# Anesthesiologist Assistants Gain Ground on Physician Extender Map

New York—Another group of nonphysician providers is stepping in to fill the empty spots in anesthesia departments—bolstering the country's much-needed anesthetist services, but also adding fuel to an ongoing battle over who is qualified to do what with anesthesia.

*'I work in a rural hospital where anesthesiologist assistants are utilized more for high-risk procedures. The anesthesiologists are our supervisors and the AAs and CRNAs are used interchangeably.'*

**—Joe Mader, MSA**

Anesthesiologist assistants (AAs), specialized physician extenders who work directly under the supervision of an anesthesiologist, are taking on a bigger role in the provision of anesthesia in hospitals and ambulatory care centers. They now practice in 17 states, with Florida and the District of Columbia opening their doors to AAs within the past 18 months. What AAs are allowed to do varies from center to center and from state to state, but includes some of the more advanced anesthesia procedures that nonphysicians can perform. AAs provide anesthesia for advanced cardiac care cases, lung biopsies and even liver transplants.

"Ten years ago, we weren't really on the map. Now we're operating in different states, and more people are aware of what we can do," said Joe Mader, an AA at the 200-bed Mercy Hospital in Springfield, Ohio. He works in a physician group with four anesthesiologists, four certified registered nurse anesthetists (CRNAs) and another three AAs. "I work in a rural hospital where AAs are utilized more for high-risk procedures. The anesthesiologists are our supervisors, and the AAs and CRNAs are used interchangeably," said Mr. Mader in an interview with *Anesthesiology News.*

Nationally, AAs account for 1% to 3% of all anesthesia providers—and that figure is rising. An estimated 900 AAs now work in the United States—an increase of at least 200 from five years ago. Educational trends indicate an even bigger jump over the next five years. The number of schools offering certified programs will double, from two to four. Sixty new AAs graduated in June 2005, representing a 50% climb from last year, and the number of graduates per year will double again by 2008.

A scan of Internet job sites suggests that there are more job openings for AAs than AAs matriculating this year. According to Donald Biggs, the president of the American Academy of Anesthesiologist Assistants, graduates are in hot demand.

"There is no end in sight. We're graduating more this year than we ever did, and those people are getting multiple job offers. There has been talk about graduates getting 10 job offers," said Mr. Biggs, an AA and the Chief Anesthetist at Emory University in Atlanta.

Despite their recent popularity, AAs have worked in the United States for 30 years in relative obscurity, limited to practicing in a handful of states. A shortage of anesthesiologists has now changed all that. In March 2003, the American Society of Anesthesiologists (ASA) officially endorsed the hiring of AAs as a way to augment anesthesia services. Since then, more states have extended practice privileges to AAs and more anesthesiologists have looked to the nonphysician providers to join the anesthesia care team, said Steven Goldfien, MD, an anesthesiologist in private practice in San Francisco and a member of the ASA committee on Anesthesia Care Teams. "What's changed is [the] shortage of personnel, both physician and nonphysician. We are experiencing a shortage of all types of providers," he said.

Thales Pavlatos, MD, Director of Anesthesia at Mercy Medical Center in Springfield, Ohio, said his hospital would be short-staffed without AAs. "In this environment, where there is a shortage, they are able to augment our services. It helps us run more rooms. Patients get better care when there are a couple of people involved."

In fact, anesthesiologists have proven to be one of the biggest drivers for the emergence of AAs in the workforce. In several states where AAs were recently approved for practice, anesthesiologists looking to hire AAs initiated the legislative drive.

Not all anesthesia providers, however, have been as welcoming. CRNAs have opposed the emergence of the AA. By all accounts, it has been an ugly political battle between the two groups, with CRNAs fighting against approval of AAs on a state-by-state basis.

The American Association of Nurse Anesthetists (AANA), the national organization representing CRNAs, argues that AAs are not as well trained or as established as CRNAs, and that Americans should be concerned about AAs being allowed to practice in more states.

"We believe that CRNAs are better qualified [and] better prepared, and have a superior breadth of clinical experience. AAs cannot practice where anesthesiologists are unavailable or are not willing to work, such as many rural and other underserved areas. Therefore, it is in the best interests of the U.S. healthcare system to produce more CRNAs, not AAs," said Barbara L. Anderson, State Legislative Affairs Associate of the AANA. She pointed out that numerous studies have concluded that CRNAs—with nearly 30,000 practicing in all states—are safe providers, while similar research studies have not been done on AAs.

The ASA has further fueled the war of words between the two professions by not only endorsing AAs, but issuing statements from members suggesting that AAs may provide better care than CRNAs. CRNAs, it said, were draining resources away from patient care with their lobby to gain privileges for independent care.

"The resultant need to constantly battle the nurses' 'trade union' has been a major albatross for our profession," wrote David C. Mackey, MD, Clinical Associate Professor of Anesthesiology, University of Florida College of Medicine, Gainesville, in the March 2003 newsletter of the ASA. "AAs are educated by anesthesiologists in a medical school environment, and many of us firmly believe AAs are actually better trained than nurse anesthetists [NAs] … The national emergence of the AA is long overdue. It is time to work with well-trained physician extenders who want to work with us and who are committed to the anesthesia care team concept."

Proponents of AAs say that the differences between AAs and CRNAs are limited to education and legislation—not skill. CRNAs have a bachelor of nursing degree, a master of nursing in anesthesia, licensure as an RN and at least one year of nursing experience prior to specializing in anesthesia; AAs, many of whom start in premedical programs, must have a bachelor of science degree and a master of science in anesthesia, and must complete the Medical College Admission Test. CRNAs are permitted to work in all states and can do so without the presence of an anesthesiologist. AAs are licensed in nine states and have been granted practice privileges through physician delegation in another eight. In places with both AAs and CRNAs, the key difference between the two is that AAs must be under the direct supervision of anesthesiologists.

"We do everything exactly the same, we induce exactly the same. Central lines, arterial lines, regional anesthetic," said Lance Franklin, an AA at Piedmont Hospital, Atlanta.

Officially, the ASA's position is that "although both are considered by the Centers for Medicare & Medicaid Services (CMS) to be mid-level anesthesia providers, and both may serve as physician extenders in the delivery of anesthesia, AAs and NAs are very different with regard to their educational background."

At hospitals where they work together, anesthesiologists, AAs and CRNAs say the atmosphere is amicable. "The differences are political, not personal," said Mr. Mader. "We work interchangeably and go to each other's children's birthday parties."

*—Christina Frangou*

*Based on interviews with* ***Joe Mader, Donald Biggs, Steven Goldfien, MD, Thales Pavlatos, MD, Barbara L. Anderson*** *and* ***Lance Franklin.***