Oppose:

A10606 (Hyndman) / S2302 (Bailey)

This bill would allow Certified Registered Nurse Anesthetists (CRNAs) to independently administer anesthesia, without a physician anesthesiologist physically present and immediately available to respond when a patient is in distress. It would allow a loosely defined "collaboration" model for anesthesia that lacks clear, enforceable standards for real time physician involvement.

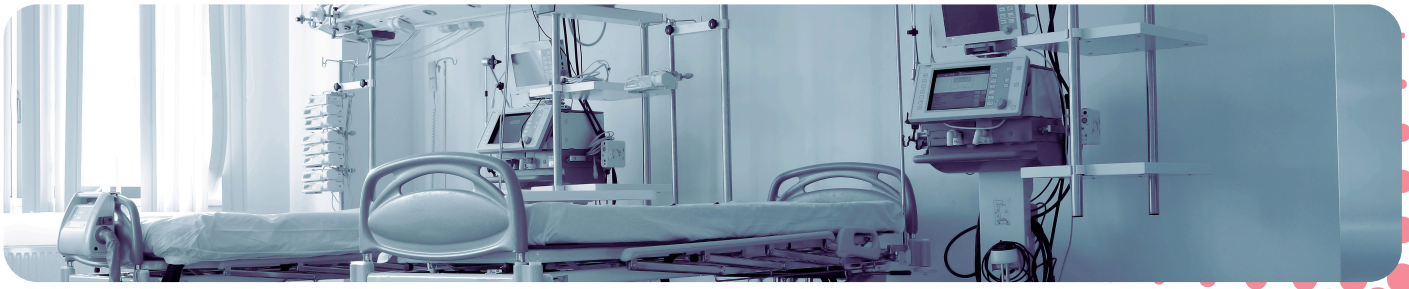
Creates a Two-Tiered Standard of Anesthesia Care

This bill permits physician involvement that is **remote, delayed, and insufficient for the realities of anesthesia care** by allowing arrangements where physicians are not on the same premises and requiring chart reviews infrequently as once every three months. **Patient safety cannot depend on retrospective review.** In anesthesia, complications unfold in real time and demand immediate, expert medical intervention.

By allowing hospitals and ambulatory surgical centers (ASCs) to grant nurse anesthetists a broader scope of practice that is **beyond their experience and training** through circumventing established credentialing procedures required by the New York State Health Code, **this bill will lower the standard of care and create a two-tiered delivery system.**

Inappropriately Expands Nurse Anesthetists' Scope of Practice

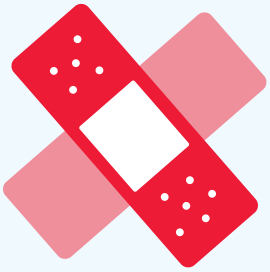
- This bill would **permit CRNAs to practice independently, including the right to prescribe narcotics and develop the anesthesia plan** during the "peri-anesthetic period," when **the role of a physician anesthesiologist is most critical** to assess the patient's tolerance for certain narcotics based on the patient's medical condition.
- Expanding **prescribing authority for CRNA without strong, immediate physician oversight introduces additional patient safety risks** at a time when New York continues to confront challenges to medication safety and opioid use.
- **Nurse anesthetists are not trained to provide independent practice** and they receive limited training on the use of narcotics.
- This bill proposes a dangerous expansion of nurse anesthetist practice that is **inconsistent with their training and contradicts national safety standards.**



Raises Patient Safety Concerns

- **Physician anesthesiologists, who have 12,000–16,000 hours of clinical training compared to a nurse anesthetist's 2,500 hours of clinical training,** are best able to diagnose, intervene and redirect care when needed. They perform a risk-benefit analysis and have the expertise and credibility needed to tell a surgeon whether surgery poses a danger to the patient.
- Nurse anesthetists are **valued members of the anesthesia care team, but they are not trained to independently manage the full spectrum of medical conditions** that can arise during anesthesia care.

Physician anesthesiologists
12,000–16,000 hours of clinical training



Nurse anesthetists
2,500 hours of clinical training

Does Not Provide Healthcare Cost Savings or Expand Access to Care

- Under Medicare and Medicaid, reimbursement for anesthesia services is exactly the **same whether it is administered by a physician anesthesiologist or by a nurse anesthetist.**
- Independent studies have shown that the odds of an **adverse outcome are 80% higher when anesthesia is provided only by a nurse anesthetist** as opposed to a physician anesthesiologist.
- Adverse outcomes **lead to higher costs for patients** in both monetary and physical terms when patients require longer hospital stays.
- According to a recent study in the peer-reviewed Journal of Rural Health, expanding scope of practice for a nurse anesthetist **does not improve rural access.**

The risks are simply too high. Put patient safety first by voting

NO on A10606 (Hyndman) / S2302 (Bailey)

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

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