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ASA President Offers 7 Reasons to Question Anesthesia Cost-Containment Study

Written by Rob Kurtz | July 01, 2010

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35

Alexander A. Hannenberg, MD, president of American Society of Anesthesiologists, discusses his thoughts and observations regarding the recent study by The Lewin Group, published in the [Journal of Nursing Economics](#), claiming the certified registered nurse anesthetist-only anesthesia model is the most cost-effective anesthesia model for delivery.

1. Scope of services provided by a physician anesthesiologist and CRNA is not equivalent. "Physician anesthesiologists provide critical care medicine services, pain management, preparation of medically complex patients in addition to after-hours and on-call coverage," says Dr. Hannenberg.

2. Comparison of outcomes invalid. "The types of procedures and patients for which data exists for "solo" CRNA care is heavily weighted toward lower complexity procedures because of patient, surgeon and facility preference for physician care of the more serious procedures and fragile patients," says Dr. Hannenberg, invalidating the data because of this bias.

3. CRNA's rarely go "solo" when administering anesthesia. There are only a few states that exempt from the federal standards requiring the surgeon performing the procedure to oversee the CRNA administering anesthesia. "Characterizing the CRNA practicing in the absence of an anesthesiologist as "solo" is a misnomer: the operating surgeon is responsible for providing medical supervision of the nurse anesthetist," says Dr. Hannenberg.

4. Use of CRNAs as sole providers could cost more for Medicare patients. In the case of Medicare, the fees for CRNA-provided anesthesia and physician anesthesiologist care are exactly equal, so there would be no cost savings if the model were adopted in the Medicare population, says Dr. Hannenberg. "The overall cost may actually be greater because of CRNA need for medical consultation and studies to assess co-existing medical conditions" he says.

5. CRNA and physician compensation not an apple-to-apple comparison. The compensation figures for CRNAs and physicians assume equivalent work hours, but this is untrue and hours beyond 40 per week substantially increase employment costs of CRNAs, says Dr. Hannenberg. "Any facility with a need for coverage of after-hours or on-call cases would experience significantly greater CRNA costs because of overtime compensation, virtually never a factor for physician coverage," he says.

Furthermore, it should come as no surprise that the typical earnings in all occupations correspond to level of training and responsibility: anesthesiologist training and responsibility greatly exceeds that of CRNA. "The conclusion that using lesser-trained personnel might reduce costs is hardly startling, says Dr. Hannenberg.

"Substituting non-specialist registered nurses or technicians for CRNAs would reduce costs further."

6. Study is unsubstantiated, inaccurate and questionable. The CDC concluded in 1980 that a comparative outcomes study was unachievable, as the authors note, because of the low frequency of major adverse events, says Dr. Hannenberg. "Such a study is substantially further from reach now when adverse events occur at a frequency less than one-tenth of the 1980 rate," he says.

Dr. Hannenberg also notes that the study misrepresents the time required for anesthesiologist training; the authors have dual conflict of interest as they are employed by subsidiary of United Healthcare and under contract to the American Association of Nurse Anesthetists; and the use of the Ingenix database as source for outcome analysis is questionable as the database is fraudulent, discredited and outlawed.

7. Patients prefer physician anesthesiologists. "Patients overwhelmingly demand, for good reason, that a physician anesthesiologist be responsible for their anesthesia care," says Dr. Hannenberg. He cites a 2001 study by The Terrance Group, titled "National Anesthesia Study III: A Survey of Public Opinion Attitudes," which revealed that 70 percent of all respondents (and 77 percent of Medicare beneficiaries) would oppose allowing a nurse anesthetist to administer anesthesia without medical supervision if an MD could supervise the nurse at no additional cost to the patient. Sixty-three percent of all respondents (and 70 percent of Medicare beneficiaries) opposed the decision to drop the requirement for anesthesia supervision by a doctor.

Final thoughts from Dr. Hannenberg

"Anesthesiologists are physicians who oversee the broad practice of anesthesia in hospitals and medical centers," says Dr. Hannenberg. "We stand for access to safe and leading care for patients. We've gone through years and years of rigorous training in medical school, internships, residencies and fellowships. Anesthesiologists provide critical knowledge and expertise needed to keep total watch over the human body, to keep people stable and intervene when they are not. We are the leaders of anesthesia care teams which include CRNAs. The role of the anesthesiologist is to keep watch over a patient's vital health when he/she is at his/her most vulnerable. We take pride in this role each and every day."

Learn more about the [American Society of Anesthesiologists](#).

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