The Case for Hiring Anesthesiologist Assistants

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Your hospital system is ready to break ground on a new surgery center. One year prior to the expected opening, the hospital administrator informs you that he would like your group to provide anesthesia services at the new facility. As president of your group, you suggest that, while there are many options for providing service, you plan to hire anesthesiologist assistants (AAs) for the new facility. Your administrator gets a confused look and responds, "What is an anesthesiologist assistant"?

The reaction by your administrator is a natural one and typical even in areas of the country where AA practice is well established. Many administrators and anesthesiologists are unaware of what AAs do and how they function within the anesthesia care team (ACT) model. The goals of this article are to educate anesthesiologists about the AA profession and to offer a rationale for why an anesthesiologist group should consider hiring AAs.

History

The AA profession was born out of a need for greater numbers of well-trained anesthesia providers during the late 1960s. An anesthesiologist-led team was conceived that included a new type of mid-level provider who could effectively multiply care when tasks were divided according to skills requirement, level of training and responsibility. The widely used ACT practice model of today can be traced to the 1970s, when the current model of care was described, formally defined, demonstrated and soon endorsed by ASA. AAs continue to serve the fundamental purpose of increasing patients' access to physician-led anesthesia care with a record of both high quality and safety.

Education

There are presently seven AA education programs. Each graduate level program is accredited by the Commission on Accreditation of Allied Health Education Programs, accepting students prepared along a pre-medical baccalaureate track. All AAs progress through at least two years of rigorous didactic and clinical education encompassing the spectrum of care environments and subspecialties of anesthesia care. Master's degree graduates enter practice following passage of the National Commission for Certification of Anesthesiologist Assistants national certification exam and must maintain certification by required ongoing CME and re-examination every six years.

Practice Status

AAs practice either under physician delegation of duties in accordance with the respective medical practice act or as enabled by practitioner-specific statutory licensure (Figure 1). In all situations, AAs provide care as medically directed by the anesthesiologist. There is no provision for AA practice under a non-anesthesiologist physician or any mode of independent practice. It is typical for AAs to be credentialed by a facility in the same manner as other midlevel providers and function equivalently to nurse anesthetists in the ACT model.

The introduction of a new type of provider into an anesthesiology group represents a significant change, and it is critical that practice leaders explain the benefits of doing so. The decision to introduce AAs to some extent is local, dependent upon whether AAs can work in your state, the nature of the clinical practice, and the acceptance of your

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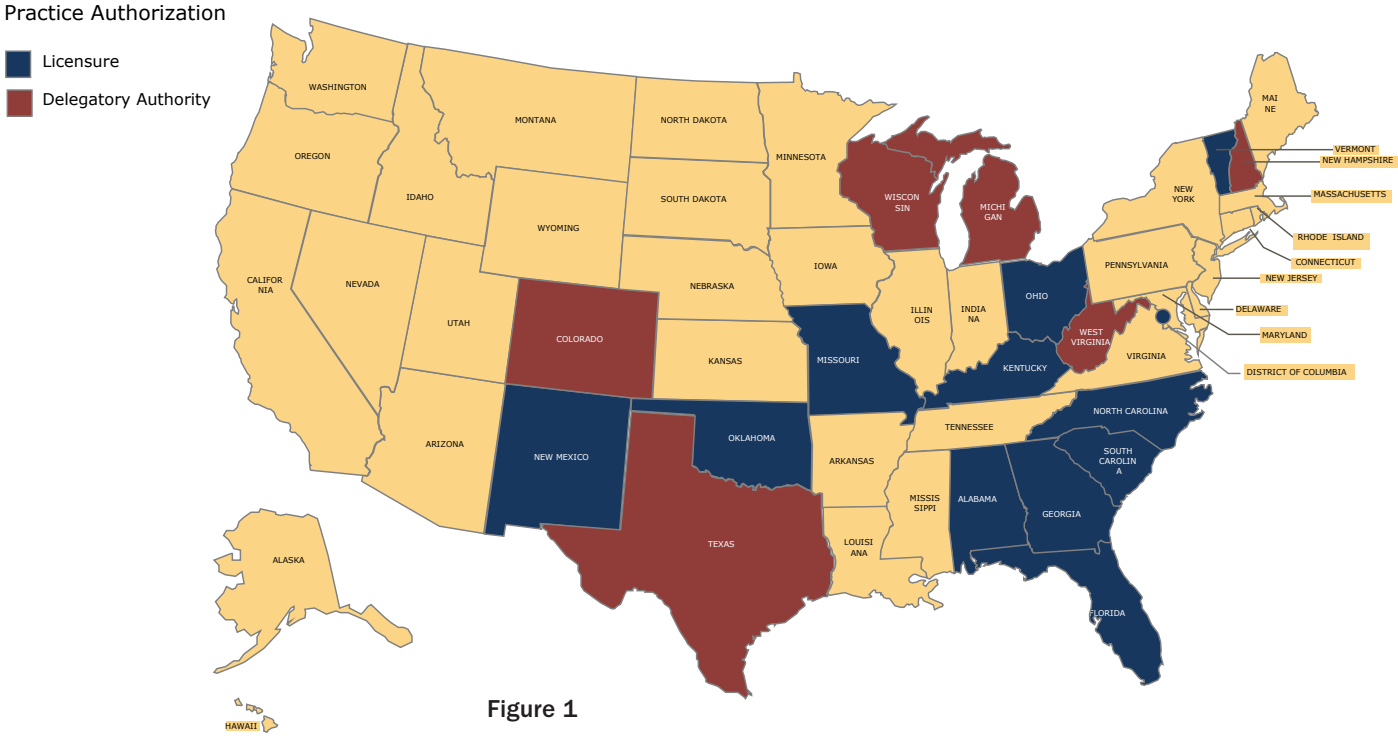

Figure 1

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surgeon and anesthesiologist colleagues. Assuming those factors are in favor, there are strong reasons a practice should consider hiring AAs.

Financial Considerations

In the medical direction model, payment for AA services is the same as that for a CRNA. The current norm among payers in states in which AAs work is that anesthesiologists may direct up to four AAs. Compensation for AAs and CRNAs is the same when working in the medical direction model. Overall, the two providers may be considered equally cost effective.

Clinical Effectiveness

As described earlier, AAs receive extensive training in all aspects of anesthesia care and administer anesthesia in any operating setting. Working exclusively under the medical direction of an anesthesiologist, AAs are skilled professionals trained extensively in the delivery and maintenance of high-quality anesthesia care. A particular strength of the anesthesia care team is that it allows the anesthesiologist to function effectively as the patient's perioperative physician, managing not only the intraoperative course but also the pre- and postoperative care. The concept of the anesthesiologist as the perioperative physician has long been supported by ASA and is consistent with the recent concept of the anesthesiologist as leader of the "Surgical Home."

"If we are going to hire anesthesia extenders, wouldn't CRNAs be better?"

One possible concern underlying this question is that introducing AAs into a practice that already utilizes CRNAs will disrupt chemistry and lower morale. For practice with both AAs and CRNAs, however, experience has shown that the two practitioners are able to work interchangeably, performing the same duties within the care team model. The key strategies to avoid conflict between providers and team dysfunction are

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Combined Training in Internal Medicine and Anesthesiology

The American Board of Internal Medicine (ABIM) and The American Board of Anesthesiology (ABA) are pleased to announce the commencement of combined integrated training in internal medicine and anesthesiology. This combined integrated program will require five, not six, years of training and allow for the development of physicians to be fully qualified and certified in both specialties.

Combined training consists of a coherent educational experience in two or more closely related specialty or subspecialty programs. The duration of combined training is longer than any one of its component specialty programs standing alone, and shorter than all its component specialty programs together.

A special agreement exists between ABIM and the ABA whereby an applicant may fulfill the training requirements for certification in internal medicine and anesthesiology by completing five years of combined training.

Physicians completing this training should be competent internists and anesthesiologists capable of professional activity in either discipline. The strengths of both an internal medicine and an anesthesiology residency complement each other to provide the optimal educational experience and develop leaders in the field.

A link to the program requirements for combined training in internal medicine and anesthesiology as well as a link to the program application can be found at **www.abim.org** or **www.theABA.org**. Both Boards are currently accepting applications from programs interested in offering this combined residency training beginning July 2013.

Every program that wishes to offer this combined training must be approved by both ABIM and the ABA before residents are recruited.

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for the anesthesiologists to a) treat both groups similarly, b) expect the best practice from all anesthesia providers and c) actively foster a culture of mutual respect and cooperation.

An administrator also might argue that CRNAs are more highly qualified due to their education and work experience in nursing. Yet there is no evidence that prior nursing experience leads to better anesthesia care. AAs have an extensive pre-medical background equivalent to those entering medical school and an intensive clinical education that covers all aspects of anesthesia care. No state in which AAs work ever has sought to rescind their license or status working under delegatory authority. During the decades of experience with both practitioners in the anesthesia care team, differences in pre-anesthesia experience have not proven to be a factor in AA qualifications or practice.

Workforce Projections

In an analysis of anesthesia workforce data, the Rand Corporation indicated that there will be significant shortages (4,500-14,000) of anesthesiologists by 2020 as the ageing population drives demand for surgical procedures. Demand for advanced practice providers, including both AAs and CRNAs, also is increasing. CRNA training programs by themselves, however, cannot fill this need. Many hospitals report that it can take over a year to recruit a CRNA. It makes sense for a practice to consider another type of anesthesia provider, AAs, in order to ensure an adequate worker supply in the coming years.

In conclusion, AAs are highly trained professionals who have delivered high-quality anesthesia within the care team model. There are multiple reasons an anesthesiology practice might consider hiring AAs. Economic, clinical and workforce needs all suggest that a practice would benefit from incorporating AAs into a care team model. By skillfully handling this proposed staffing scenario, you will capitalize on a valuable opportunity to clearly define your role as anesthesiologists, set expectations related to your future practice, and strengthen the relationship with your organization by contributing to a mutually successful enterprise.

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