State of New Hampshire
Supreme Court

Docket No. 2019-0716

Appeal of
New Hampshire Association of Nurse Anesthetists

Rule 11 Petition
From the New Hampshire Board of Medicine

Brief of American Medical Association and American Society of Anesthesiologists as *amici curiae* in support of Respondents

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Introduction

Anesthesiology is a physician specialty and is the practice of medicine. As such, the title anesthesiologist has always been used solely by physicians. A nationwide survey by the American Medical Association has demonstrated the public knows that anesthesiologists are physicians.[1] The Board of Medicine's (BOM) ruling correctly recognized what is well-known and accepted throughout the country. The title of Certified Registered Nurse Anesthetist (CRNA) has always been reserved for those nurses with specialized training in anesthesia care, and in fact, the *amicus* brief of the American Association of Nurse Anesthetists (AANA) filed in support of the petitioner makes that clear. A decision by this Court to the contrary would make New Hampshire an extreme outlier and open the state to other inappropriate challenges to accepted medical specialty titles and terminology.

While there is no question about the level of service and professionalism CRNAs bring to anesthesia care, they are not anesthesiologists, in the same way nurses are not physicians. Overruling the decision of the BOM would do nothing to improve patient care. Rather, allowing the proposed title of "nurse

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[1] *See* App. 4-5, American Medical Association, *Truth in Advertising Survey Results* (2018), *available at* https://www.ama-assn.org/delivering-care/patient-support-advocacy/truth-advertising (hereinafter, AMA, *Truth in Advertising*).

anesthesiologist" would confuse patients and the public about the education and role of CRNAs as well as place an unnecessary burden on patients to decipher whether their health care professionals are physicians or nurses. *Amici* respectfully submit that the BOM ruling was proper and well-founded, and it should be allowed to stand.

Interest of *Amici Curiae*

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state, including New Hampshire. The AMA opposes any misappropriation of medical specialties' titles and supports that nonphysician providers use only the titles and descriptors that align with the nonphysician providers' state issued licenses.

The American Society of Anesthesiologists (ASA) is a national, nonprofit association of more than 54,000 anesthesiologists organized to raise and maintain the standards

of the medical practice of anesthesiology and improve the care of patients. Since its founding in 1905, ASA has functioned as a research, scientific, and educational resource for anesthesiologists, patients, the public, and policymakers and has continuously provided highly respected guidance and expertise, particularly regarding patient safety matters. ASA was the first medical organization to create a foundation focused on patient safety–the Anesthesia Patient Safety Foundation, founded in 1985. In 1986, ASA was also the first medical specialty to adopt standards of care for its members.

ASA's achievements have made it an important voice in American medicine and the foremost advocate for all patients who require anesthesia, critical care, or pain relief. The majority of practicing anesthesiologists in the United States belong to ASA, making it the preeminent voice of the specialty.

The AMA and ASA strongly believe use of the term anesthesiologist should be limited to qualified physicians, and that CRNAs should only use the titles that align with their nursing license, education and training (such as "nurse anesthetist" or "certified registered nurse anesthetist"). Use of the title "nurse anesthesiologist" is a risk to patient safety, as patients may provide consent to who they believe is a medical doctor but is instead a CRNA.

Argument

Health care in this country takes an incredible team of individuals committed to the best interest and care for their patients. The system relies on specialized physicians, and practitioners,[2] such as nurse practitioners, physician assistants, and clinical social workers, each contributing their unique skill set commensurate with their education and training to ensure the safe and optimal level of patient care. Petitioner and *amicus* American AANA are asking this Court and the State of New Hampshire to ignore the unique education, training, and licensure among health care professionals, simply so CRNAs can be referred to as "nurse anesthesiologists."

But to ignore the "degree of the healthcare provider" would be absurd. AANA Br. at 1. In fact, the difference in education and training between a CRNA and an anesthesiologist is vast, and for good reason, as anesthesiologists are charged with medically managing and preventing negative outcomes that might occur while a surgical patient is under anesthesia. Indeed, patients understand that anesthesiologists are physicians, and allowing CRNAs to now change a title that has been in place for 150 years would confuse and undermine the delivery of care. *Id.* Creating such a change would not only move New Hampshire out of step

[2] *See* 42 U.S.C. § 1395u(b)(18)(C) (defining "practitioners" under the Medicare program).

with the rest of the medical field and the country on this issue, but it would also open itself up to further attack by practitioners who wish to alter the nature of medical professional titles for their own gain. Petitioner and *amicus* AANA have failed to demonstrate that the BOM's decision was unlawful, and if anything, have shown exactly why this Court should not disturb its ruling.

I. Anesthesiologists receive extensive education and training to medically manage patient care and prevent or respond to negative outcomes for those receiving anesthesia.

Few professions require "more careful preparation by one who seeks to enter it than that of medicine." *Dent v. State of West Virginia*, 129 U.S. 114, 122 (1889). Although CRNAs are valued members of anesthesia care teams, there is no question that they are without the formal medical education and training necessary to meaningfully and comprehensively medically manage anesthetized patients. *Amici* do not suggest that CRNAs are not highly trained, as described by the petitioner's *amicus*, nor diminish their accomplishments and effort, but they simply do not endure the same rigorous and expansive medical education that anesthesiologists receive. This is not just about the act of *administering anesthesia*, as the AANA brief suggests, *see* AANA Br. at 11-12, but also preventing and responding to a host of possible issues, complications, and complex situations that anesthesiologists must manage. Formal education, training, and

experience are critical in the medical field and should not be cast aside here.

a. Anesthesiologists undergo significantly more formal education and training than CRNAs.

From every meaningful metric, the education and training of an anesthesiologist is more expansive than for CRNAs. Nurse anesthesia education and training ranges from four to six years after high school. CRNAs trained in the past two decades have obtained a baccalaureate degree in nursing (four years), worked a minimum of one year in an intensive care setting, and then participated in an approximately 30-month anesthesia training program, graduating with a master's degree. However, there are still those practicing who never graduated from college. For example, an independent 2011 workforce report in Colorado showed 39 percent of nurse anesthetists held no graduate degree. This includes those with a two-year associate's degree in nursing and a "certificate" or other non-degree diploma in nurse anesthesia.[3] CRNAs average about 2,000 hours of patient care training in their curriculum.

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[3] *See* App. 18, Colorado Health Institute, *A Profile of Colorado's Advanced Practice Nurse Workforce* at 13 (2012), *available at* https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHI_2010_APN_Workforce_Survey_Report_Revised_Jan_20121.pdf.

Conversely, a physician's education and training spans at least 12-14 years after high school. For example, to become an anesthesiologist, a physician must complete a bachelor's degree with a pre-medicine curriculum (four years) and medical school (four more years). Only then does a physician begin their specialty residency training in anesthesiology (four years), which includes broad education in fundamental clinical skills of medicine relevant to the practice of anesthesiology including internal medicine, surgery, pediatrics, critical care medicine, and emergency medicine. After residency, many anesthesiologists also complete subspecialty training (one to two additional years after residency) in areas including: pain medicine, cardiac anesthesia, pediatric anesthesia, neuroanesthesia, obstetric anesthesia, or critical care medicine. Altogether, anesthesiologists have anywhere from 12,000-16,000 hours of patient care training in their curriculum. This results in anesthesiologists accomplishing twice the educational years and five times the clinical hours compared to CRNAs, in order to practice medicine.

Equally important as the difference in education and training is the difference in depth of knowledge. Physicians complete all courses relevant to the practice of medicine, including associated laboratory courses, as well as specialized courses and clinical care focused on the practice of anesthesiology. The breadth of courses plus the duration and

hours of course work allow for both detailed, comprehensive medical knowledge and specialized knowledge in the practice of anesthesiology. CRNAs take selected courses related to anesthesia. The limited number of courses and narrower focus, plus the shorter duration and fewer hours CRNAs receive does not allow for this detailed, comprehensive medical knowledge.

CRNAs' education and training are consistent with their role within the care team. Anesthesiologists are educated and trained to assume full responsibility for the medical needs of the patient and to lead the patient care team. Throughout an anesthesiologist's decade or more of education and training, they are closely guided, supervised, and tested by medical faculty, while gradually gaining greater independence as they demonstrate the clinical acumen, knowledge, and ability to meet the clinical trust given to them by their patients. An anesthesiologist has been educated, trained, tested, and re-tested countless times, with years and years of classroom and clinical experience to ensure the development and maintenance of the medical expertise and split-second critical decision-making skills required to address immediate and long-term patient care needs. CRNAs, on the other hand, are trained to work within the physician-led care team, under physician supervision. Their nursing-based training, with its limited classroom duration and

dramatically fewer hours of clinical training, does not allow for detailed, comprehensive medical knowledge.

b. The difference in education and training is necessary because of the greater role and responsibility entrusted to anesthesiologists over CRNAs.

The medical practice of anesthesia extends far beyond the administration of the drugs needed to perform surgery. Before surgery, anesthesiologists, individually or working with their care team members of CRNAs and anesthesiologist assistants, ensure patients are optimally prepared for surgery by addressing underlying medical problems. During surgery, the anesthesiologist is the medical expert monitoring the anesthetized patient's brain, heart, lungs, kidneys, and more. Should any medical complications arise during surgery, the anesthesiologist is prepared to address the problem. After surgery, the anesthesiologist similarly ensures the patient's medical needs are addressed in the post-anesthesia care unit.

Though *amicus* AANA argues that CRNAs should be viewed as an "independent anesthesiology practitioner," AANA Br. at 28, that is simply false. Critically, there are no well-designed, peer-reviewed outcomes studies on the practice of unsupervised CRNAs. In fact, a 2014 internal evaluation by the U.S. Department of Veterans Affairs' (VA) Quality Enhancement Research Initiative (QUERI) raised significant questions about the safety of the "solo CRNA" or nurse-only model of anesthesia.

After reviewing existing studies, even including self-funded nursing advocacy studies, the VA concluded the evidence did not prove it would be safe to implement nurse only models of anesthesia, specifically questioning "whether more complex surgeries can be safely managed by CRNAs."[4]

An independent outcomes study published in the peer-reviewed journal *Anesthesiology* found that the presence of an anesthesiologist prevented 6.9 excess deaths per 1,000 cases when an anesthesia or surgical complication occurred.[5] CRNAs often advocate that substituting nurses for physicians cuts costs without increasing patient deaths or complications, but independent studies have shown that the odds of an adverse outcome are 80 percent higher when anesthesia is provided only by a CRNA, as opposed to an anesthesiologist.[6] Additionally,

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[4] *See* App. 93, Dept. of Veterans Affairs, Health Services Research & Dev. Service, *Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses* at 15 (Sept. 2014), *available at* https://www.hsrd.research.va.gov/publications/esp/ap-nurses.pdf.

[5] *See* App. 124-135, Dr. Jeffrey H. Silber, *et al.*, *Anesthesiologist Direction and Patient Outcomes*, Anesthesiology at 152-163 (2000), *available at* https://anesthesiology.pubs.asahq.org/article.aspx?articleid=1945839.

[6] *See* App. 113-123, Dr. Stavros G. Memtsoudis, *et al.*, *Factors influencing unexpected disposition after orthopedic ambulatory surgery*, Journal of Clinical Anesthesiology at 89-95 (Mar. 2012), *available at*

adverse outcomes lead to higher costs for patients in both monetary and physical terms.

As recently as 2018, the World Health Organization's International Standards for a Safe Practice of Anesthesia highly recommended that an anesthesiologist should lead or oversee anesthesia when administered. [7] Per the WHO Standards:

> Anesthesia is a vital component of basic healthcare and requires appropriate resources. Anesthesia is inherently complex and potentially very hazardous, and its safe provision requires a high level of expertise in medical diagnosis, pharmacology, physiology, and anatomy, as well as considerable practical skill. Therefore, the WFSA views anesthesiology as a medical practice. Wherever and whenever possible, anesthesia should be provided, led, or overseen by an anesthesiologist (HIGHLY RECOMMENDED). When anesthesia is provided by non-anesthesiologists, these providers should be directed and supervised by anesthesiologists, in accordance with their level of training and skill. When there are no anesthesiologists at a local level, leadership should be provided by the most qualified individual. Policies and guidelines consistent with this document should be developed at

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3303976/pdf/nihms-347862.pdf.

[7] *See* App. 104-111, Adrian W. Gelb*, et al., World Health Organization-World Federation of Societies of Anaesthesiologists (WHO-WFSA) International Standards for Safe Practice of Anesthesia*, Anesthesia & Analgesia at 2047-2055 (June 2018), *available at* https://journals.lww.com/anesthesia-analgesia/Fulltext/2018/06000/World_Health_Organization_World_Federation_of.39.aspx.

> a local, regional, or national level by a team of anesthesia providers led by an anesthesiologist.[8]

The decision to distinguish between CRNAs and anesthesiologists reflects the broad difference in their formal education, training, and experience, and this Court should reject the attempts by the petitioner and *amicus* AANA to ignore these critical differences between the two.

II. Allowing nurses anesthetists to refer to themselves as anesthesiologists creates significant patient confusion that could lead to negative health outcomes.

Due to the wide variety of providers who work in health care settings, patients can be easily confused and misled regarding who is providing their care. *Amici* are concerned that reversing the BOM decision here would magnify that confusion. When making important health care decisions, patients deserve complete clarity about the title, license, training, and education of their health care provider. It is vital that all health care providers use only the titles and descriptors that align with their license, education, training, and board certification, and as such, the BOM decision here is correct.

The use of the term "nurse anesthesiologist" combines a nursing title with a medical title, making it difficult for the layperson to determine if the individual is a nurse or a physician. It is commonly understood, and many professional health care

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[8] App. 107, *Id.* at 2050 (capitalization in original).

organizations have agreed, that anesthesiology is the practice of medicine. For example:

- The World Health Organization views "anesthesiology as a medical practice" that should be directed and supervised by an anesthesiologist.[9]
- AMA policy is that "anesthesiology is the practice of medicine."[10]
- The Council on Accreditation of Nurse Anesthesia Educational Programs, the accrediting agency for CRNAs, defines "anesthesiologist" as a "doctor of medicine (MD) or doctor of osteopathy (DO) who has successfully completed an approved anesthesiology residency program."[11]

When introduced to their "nurse anesthesiologist," patients may only hear the title anesthesiologist and believe that their

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[9] App. 107, *Id.*

[10] App. 3, American Medical Association*, Anesthesiology is the Practice of Medicine H-160.929, available at* https://policysearch.ama-assn.org/policyfinder/detail/H-160.929?uri=%2FAMADoc%2FHOD.xml-0-744.xml.

[11] *See* App. 60, Council on Accreditation of Nurse Anesthesia Educational Programs, *Standards for Accreditation of Nurse Anesthesia Educational Programs* at 27 (2019), *available at* https://www.coacrna.org/wp-content/uploads/2020/01/2004-Standards-for-Accreditation-of-Nurse-Anesthesia-Educational-Programs-revised-October-2019.pdf.

provider is a physician, not a CRNA with far less education and clinical training, as discussed above.

Today, more than ever, patients are expected to play a greater role in their health care decision-making. Yet, patients are often confused about who is providing their health care. Patients, however, clearly understand the difference between an anesthesiologist and a CRNA. Based on a recent study conducted by the AMA, 70 percent of patients recognized an anesthesiologist as a physician, and 71 percent responded that a nurse anesthetist was not a physician.[12] This provides strong evidence that patients understand the difference between these two professions. Allowing CRNAs to now use the term "nurse anesthesiologist" muddies the waters and will serve to further confuse patients. At the very least, it does nothing to clarify the distinction between the professions for the remaining 29-30 percent of the public that do not recognize the difference.

In fact, the AANA *amicus* brief and its public survey on terminology demonstrates that individuals give weight to the term anesthesiologist as the expert in the field of anesthesiology. AANA Br. at 15-16, App. 256. Tellingly, nearly half of those surveyed could not say with certainty that someone referring to themselves as "nurse anesthesiologist" is a member of the nursing profession. *Id.* Such confusion does not support the use of

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[12] *See* App. 4-5, AMA, *Truth in Advertising*.

"nurse anesthesiologist," as *amicus* AANA and the petitioner certainly hope, but rather counsels in favor of reserving the term specifically for physicians.

Amicus AANA also cites to a handful of court decisions in which "nurse anesthesiologist" was used, but here too, they unwittingly provide evidence that the BOM's decision was correct. Though the cases they cite use the term "nurse anesthesiologist," they are only a few of the 83 total cases on the Westlaw service that use the term. But, when one searches instead for CRNA, there are more than 850 results, and moreover, when one searches for nurse anesthetist, there are more than 2,200 results. While the volume of Westlaw search results does not holder greater weight than the well-founded BOM ruling, it demonstrates that the cherry-picked examples from the petitioner and *amicus* AANA similarly should not undermine the BOM decision. It also demonstrates that the large majority of states and courts refer to CRNAs using the accurate terminology that properly aligns with their profession, education, and training.

Health care professionals should strive to ensure clarity of care team members for their patients which is why proper use of the term anesthesiologist is vital. If patients confuse CRNAs with anesthesiologists, they may consent to receiving anesthesia believing they are under the care of a medical doctor, not a nurse.

The use of inaccurate and confusing titles removes the patient's informed choice of provider and their ability to provide informed consent. This confusion could lead to understandable complaints and even significant litigation from patients who, if something goes awry during surgery, may claim they never properly consented to receiving anesthesia for the procedure. The risk of exposure to future litigation for health care professionals and facilities in allowing CRNAs to inaccurately use the term anesthesiologist is significant.

III. Reversing the decision of the Board of Medicine will make New Hampshire an extreme outlier and open to further overreach and abuse in professional titles and regulation.

Not only is the BOM's ruling supported by evidence regarding the differences in education, training, and experience between CRNAs and anesthesiologists and public understanding of the terms, but it is also consistent with professional board practices around the country. Indeed, *amici* are not aware of, nor has the petitioner or *amicus* AANA cited, any decision from any court that has approved the tactics employed by the petitioner and Board of Nursing (BON) in this case. Doing so here would place New Hampshire outside of the established mainstream and may open itself up to weaponized licensing boards and numerous battles such as this one.

First, the BOM decision here is perfectly aligned with medical licensing boards around the country. In fact, it is the

BON decision that is out-of-step, as *amici* are aware of only one other nursing board in one other state, Idaho, that has taken steps to allow the use of "nurse anesthesiologist" among its members. One other nursing board in Florida has sanctioned the term for use only by one individual member in the entire state.[13] Thus, this Court would be well within the mainstream in upholding the BOM ruling here.

Second, if the Court allows the "nurse anesthesiologist" title to be used and approves the way it was adopted, it may open the floodgates for manipulation of many more medical titles, making it nearly impossible to determine the nature of a provider's license, education, and training based on their title. If CRNAs are successful here, other non-physician providers may also attempt to alter medical specialty titles in the future, leading to confusing titles like "nurse cardiologist," "nurse pediatrician," and "nurse dermatologist." Patients may only hear the associated medical titles and make inaccurate assumptions about the

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[13] Similar to New Hampshire, these nursing boards did not seek guidance from the legislature or even the public in their unilateral actions. Idaho did not request public input for its position statement to allow use of the term "nurse anesthesiologist," which to date has not been publicly issued. The Florida Board of Nursing similarly prevented public input by denying as intervenors the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Society of Anesthesiologists, and the Florida Association of Nurse Anesthetists.

education and training of that health care professional, potentially resulting in lack of informed patient consent. Ultimately, the burden should not be on the patient to decipher the type of professional treating them.

Occupational licensing boards, including state boards of nursing and boards of medicine share a common mission: to protect the health, safety and welfare of the public. *Amici* strongly believe that allowing CRNAs to refer to themselves as "nurse anesthesiologists" is both misleading and confusing and does not further the mission of protecting the health, safety, and public welfare of the citizens of New Hampshire.

Conclusion

Amici American Medical Association and American Society of Anesthesiologists respectfully request that this Court find that the Board of Medicine's ruling was proper and lawful and deny the petitioner's attempt to add confusion and misinformation to the medical practice of anesthesiology in the State of New Hampshire.

Date: July 8, 2020

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Certification Pursuant to Rule 16(11)

I certify this brief complies with the word limitation in Supreme Court Rule 16(11) of 9,500 words. This brief contains 3,910 words, exclusive of pages containing the table of contents, tables of authorities, and the appendix.

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Certificate of Service

I hereby certify that on July 8, 2020, a copy of this Brief of *Amici Curiae* American Medical Association and American Society of Anesthesiologists was served electronically using the Court's electronic filing system.

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