 **Board of Registration in Nursing**

 **Proposed Regulations 244 CMR 4.00**

 **Advanced Practice Registered Nurses**

 **July 16, 2021**

These comments are submitted on behalf of the Massachusetts Society of Anesthesiologists (MSA), which represents 1,000 physician anesthesiologists practicing in the Commonwealth.

While the MSA recognizes the changes Chapter 260 of the Acts of 2020 made to statutory provisions that allow certain certified registered nurse anesthetists (CRNAs) to practice without physician supervision, we strongly believe that the team based provision of anesthesia care of a CRNA working with an anesthesiologist reduces risk and ensures the safe delivery of quality anesthesia care. This is the best practice model for our patients.

MSA’s comments are focused on the following provisions of the emergency regulations:

**I. CRNA Scope of Practice 244 CMR 4.06 (1) (b).**

The MSA has strong concerns and opposes the provisions of the emergency regulations expanding the scope of practice of CRNAs beyond the current regulations by adding chronic pain management to the scope of practice.

**Anesthesia and related care does not include chronic pain care.** This is illustrated by the fact that anesthesiologists are not the only physicians that specialize in chronic pain. Chronic pain is multidisciplinary; to be board certified in pain medicine, a physician must complete a fellowship training program and pass a board certification examination created by a multidisciplinary committee with representatives from the fields of anesthesiology, physical medicine and rehabilitation (PM&R), neurology, and psychiatry. In addition, orthopedic surgeons, family physicians, neurosurgeons, oncologists and others provide chronic pain management services. This multi-disciplinary approach to chronic pain treatment is known to improve outcomes and is reflected in the professional societies that represent pain care medicine. For example, the membership of the American Academy of Pain Medicine (AAPM), the North American Spine Society (NASS) and the Spine Intervention Society (SIS) include not only physician anesthesiologists, but also physicians across a broad range of medical specialties.

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The procedural aspects of treating chronic pain are also unique. For example, placement of an epidural for labor pain is not the same as an epidural steroid injection for chronic pain. The indications, procedures, and management of an epidural catheter placement for obstetrical analgesia are much different than those for chronic pain and the training and experience for one does not equate to being sufficient for the other. To elaborate, in providing an epidural for labor or surgical pain relief, one avoids areas with pathological changes and the target size for a successful outcome is much larger. In chronic pain interventions, the target is specific, usually limited in size, and in most cases, requires image guidance for procedural success, and often involves areas with significant anatomical abnormalities. What is a contraindication for acute pain management is often the very reason for the intervention in chronic pain.

Moreover, there are significant risks involved with interventional chronic pain procedures, and nurse anesthetists’ training does not prepare them to respond to medical complications. Even in the hands of specially trained physicians, chronic pain procedures are inherently dangerous due to the anatomy and delicate structure of the spine and nerves upon which chronic pain interventions are performed. Specifically, many chronic pain procedures are administered in and near the spinal column, and, as mentioned above, involve anatomically abnormal structures. This substantially increases risks to patients. Potential complications include allergic reactions, infections, bleeding, nerve damage, spinal cord injuries (e.g., paralysis), and brain stem tissue damage – all of which can require extensive and costly medical interventions to address. Delayed diagnosis and intervention may worsen the injury, and in some cases, irreversibly.

**The training and education of nurse anesthetists is inadequate for safe, effective and appropriate independent practice of chronic pain medicine. While nurse anesthetists receive education and training to provide anesthesia in the acute perioperative setting, their curriculum does not require sufficient education or clinical training required for the evaluation, diagnosis and management of complex pain, especially, advanced invasive interventional procedures.** There are significant risks involved in interventional procedures for chronic pain, and nurse anesthetists are not prepared to respond to medical complications that may arise.

**MSA would urge the Board not to expand nurse anesthetist scope of practice to include chronic pain management.**

**II. CRNAs administering anesthesia without prescriptive authority 244 CMR 4.06 (1) (c)**

MSA wishes to express its strong concerns regarding the deletion of the language in clause (c) which specifies the parameters of the protocols developed with the responsible physician and a CRNA without prescriptive authority for the administration of anesthesia, and we urge that the language “and which specify the parameters for dosage, strength, route of administration and dose interval” be retained.

This provision of the regulations was carefully constructed as part of the implementation of Chapter 191 of the Acts of 2010 that authorizes CRNAs to prescribe medications, including anesthesia agents, during the immediate peri-operative period. That statute provided that the administration of anesthesia does not require prescriptive authority so that CRNAs who choose not to obtain prescriptive authority would not be effected by the statute and could continue to administer anesthesia without the need to obtain prescriptive authority. That same statutory provision carried forward as part of section 80H of MGL Chapter 112, as amended by section 36 of Chapter 260 of the acts of 2020, which reads “Nothing in this section shall require a nurse anesthetist to obtain prescriptive authority to deliver anesthesia care, including the proper administration of the drugs or medicine necessary for the delivery of anesthesia care.” Intrinsic to that provision, however, is the legal requirement under the controlled substance statutes that such a nurse can only administer anesthesia pursuant to a signed order of a prescriber (physician), and that was reflected in clause (c) of the regulation prior to these proposed regulations.

To the extent a CRNA is administering anesthesia pursuant to the signed order of a physician, the requirement that the protocols around which the medication order is implemented should reflect the type of parameters that any other medication order would contain. That would include dosage, strength, route of administration and dose intervals. The deletion of such language runs counter to what ought to be included in a medication order, and we urge the Board to retain its original regulatory language.

Respectfully submitted,

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President

Massachusetts Society of Anesthesiologists