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2008 DEC -4 AM 9: 22

INDEPENDENT REGULATORY
REVIEW COMMISSION

November 26, 2008

Arthur Coccodrilli, Chairman
Independent Regulatory Review Commission
333 Market Street
Harrisburg, PA 17101

Re: Proposed Regulations Number 16A-5124 – regarding Certified Registered Nurse Practitioners – Proposal by the State Board of Nursing on October 21, 2008

Dear Mr. Coccodrilli:

As a Pennsylvania physician specializing in anesthesia, who works with Certified Registered Nurse Practitioners (CRNP's) in several capacities, I applaud the significant contributions they currently make to the State's healthcare system, and to the care of individual patients. They are an important part of the health care team. Currently CRNP's practice effectively in very well-defined collaborative relationships with physicians of many specialties, and offer both primary care and specialty services in both the in-patient and the out-patient setting. Their services complement, with little duplication or overlap, those of their physician counterparts.

However, the regulations proposed by the State Board of Nursing as number 16A-5124, not only represent a threat to the current level of patient safety and continuity of care, but also have the potential to significantly reduced the effectiveness of CRNP's, by removing essential safeguards which define the relationship between a physician and the CRNP, This relationship is necessary to allow the CRNP to function most effectively. Important safeguards include:

1. Requirements that a collaborating physician be actively practicing in the CRNP's specific area of practice and have experience with the medications the CRNP is authorized to prescribe. In the absence of this experience, the various forms of supervision and review become meaningless. That "knowledge and experience requirement" is in the existing regulations and it should not be deleted in section §21.287(5).

2. To be meaningful, a collaborative agreement must be in writing and clearly specify essential elements of the physician-CRNP relationship, including the specific CRNP responsibilities and incorporation of medical direction into those responsibilities.

3. In many places the proposed regulatory changes support what appears to be independent or near-independent practice by CRNPs. But statutes require physicians and CRNPs to interact in multiple ways, ranging from "immediate availability … through direct communications or by radio, telephone or telecommunications" to "chart review". Therefore, it appears that the proposed regulatory changes go beyond what is authorized by statute. Beyond being required, these interactions with physicians are necessary to make sure that CRNPs do not unintentionally go beyond their area of expertise, have access to specialized physician experience when needed, and are up to date on changes in practice. Requirements for these

forms of supervision and review should be added into the proposed regulations, or, more simply, that language under the definition of "direction" in the present regulations should be maintained.

In my everyday practice, I function as a collaborating physician for several CRNP's in a preoperative evaluation clinic, in which anesthesiologists see surgical patients in preparation for surgery. In this context, CRNPs commonly take a preoperative surgical history from the patient, perform physical examinations, and order diagnostic testing and consultations. The anesthesiologists perform the specific preoperative anesthesia evaluation, discuss the contemplated anesthetic plan, and obtain patient consent to care. In the course of our work, as we determine a patient's readiness for surgery and anesthesia, we often request consultations from physicians in other specialties, such as Cardiology, Endocrinology, and Pulmonary Medicine. These consultations are frequently provided by similar teams of specialty physicians and CRNP's. Much of the value derived from these consultations comes from the teams of physicians and CRNPS working together. This relationship, in which physicians provide appropriate supervision and consultation for CRNPs allows us to provide the highest in sub-specialty expertise, patient safety, continuity of care, and healthcare quality.

It appears that one of the effects of the proposed regulatory changes is to remove, or to dilute, the physician contribution to the collaboration with and direction of CRNP's. This represents a step backward, would remove essential physician oversight, and have the potential for reducing the value of CRNP's, particularly those involved in providing specialty medical services. It heightens the risk that CRNPs will act beyond their expertise and that medical errors will result. Therefore, I oppose the proposed regulations 16A-5124, as they are currently written.

Sincerely,

Donald E. Martin

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