

## Nurses, doctors locked in new battle

By SARAH AVERY, Staff Writer

North Carolina's doctors and nurses are once again locked in a legal wrangle over how anesthesia is given -- this time to patients during office procedures.

The matter, which became the subject of a lawsuit in Wake Superior Court this fall, has reignited a 10-year-old dispute that everyone thought had been settled.

At its most basic, the disagreement centers on the interpretation of two words: Collaboration vs. supervision as the basis of the doctor-nurse relationship in the specialized realm of anesthesia services.

Doctors, led by the N.C. Medical Society, think that certified registered nurse anesthetists, or CRNAs, can administer anesthesia care to patients undergoing outpatient procedures if the nurses are directly supervised by a physician -- a relationship that reinforces a hierarchy in which the doctor is ultimately in charge.

Nurse anesthetists, led by the N.C. Board of Nursing, contend that a 10-year-old rule enables them to perform anesthesia services "in collaboration with a physician," a relationship that acknowledges their expertise.

Both sides contend they have the patients' best interest at heart. Patients get anesthesia during major and minor operations, and the drugs that ease pain can also cause paralysis and death if administered incorrectly.

An estimated 30 percent of medical procedures are now done in doctor's offices, away from the trauma supports inherent at hospitals, according to the American Society of Anesthesiologists. As a result, the issue of by whom and how anesthesia is being administered has gained urgency.

"It's really easy to look at this as a turf issue, but it's not," said Dr. Gerald A. Maccioli, a Raleigh anesthesiologist and president-elect of the N.C. Society of Anesthesiologists. "It's really easy to look at this as a money issue, but it's not. It's really easy to look at this as a power issue, but it's not. This is about one thing and one thing only. It's about patient safety."

Nurse anesthetists administer about 65 percent of the 26 million anesthetics given to patients each year in the United States, reports the American Association of Nurse Anesthetists. And demand for their services at doctor's offices is growing along with the number of outpatient procedures. The trend is especially evident in the cosmetic surgery industry, where face-lifts and liposuctions are routinely done in doctor offices.

In those instances, CRNAs often do all of the anesthesia services -- figure out the drug dosages to induce unconsciousness, administer the anesthesia, monitor patients during surgery, return them to consciousness and manage their postoperative pain. Ultimately though, the nurse answers to a plastic surgeon whose expertise may not be anesthesia.

But the trend toward more office-based procedures predated any written rules governing them. It was the process of crafting those rules that sparked the current tiff.

"What we began noticing with office procedures was an increase in the complication rates that exceeded what we would have expected based on the patient population -- young, healthy patients with complications," said Dr. H. Arthur McCulloch, a Charlotte anesthesiologist and member of the N.C. Medical Board, which licenses and disciplines doctors.

### **A new position**

McCulloch said the Medical Society formed a task force to draft guidelines for office-based procedures. The guidelines included this declaration: "Anesthesia should be administered by an anesthesiologist or a CRNA supervised by a physician."

The guidelines were adopted last January by the medical board as a position statement, which the board uses as a clarification of the rules of medical practice.

Even before the position paper was adopted, however, nurses bristled at the use of the word "supervision." That language, they argued, undermined the training and expertise of CRNAs.

Instead of supervision, the nurses prefer the term "collaboration," which they have defined as a process in which both doctors and nurses contribute expertise.

"This is a turf war," said Howard A. Kramer, attorney for the nursing board. "Part of it is ego, and the other part is reimbursement by the feds" through Medicare and Medicaid programs that offer nurse anesthetists direct reimbursements for services.

Kramer said doctors fear that CRNAs will usurp business: "It's less expensive to pay them than anesthesiologists."

The nurses complained that the doctor's position statement ignored a hard-fought agreement that was reached 10 years ago. Back then, the nurses had

drafted a rule for anesthesia services that focused on collaboration, doctors sued to demand supervision, and the matter was resolved by a 1994 consent order.

In the agreement, the nurses were allowed to adopt a rule that spoke of the collaborative approach between doctors and CRNAs. But the nurse's rule also specifically noted that nurses could neither prescribe treatment nor make a diagnosis except under a doctor's supervision.

The truce held, until this year.

"For close to 10 years, the medical board has taken no action against any physician, anesthesiologist or surgeon for working in collaboration with a CRNA," Kramer said. "By adopting this position paper, we feel that they have violated the consent agreement."

### **Case arises**

One case, however, did come to the medical board's attention as the new guidelines for office-based procedures were being drafted.

In 2001, a patient undergoing a mini-face-lift in a Charlotte plastic surgeon's office died after a nurse anesthetist gave a dose of narcotic during recovery. The surgeon, Dr. Peter Loren Tucker, was punished by the board in November for failing to supervise the nurse anesthetist who administered the fatal dose.

"Did that appear to underscore the need for guidelines?" McCulloch asked. "Absolutely."

Initial arguments have been presented in the case, but a judge has not made any rulings.

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