 thousand members.

To better understand and appreciate my comments here today, it might be helpful for you to know that I'm a board certified general surgeon, practicing here in Pennsylvania for over 30 years. I want to begin by saying that I sincerely appreciate this opportunity as a surgeon to share my thoughts with you about House Bill 1866. I would also like you to know from the outset that nurse anesthetists play a critical role on many surgical teams including my own.

I use the term team with utmost respect for all individuals who work with me in the operating room. As a leader of my surgical team, I rely on each and every member of the team. Today, we're specifically addressing the responsibilities, functions and duties of a frequent and important member of my team, the nurse anesthetist. I am

first to admit that at times, they are invaluable in my operating room.

However, I have serious concerns about their position on my team if change in House Bill 1866 were enacted, which is why we at the Pennsylvania Medical Society oppose this bill. Obviously, as has been stated, the education and training of any professional, be it a lawyer, architect or pilot, clearly dictates their authority to perform a particular function.

But despite considerable education, paralegals are not permitted to practice law, draftsmen cannot consider a particular beam structurally sound and I don't think any of us would want a recreational pilot at the controls of a 747. Nurse anesthetists are incredibly talented individuals, but they have limitations. I too have limitations.

As a physician, I hold an unlimited license here in Pennsylvania to practice medicine, but as I mentioned earlier, I am a general surgeon. I cannot practice or perform ophthalmic surgery, neurosurgery or cardiac surgery. I was educated and trained to perform general surgery. Again, I have clinical limitations. Nurse anesthetists are no different.

While they may effectively administer anesthesia and skillfully monitor an anesthetized patient

to assure safe and quality of patient care, they require supervision by a physician ideally, an anesthesiologist who is physically present and available in the operating room. It is not the time, in my opinion, to lower the bar on patient safety and quality of care. The current structure of supervised anesthesia care works. In fact, it works quite well.

Ironically when I first learned about this committee and its hearing here on House Bill 1866, my first thought was not to advocate for any relaxation of current regulations, but rather strengthen the current term supervision of procedures to include a clearly defined and written protocol between nurse anesthetists and physician supervisor; a collaborative agreement, which specifically defines the duties and privileges of the nurse anesthetist and provides for the direct supervision by an anesthesiologist or physician who is physically and immediately available at the time of administration of anesthesia.

That is something I would encourage this committee to strongly consider in lieu of the language currently found in House Bill 1866. Please know that my goal today is not to scare you into thinking that undergoing surgery even for a minor procedure is like rolling the dice, but I do want you to understand that bad

things can happen that are unpredictable and completely out of everyone's control.

And when things go wrong -- and believe me. I've seen things go wrong quite quickly. Patients can crash in seconds in my operating room. I want the experienced pilot who is controlled and has flown that 747 for 20 years and not a weekend aviator. Again, nurse anesthetists are highly skilled, but they have limitations. Let's put aside for a moment the issue of physician supervision of nurse anesthetists and consider what this bill will and will not do.

In my opinion, the changes proposed in this bill will create a degree of uncertainty in my operating room, and that may potentially lead to incidents that I would otherwise not encounter with my current work flow. While I do not wish to paint for you a picture whereby patient mortality will significantly increase in every operating room if House Bill 1866 were enacted, I can assure you that incidents will occur and will put patients in serious jeopardy because anesthesiologists were not immediately available.

If only one patient incurs any close call, or God forbid something worse, as a result of this proposed change, in my opinion, that is one patient too many. The last thing I would briefly like to touch upon is the

recurring question of access to anesthesia care that we have already heard raised in this hearing. We have heard a claim that they can provide care to patients where physicians are unwilling to practice. This is simply not true. Are there areas of the state that do not have the luxury of having an anesthesiologist on site? You bet there are, but those same areas also do not have nurse anesthetists either.

Both CRNAs and anesthesiologists largely practice where the patients are, in the same large urban or suburban area. In an effort to more effectively address this issue of access to anesthesia care here in Pennsylvania, I have attached two exhibits that speak to the distribution of both physician and nonphysician anesthesia providers here in the Commonwealth.

The data source for these charts was the Pennsylvania Bureau of Professional and Occupational Affairs, the American Medical Association and the American Osteopathic Association. I believe you'll find them quite helpful. Suffice it to say that operating rooms are now functioning quite safely as it relates to anesthesia care, I cannot imagine that any of your constituents have contacted you because of their inability to secure quality anesthesia care. There's a reason that your phones are not ringing.

Again, Mr. Chairman, thank you for this opportunity to share with you the Pennsylvania Medical Society's concerns about this legislation. To the best of my ability, I'll be happy to answer questions at this time.

CHAIRMAN MCGEEHAN: Thank you, Dr. Goodyear, for being here.

Are there questions for Dr. Goodyear?

(No response.)

Thanks very much, Doctor --

DR. GOODYEAR: Thank you.

CHAIRMAN MCGEEHAN: -- for taking time out of your schedule to be here and add to the testimony.

Our next testify -- testifiers -- pardon me; there's been a change -- Betsy Snook, she's the CEO of PSNA; and Guy Horning, he is a nurse anesthetist. Good evening.

MS. SNOOK: Good evening.

CHAIRMAN MCGEEHAN: Get comfortable and begin when you're prepared.

MS. SNOOK: Good evening, Chairman McGeehan, Vice Chairman Stevenson and members of the House Professional Licensure Committee. My apologizes that Dr. Henker could not make it today. He had some car trouble on the interstate early on the turnpike, so I will be just providing you with some very basic information. You can

read Dr. Henker's testimony. I wouldn't repeat it for you right now.

Just to let you know that I represent the Pennsylvania State Nurses Association. We are a statewide professional organization representing the interests of the 208 thousand registered nurses in this state, and we want to put on record that we support the legislative interests of the Pennsylvania's 11 thousand advanced practice nurses and the 40,200 CRNAs. And with that said, I will open the floor for any questions for Guy Horning.

MR. HORNING: My name is Guy Horning. I'm a nurse anesthetist. I would like first to address a recurring theme of today's hearing, and that's patient safety. That is the number one priority of nurse anesthetists and anesthesiologists, and to reiterate what has been -- Joe had said and Steve, we are not seeking independent practice with this bill. It is not our goal. It never was, and it never will be.

We are not removing physician involvement with anesthesia, whether it's an anesthesiologist or a surgeon. It's clear. It's in the bill. There was a comment made that anesthesia is the practice of medicine, and I'll refer you to the Federal Registrar. We cannot agree that anesthesia administration is the practice of medicine, and therefore, it can only be done after medical school

training. Moreover, the rule does not allow any provider to practice outside the perimeters of his or her professional license.

We are talking about the practice of nurse anesthesia, not the practice of medicine, and we need to be very clear about that. Regarding overall direction, that term has been thrown around a couple times today. That is in Regulation 123.7, and electronic communication exists in the State Board of Nursing regs in 21.17. There was also the question about reciprocity, and I have personally experienced reciprocity.

And I'll tell you where the loophole exists. I'm an administrator in a hospital. Throughout the CRNA shortage three years ago, we brought in 14 patient CRNAs. If you're not familiar with how that works, a hospital contract with a staffing agency, they credential the providers and send them to you. They do not go through any credentialing process at the state. They do apply for a temporary nursing license, which they can have for up to six months.

They have their CRNA certification from the Council of Accreditation, which is the national certifying board for CRNAs. In that six-month period, if they don't get their permanent license, anything that they do disappears. They can leave the state, and it happened to

me. One of our administrative coordinators detected that there was somebody practicing with an expired national certification. That would have been picked up by the State Board of Nursing day one. They would have never gained entry into the state.

That put patient safety at risk and also forced a hospital to basically to give out four months worth of bills from that CRNA's services. So this bill, by codifying our scope of practice, will give the State Board of Nursing to say you got to meet these requirements. We'll certify you to practice. That will give the hospitals a little bit of a safety barrier knowing that they already passed the litmus test. They're not getting unknown providers in the state.

Regarding the opt-out provision, 15 states have opted out. We're not asking for opt, but just to give you some clarification, most of these states, Kansas, Iowa, Nebraska -- California just opted out. California's not so rural, and it's just for a frame of reference. Military CRNAs, I served in the Army for nine years as a nurse anesthetist. When I would deploy to the field, there wasn't an anesthesiologist there. I was under the medical direction of a trauma surgeon.

And I never heard a complaint about my service, and that's how it is today. The men and women who serve

our military as nurse anesthetists are out there working under the medical direction of a surgeon, an orthopod, a general surgeon, not an anesthesiologist. To me, this bill comes down to just common sense. What we're asking for, and I'll reiterate, is nothing new. We want to take our regulation and just make it law, and I think that the Board would agree that there are definitely negotiating points here with the PSA.

I think that we agree on one thing right out of the gate, and that's patient safety. I also think we agree on another point, which is we are not asking to remove the physician requirement anywhere in this bill. Now whether that has to be defined better so it's clearly stated, I think that's fine, but again and again today, that's the recurring theme, we're trying to remove supervision. We are not. We don't want it.

CRNAs practice in a variety of settings in the state with anesthesiologists, with surgeons, in ambulatory surgical facilities, in hospitals. That's what we want to keep, but we also want the State Board of Nursing to have some teeth in regulating the practice of nurse anesthesia. And I'm not saying the State Board of Nursing creating independent practice. I'm talking about regulating who's coming into the state.

And further, New Jersey, which just

passed -- they have an advanced practice nursing law for CRNAs. I cannot practice there because I'm not an advanced practice nurse. So I'm locked out. Now, I don't want to go to New Jersey, but if I wanted to, I couldn't because Pennsylvania does not have a law which defines or gives us entitlement that says we are advanced practice nurses.

And I appreciate my anesthesiologist colleagues who respect our educational level. We've also taken some things here. We're graduate prepared now, four years of undergrad. In my case, I got two undergrad degrees, and I worked two years in an intensive care unit in inner city Philadelphia before I decided to become a nurse anesthetist.

I went out to the midwest and trained for three years in the situation where I had almost no anesthesiologists because I went to a program which was training people to go to underserved areas, but I came back to Pennsylvania because that's my home. And I'm going to stay here. By making this law, we have a better chance of keeping people here. I went around today and met with some representatives, and I was able to graphically show -- I had 14 students with me from Scranton, 14.

Thirteen were from out of the state and were leaving. Only one of those students who came to Pennsylvania to learn the art and science of nurse

anesthesia is staying. And that's not a firm commitment on her part. That's all I have to say. I'd be happy to answer any questions.

CHAIRMAN MCGEEHAN: Thank you, Mr. Horning, Ms. Snook.

The first question is Representative Gergely.

REPRESENTATIVE GERGELY: Just a couple quick, you said education and then moved forward from there. I think that should be defined to me so that we have incredible clarity what this is. It says that by 2015, we'll see that requirements rise to a clinical doctorate as directed by the National Council on Accreditation which oversees CRNA education. Can you please identify for me a clinical doctorate?

MR. HORNING: I believe what you're referring to is nurse anesthetists nationally striving to better their education, and it's not to pass themselves off as anesthesiologists. It's no different than medical physicians who were trained in medical school by Ph.Ds. They are people who knew anatomy, physiology, whatever. In nursing and in nurse anesthesia, the science is so complicated and the requirements are so stringent that it makes sense to have people trained at the doctorate level to teach people at the master's level.

There was a day when nurse anesthesia was simply

a certificate. There was a time before that where it was simply a handshake with a surgeon and you could do anesthesia. It's evolved, and our profession is evolving. And it's sort of what the public's calling for. They want to make sure that you're credentialed. It is not to pass ourselves off as anesthesiologists. We are nurse anesthetists, and we're very proud of that.

REPRESENTATIVE GERGELY: And this isn't necessarily any specific entity, but those states that have opted out have provided independent administration of this. We need to find, above and beyond these two entities, some studies that show if there is legitimate increase in patient safety from the administration of anesthesia without oversight so that this is a relevant discussion. I just, I want that.

I don't want it from -- no offense from the anesthetists, I don't want it from you. I don't want it from the anesthesiologists. I would ask this committee to find an independent study without anyone else to identify for this committee where this legitimately stands so we can look at this wholistically and fairly and not put one against the other.

Thank you.

CHAIRMAN MCGEEHAN: Thank you, Representative.

Any questions for Mr. Horning or Ms. Snook?

(No response.)

Thank you for being here for this very long day. Thank you for taking time out of your busy and important schedules.

MS. SNOOK: Thank you.

CHAIRMAN MCGEEHAN: Our last testifier is Carey Plummer, the President and Chief Executive Officer of Jersey Shore Hospital in Jersey Shore, PA.

Mr. Plummer, thank you very much for being here this evening.

MR. PLUMMER: Thank you, Mr. Chairman --

CHAIRMAN MCGEEHAN: Please be seated and begin when you're comfortable.

MR. PLUMMER: -- for allowing me to be here. I believe I am the last.

CHAIRMAN MCGEEHAN: You are, sir.

MR. PLUMMER: And, you know, in a malpractice case, it's the same way it ends up too, the professionals leave and the hospitals are left.

CHAIRMAN MCGEEHAN: You were patient with us certainly all day, and we're certainly here to hear your testimony.

MR. PLUMMER: I do not want to read the testimony that was submitted to you in writing earlier. It has been a long day for all of us. We've all heard a lot

of comments, personal opinions, professional justifications here this evening. And I believe that every one us in this room understands that the anesthesiologists and the CRNAs are all professionals and the healthcare industry would not survive without any of them. I'm also here to tell you that I've been a hospital CEO affiliated with rural and critical access hospitals for 27 years.

I have been the CEO of those hospitals for 25 years in Ohio and in Pennsylvania. I've been in Pennsylvania two-and-a-half years, and I'm here to tell you in my 24, 25 years of physician recruitment efforts, I have never been successful in recruiting an anesthesiologist to a rural hospital. Now, there's a reason for that: Number one, they don't want to be the lone ranger; number two, there's no night life, shopping centers, malls, those types of activities, cultural things in a rural community.

It takes a special person to live in the rurals of Pennsylvania. It takes a special person to live in the rurals of Ohio. Is the market there; is the business there? It certainly is, but recruitment of anesthesiologists for rural community hospitals is not going to happen. And in the State of Pennsylvania, I've heard numbers here today. I know for a fact, the number of anesthesiologists, the number of physicians in Pennsylvania are shrinking.

And why is that? It's because of the malpractice claims in the malpractice industry right now. I believe the number of CRNAs has gone steady in the State of Pennsylvania. We have tried for two years to recruit CRNAs, have been successful in recruiting one who we have on a locum tenens basis. And by the way, any hospital who would give privileges to a CRNA or a physician without making sure they were licensed and what they really were shouldn't be paid for services.

That's part of the hospital bylaws. No one comes to my hospital who does professional work without going through credentialing by the medical staff. CRNAs are a part of the Allied Health Division of the medical staff of the Jersey Shore Hospital. They're evaluated by physicians, and they're evaluated by peers.

I believe that's complying with the patient safety rules in Pennsylvania, and I believe that's a good judgment on the part of the Board of Directors of Jersey Shore Hospital or any other hospital in the State of Pennsylvania. Additionally, there's no physician that comes and practices medicine at Jersey Shore Hospital without being credentialed by the Credentialing Committee of the medical staff.

And given due process, it doesn't happen 10 days or 15. It usually takes 60. I'm here to tell you that the

rural hospitals in the State of Pennsylvania or anywhere in the United States need the CRNAs. I'm here to ask you to consider what your own Department of Health rules are. Do not write another law if you don't have to, but your own Department of Health law says CRNAs can function and provide anesthesia under the supervision of an M.D. or a D.O. It very explicitly says that. It doesn't say anything about doctor.

It doesn't say anything about physician. It says M.D. or D.O. They do not have to be under the supervision of an anesthesiologist. That's been discussed here a lot today. But they do have to be under the supervision of an M.D. or a D.O. In our hospital, before we recruit surgeons -- and I've recruited two since I've been in Jersey Shore -- we make them aware that when they come in, they're going to be responsible for the actions of that CRNA so they're not blind sided.

Could we recruit more surgeons? Yeah, if we had an anesthesiologist, but we're not going to get one. We know that. We've tried too hard. I want to address next the issue of cost. We're all concerned about healthcare costs. For Jersey Shore Hospital to provide anesthesia services, per the Department of Health guidelines, it would cost us over a million dollars a year.

Right now, Jersey Shore Hospital provides

anesthesia coverage per the Department of Health guidelines, your Department of Health guidelines. It would cost me about $450 thousand a year because we do it with CRNAs. Now, to be fair to the anesthesiologists and everyone else in this room today, we don't do brain surgery. We don't do neurological surgeries. We don't do those kind of surgeries, and we never will.

Your community hospitals provide general surgery, orthopedic surgery. And when you make whatever regulation you're going to be making, don't shut the door on your rural hospitals of what they can and can't do when it comes to these surgeries. There's no reason anyone should have to leave Jersey Shore to have a simple appendectomy.

There's no reason anyone should have to leave Jersey Shore to have a hip replacement as long as you've got skilled professionals working in your surgery department and skilled professionals providing you anesthetics and, of course, skilled nurses taking care of that patient once they reach the recovery room.

I'm also here to tell you that in my 27 years or 26 years with hospital affiliation, not once has there been an anesthetic incident where we needed to, for anesthesia, the general surgeon needed to call an anesthesiologist in because you need to know the limits of what you can do in

your surgery department. I am here to ask you to support this bill as it is. I've heard it here today. Should there be some amendments to it now that I've sat here and heard all the discussion? Yeah, I believe now I might look at that a little different and ask for a little different wording in a couple of different places. And I want you to be careful -- and this is the hospitals in the State of Pennsylvania talking -- there's a difference between hospital surgery and ambulatory surgery centers.

And you need to put a limitation on what can be done in those ambulatory surgery centers because if you don't, they can become the highest risk areas in the medical field. I guess I've said my peace. One other thing I do want to say is quality and safety is always an issue when surgeries are done in a hospital.

The rural and community hospitals in the State of Pennsylvania, I believe historically, we will put them up against any hospital as far as the quality and safety standards in the state or any other. I'll take any questions anyone might have for me right now.

CHAIRMAN MCGEEHAN: Well, I dare to say, Doctor -- pardon me -- Mr. Plummer, that your extemporaneous remarks were certainly profound, and I know why you're the CEO of a hospital today because of your expertise that you're sharing with us. Many of us don't

know the rural character of the state, and I come from a big city in Philadelphia. So I don't realize the unique means of rural communities and the dire lack of professional services that are afforded to these rural communities, and I think it's important to hear from you.

Your vast experience of 26 years as an administrator of Jersey Shore Hospital, it's important, and that map graphically speaks to some of the deficit of professional services that are available in some of our more rural communities. So we appreciate you coming out today.

Are there any questions for Mr. Plummer?

Yes, Representative Petrarca?

REPRESENTATIVE PETRARCA: One question. Thank you for being here. Am I correct in stating that hospital policies take president over the regulations that we discussed earlier, and what's your opinion on that?

MR. PLUMMER: Your impression is accurate because hospital policy has to follow Department of Health regulation, so hospital policy doesn't take president over that regulation.

The Department of Health regulation takes president over everything except CMS, Medicare, but our policy has to be written to comply with the Department of Health in order to receive licensure in the State of

Pennsylvania or in any other state for that matter. I might add also, our hospital is also joint commission accredited. Even though we're 25 beds, we do meet the standards.

REPRESENTATIVE PETRARCA: Okay. Thank you.

CHAIRMAN MCGEEHAN: Mr. Plummer, thank you very much for traveling from Jersey Shore, PA, to be with us and share your expertise with this committee and help us make a more informed decision. Thank you very much.

MR. PLUMMER: Thank you.

CHAIRMAN MCGEEHAN: As we conclude, I just have to add that I've been the Chairman, this is beginning my second year, and never more has the title of professional licensure as a committee been more profound to me. I'm in awe of the educational attainment and the professionalism, not just of the anesthesiologists, but the nurse anesthetists.

I was not part of this committee when I heard much of the testimony about how close we actually came to a compromise that would allow each of your outstanding professions to practice at the highest level of your education and professionalism. Working with Representative Gergely, I hope that this committee doesn't fall short this term. I want to applaud Representative Gergely for bringing this contentious issue and for having the guts to

take some of the slings and arrows that have been directed to him.

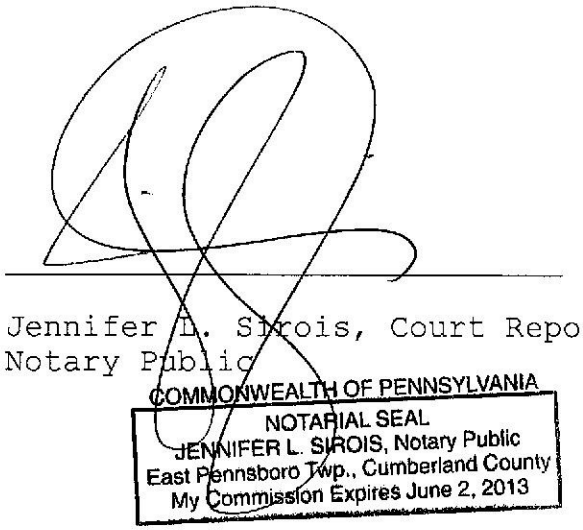
It's not because he's been a particular advocate for one cause or another, but wants to, I think, and I think the Committee shares it after hearing the testimony, again, finding a common ground where each of these outstanding professional fields can practice to the highest ability.

And I pledge to you, Representative Gergely, working along with Chairman Stevenson, hope to finally reach that goal that's been eluding us for some time now. I want to thank those who participated today for their patience in being here for what is a long day for taking time out of your important careers to share your testimony and to educate the Committee.

And to the Committee members after a long day, thank you for your attendance. And having said that, I'll adjourn this hearing of the House Professional Licensure Committee.

(The hearing was concluded at 5:56 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately to the best of my ability in the notes taken by me on the within proceedings, and that this copy is a correct transcript of the same.



Jennifer L. Sirois, Court Reporter,
Notary Public

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NOTARIAL SEAL
JENNIFER L. SIROIS, Notary Public
East Pennsboro Twp., Cumberland County
My Commission Expires June 2, 2013