Oppose:

A6771A (Reyes) / S357B (Cooney)

This bill would significantly alter New York State's established anesthesia care framework by **removing clear requirements for physician supervision, responsibility, and immediate availability for medical decision-making.** It replaces these basic patient safety standards with undefined terms and a lack of accountability, creating confusion about how care will be coordinated when patient conditions change or who is responsible for making critical medical decisions.

Eliminates Existing Standard of Safe Anesthesia Care

- Under New York's **existing standard of care, a physician anesthesiologist is required to be physically present and immediately available** when supervising a nurse anesthetist, ensuring that responsibility for patient care and medical decision-making is clearly established, reducing uncertainty in clinical settings and supporting consistent application of care standards across facilities.
- This legislation would allow a nurse anesthetist who has practiced more than 3,600 hours to work in an "interdependent role" as a member of a health care team in which the medical care of the patient is "overseen" by a physician, dentist or podiatrist. However, **these terms are not defined in the bill and do not require physical on-site presence of a physician anesthesiologist.**
- The bill also **expands prescriptive authority for nurse anesthetists,** including controlled substances, without clearly defining the scope, clinical context, or oversight under which that authority would be exercised. This represents a significant change from current anesthesia practice, where medication management occurs within a clearly defined and supervised care structure.

Creates a Disconnect in Patient Care Delivery

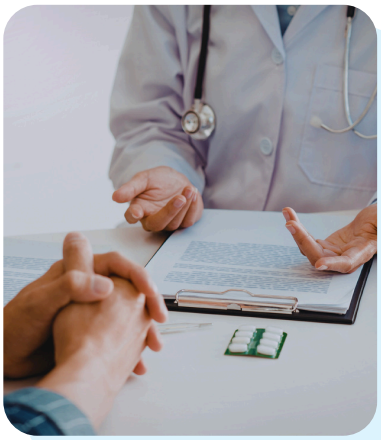
- Under New York's current regulations, a supervising physician anesthesiologist must be physically present and immediately available and **assumes medical and legal responsibility for the patient's care.**
- This bill **removes those requirements** and replaces them with **undefined concepts that do not establish who is responsible** for recognizing changes in a patient's condition or initiating timely medical intervention.
- This creates uncertainty in how care teams function in practice and **increases the potential for confusion** in the operating room. This lack of clarity can lead to **inconsistent practices across facilities**, particularly in office-based surgical settings where the physician's role is not clearly addressed in the bill.

Compromises Patient Safety

- It is essential to **preserve equal access for all patients to the physician-led supervision standard** of anesthesia care, which increases safe patient outcomes and reduces the risk of creating two-tiered delivery of anesthesia care.
- Evidence indicates that **reducing physician involvement in anesthesia care can increase the risk** of delayed recognition and response to complications, which are key drivers of **serious patient harm**.
- In 2024, the **Centers for Medicare and Medicaid Services revoked the accreditation of two hospitals** in California that allowed nurse anesthetists to practice without a physician's order and beyond the scope of their authority. There is proven patient harm when nurse anesthestists practice outside their scope and beyond their training.
- State investigations **identified numerous cases of patient injury**, including intraoperative deaths, and attributed these outcomes to inadequate oversight of anesthesia care. These findings **highlight the risks associated with care models that lack clearly defined supervision** and immediate availability of a responsible physician.

Does Not Expand Access to Care or Lower Healthcare Costs

- Research shows that expanding scope of practice alone **does not significantly increase rural access to anesthesia care** as most nurse anesthetists continue to practice in metropolitan areas, while physician anesthesiologists already provide care in many of these communities.
- **Medicare and Medicaid reimbursement for anesthesia services is the same** regardless of whether care is delivered by a physician anesthesiologist or a supervised nurse anesthetist, **limiting the potential for cost savings**. To the extent that changes in care models delay recognition or response to complications, they may also result in higher downstream costs driven by complications, longer hospital stays, and additional interventions.



Vote NO on bill A6771A (Reyes) / S357B (Cooney)

Without current clearly defined physician supervision requirements and the immediate presence of a physician anesthesiologist, clinical decision-making processes would be compromised and there is risk for delayed recognition and response to patient complications.

This bill is a dangerous erosion of patient safety standards that contradicts national best practices and puts lives at risk.

To find out more about protecting patient safety and anesthesia care, visit: www.safeanesthesia.com

Questions? Contact Babette Atkins, NYSSA Executive Director at 929-284-7202 or babette@nyssa-pga.org