Is The Nurse Still Needed In Anesthesia?

By Dr. Ian White

The health care industry is experiencing extremely unsettled times and all health care professionals are profoundly affected. Health care is responsible for approximately 33% of most provincial budgets and expenditures and represents approximately 9.6% of the Gross Domestic Product (GDP). Health care costs have continued to increase two to four percent above the increase in GDP despite the "cut backs" instituted by governments over the past several years. If governments are to reduce the deficit, without increasing revenues from taxes, they are obliged to reduce overall expenditures and health care, then, will be a prime target.

In the face of these pressures, the health care environment has become increasingly complex and difficult. Over the last two to three decades there has been a move away from the bedside by most physicians, reducing their direct contact with the patient. This has been caused by the increase in the medical knowledge base and the increased use of technology with less opportunity for physicians to have direct contact. Therefore, physicians have transferred increasing responsibility to Health Science Professionals.(HSP)

At the same time there has been increasing specialization by both MD's and HSP's. These pressures have resulted in a shift in the interface between the HSP's and MD's in the patient care continuum. This extends to both the diagnostic and therapeutic areas of patient care, and these changes have occurred by both active and passive processes.

Present Scope of Practice

Nursing is associated with Anesthesia in many different ways. There are also many different regional and hospital variations in this interface which make generalizations difficult. However, the conventional interface between nursing and the physician has been restricted to a nursing preoperative assessment, assisting the anesthetist with induction of anesthesia and during the intra-operative phase, in 'crisis' management, accompanying the patient to the recovery room and in monitoring the patient during the recovery process prior to discharge to the ward.

Future Practice and Pressures

The pressures exerted by government are to reduce health care expenditures by reducing overall expenditures, de-institutionalize health care by moving health care to the community, and move spending from illness care to wellness care. In the face of these

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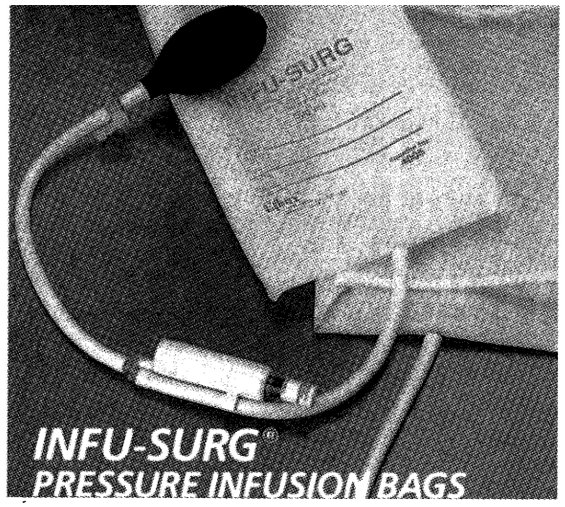

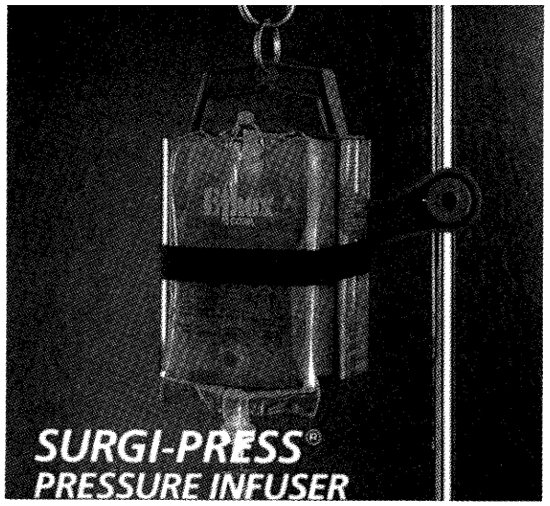

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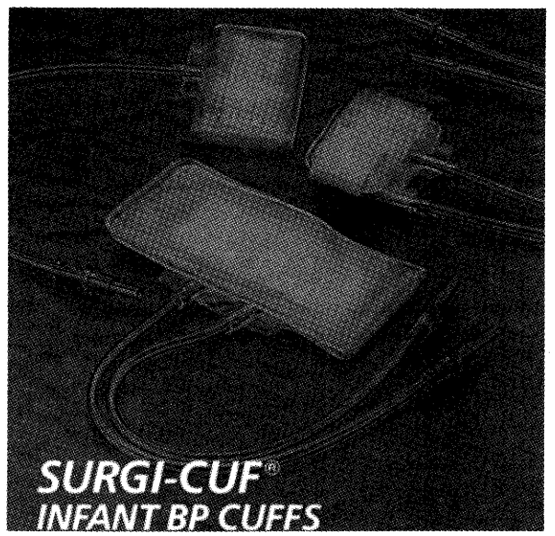

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pressures we have an increasingly complex technological environment, and an increased need to maintain and improve standards and quality of care within this reduced funding envelop. It is unlikely that the caseload volume will change significantly. We will have to do more with less. Not only do more, but do better!

How can anesthesia respond to these pressures and how do the health science professions fit into the picture? Anesthesia has to move out of the safety of the operating room and deliver care in the community. They must strive to reduce the time spent by patients in hospital by reducing the effects of anesthesia in the post-op period, by reducing nausea and vomiting, by reducing post-operative myalgias, and in particular, reducing post-op pain. In addition, the anesthetist has to better assess patient suitability for surgery and for resource allocation, (i.e. does the patient need to be admitted, will they need special care) they also have to ensure that patients have received optimal care and have not experienced untoward complications from anesthesia and surgery (quality care, quality management). Do health science professions have a place in this changing patient care environment? Absolutely!

What lessons can we learn from other Health Science Professions ?

Neonatology

Over the years the medical profession has had difficulty recruiting appropriate physicians to work in neonatal intensive care units around the clock. This was identified by the Canadian Society of Respiratory Therapists(CSRT) four to five years ago. An advanced diploma program has been created for health science professions with the transfer of delegated acts such as chest tubes and arterial catheterization. This dual entry model (nursing and respiratory therapy) is in its infancy, but appears very successful. It has built on the skills of both professional groups adding to those skills not present and enhancing those already in place to improve the quality of patient care.

Clinical Perfusion

This group of health science professions was developed in the late 1970's. Initially certification was obtained through the American College of Clinical Perfusion who set the standards, accredited the programs and administered the final examinations. Entry into this profession was from respiratory therapy, representing 75%; nursing, representing 20% and about 5% from other HSPs. Again the programs built on the skills of both groups, supplementing where appropriate.

The Canadian Perfusionists identified in the late 1980's that they would have to set up their own society to oversee the functions of accreditation standards and certification in the national context. This group was unwilling to have one of several organizations (nursing or respiratory therapy) oversee this process and therefore an independent "Society" has been created. There are, however, only two programs in the country and only 150 perfusionists. This makes independent assessment, national certification etc., very difficult and very expensive. Probably not sustainable in the long term.

Midwives

I will probably get into big trouble for discussing this group of health science professionals, but I will because I think there are lessons we (as a medical profession working with health science professions) can learn. This group is midwifery, in particular, as it is being developed in Ontario.

In the 1970's there were many attempts by the nursing profession and others to dialogue with the medical profession in respect to midwifery. The medical profession essentially said "No". We don't need to. We can do it all ourselves thank you very much and walked away. The desires of health science professions were still there and became more intense. Through the late 1980's the medical profession became less interested in obstetrics, family physicians stopped doing obstetrics and an increased number of female physicians entered the professions with different expectations. At the same time the "midwife" became more active, gained public support and as a part of the reform of Regulated Health Care Act, 1991, became an independent College of Midwives with an independent scope of practice that includes both home and hospital patient care. I won't discuss the pro's and con's of this, suffice to say I have worked with Midwives extensively in the past. I probably learned more obstetrics from midwives then anyone else, but I regard what has happened in Ontario as a failure. The medical profession has lost, the nursing profession has lost, the government has lost, costs will increase, and the patient has lost. Increased home deliveries can only increase the neonatal mortality rate. Canada has the lowest rate in the world.

This experience identifies two messages:

1. All the health professions and government need to work together
2. We don't need to create new professions, we need to build on what we have.
3. We need to concentrate on team work and patient central care.

Where does this leave us for the future?

1. We have a group of highly motivated, well trained health science professionals (nursing and respiratory therapists) that are committed to assisting anesthetists in their professional activities.

2. The Canadian Anesthetists Society has described the duties of the "Anesthesia Technician" which concentrates on O.R. activities.

3. There are extensive changes in health care underway, particularly in institutional care and they are directed to reducing human resources. Therefore, we must do more with less.

4. The care of all patients will move from the hospital to the community. Anesthesia care will be no different. There will be an increased need for outpatient assessment of patients and follow up of patients. This will require appropriately trained health science professionals.

5. Technology and the aging population will place increased demands on anesthesia services for appropriate maintenance of equipment (in house where possible to contain costs).

How can we meet these demands ?

Clearly the anesthetists requires assistance in the performance of his/her duties. The extent of those duties are expanding, pre-anesthetic clinics, consultation clinics, pain clinics (acute and chronic), post anesthesia recovery and follow up, equipment maintenance and in university centres, research. Certainly a broad area of responsibility in addition to the conventional wisdom of assisting the anesthetists in the O.R. with preparation, induction, maintenance, recovery and transfer to PARR. Can all these duties be met within the current resource pool?

Yes! We don't need to create a new specialty group. We have the basic skills in both the nursing and respiratory therapy professions. We can build on those basic skills to meet the broad needs of patient care and the anesthesia profession.

The reasons that this project has not moved ahead is the "fear" of the product, i.e. nurse anesthetists. By that I mean independent, non-physician practitioners providing unsupervised anesthesia delivery, similar to the CRNA in the U.S.A.

This model is seen as a threat by all of the professional groups, but governments, e.g. Manitoba, sees this model as a way of delivering care in remote areas, as an alternative in an area where physician recruitment is difficult and at reduced costs.

I, and almost all other anesthetists, together with those senior nursing and respiratory therapists do not support this thrust. However, until this 'fear' is dealt with nothing will move ahead in the area of post diploma anesthesia assistants.

What can we all do?

(1) Work together
The professions of nursing, respiratory therapy and anesthesia need to clearly identify the need for an anesthesia assistants with a dual entry model.
(2) Develop curricula and examinations that will build on skills already obtained by respective professions. These skills would be obtained where possible, while remaining in the workforce.
(3) Clearly defined roles need to be identified.
(4) Lay to rest the threat of the nurse anesthetist. ■

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The RNAA Program Enhances the OR Team

By Jack Kress, R.N.

Working in the operating room (OR) requires the expertise of numerous specialties involved in perioperative patient care. This is especially true for a tertiary care hospital which provides a broad spectrum of patient care services. As reflected in the St. Boniface General Hospital (SBGH) mission statement, the goal of the hospital is to promote excellence and high quality patient care.

The complex and demanding practice of anesthesia is further influenced by a number of factors such as; a technological explosion; increased patient acuity; expanding ambulatory surgery; and greater patient expectations of convenient quality care in the face of fiscal restraint and health care reform. These factors have accentuated the need for more education and alternative methods of implementing perioperative patient care.

At the present time in Canada, anesthetists rely on OR nurses and/or Respiratory Technicians for additional support with patient care. A number of issues regarding anesthesia support in perioperative patient care need to be addressed. They include: the importance of dedicated assistance in the OR; the lack of specific educational programs in the field of anesthesia for the present assistants; enhanced perioperative patient care to include more of the pre and post operative phases; and, the need to bridge the communication gap between anesthesia and nursing.

The advanced knowledge and skills that the OR nurses require have not been taught in the basic nursing programs. Traditionally, OR nurses have acquired their skills and expanded their knowledge through continuing education programs and self directed learning. OR nurses must enhance their knowledge and skills in order to effectively assist the anaesthetist. Areas of study should include the induction and maintenance of anesthesia, as well as physiology, monitoring techniques and technology.

Basic nursing education provides the knowledge of biological, physical and psychological sciences with nursing theory as the basis for assessment, diagnosis, planning, intervention and evaluation in the promotion and maintenance of health. It is these basic nursing strengths coupled with OR and/or critical care experience that provides a solid foundation for an expanded nursing role.

To explore the feasibility of this role, a one year pilot project was developed at SBGH. Following approval of the Department of Anesthesia and Nursing Division, the Registered Nurse Anesthesia Assistant (RNAA) program was initiated. This program was developed by Dr. R. Friesen, Associate Head, Department of Anesthesia, in collaboration with G. Boughen RN, BN, Assistant Director, OR Nursing.

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Jack Kress, R.N., Perioperative Nurse Clinician, has completed the Registered Nurse Anesthesia Assistant Program at St. Boniface General Hospital, Winnipeg, Manitoba. This article is a summary of his presentation in a panel discussion at ORNAC's 13th National Conference in Québec City last June. See also the articles by Anesthetist Dr. Ian White and Nurse Clinician and educator, Gloria Stephens.