MARYLAND SOCIETY OF ANESTHESIOLOGISTS

MedChi
The Maryland State Medical Society

March 27, 2020

The Honorable Lawrence J. Hogan, Jr.
Governor of the State of Maryland
State House
100 State Circle
Annapolis, MD 21401
VIA: https://governor.maryland.gov/contact-us/

Secretary Robert Neall
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201
VIA: robert.neall@maryland.gov

Dear Governor Hogan and Secretary Neall,

We appreciate your immediate acknowledgment of the Maryland Society of Anesthesiologists (MSA) letter urging your Administration to take the bold but necessary step to cease elective surgeries. The letter coincided with your announcement on Monday, March 23rd to stop elective surgical cases. It is easier to appreciate the letter's redundancy as yet another testament to your forward-thinking and strong leadership. Your team is steps ahead of the medical professional societies and other States. Thank you!

There is another concern we would like to bring to your attention. Unfortunately, at the urging of Nurse Anesthetist Associations across the country, a few of our surrounding states have secured elimination of anesthesiologist supervision and physician oversight requirements. This has been accomplished through Governor issued executive orders, for example, in New York and West Virginia. Also, Arizona's Governor opted out completely from federal CMS supervision requirements. The pandemic-driven executive orders not only dismantle the team-based anesthesia model, but they also make no sense in the context of the crisis they supposedly are trying to address.

In Maryland the CRNAs (nurse anesthetists) scope-of-practice regulations and statute pertain to providing anesthesia for procedural and surgical cases. The demand for anesthesia for surgical and procedural cases in Maryland has **significantly decreased** with the cancelation of elective cases.

However, this crisis is creating a very, very high demand for ICU care, especially ICU nursing care. Most CRNAs have ICU level nursing training and are comfortable with anesthesia machine ventilators. **Both CRNAs and Anesthesiologists are shifting away from surgical cases, and the number of anesthesia providers in surgical cases is down to a minimum to limit staff exposure.** The University of Maryland and Johns Hopkins hospitals are cross training staff to meet these ICU demands. For example, CRNAs are cross-training to aid ICU nurses and respiratory therapists-with ICU ventilators.

Therefore, there is no justification for expanding the scope of practice for nurse anesthetists, even if temporarily. The elimination of physician supervision is not indicated for this crisis. The dismantling of the team-based anesthesia model in a time of crisis would be detrimental and create more confusion during this critical time.

CRNA's and Anesthesiologists are being deployed in ICUs and critical care settings for their respiratory and ventilation expertise. **This is the area where the need is greatest,** and CRNAs, because they are not administering anesthesia are not bound to any supervision requirements for those services. If physician supervision for CRNAs administration of anesthesia is eliminated for the duration of the crisis, we feel it will yield little in the way of clinical relief due to the current state of the surgical health care delivery landscape.

Thank you for your attention to this important matter.

Sincerely,

Haitham Al-Grain M.D., President
Maryland Society of Anesthesiologists

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