the nurse anesthetist (unlike an anesthesiologist) must render his or her services under medical direction or supervision, which may be provided by either a physician or, for a dental patient, by a dentist. Thus the services of the two are not identical, and a study comparing the services of nurse anesthetists functioning fully independently and anesthesiologists would be contrary to law in most, if not all, states.[1]

The North Carolina study cited by Ms. Jenkins indicated that the ratio of anesthetic administrations to anesthetic-related deaths was slightly greater for CRNAs (and thus favorable to CRNAs) than the ratio for all anesthetic administrations to anesthetic-related deaths during 1969–1976. However, such data does not compare CRNAs in a fully independent situation with anesthesiologists; because North Carolina law requires medical "supervision,"[2] there is no way to determine how much independent judgment of the CRNAs was involved in their administration of anesthetics, and there is no way to determine how much consultation or supervision by a physician was present in the provision of the entire anesthesia service to the patients.

My point is that administration of anesthesia can be viewed narrowly, as the introduction of the anesthetic to the patient, or broadly, as the range of activity in anesthesia service, including, but not limited to, the administration of the anesthetic to the patient. Any practitioner subject to the direction or supervision of another, ostensibly more highly trained, practitioner, is not independent and does not provide a service comparable to a practitioner who is not subject to direction and/or supervision.

References

1. *See* ANESTHESIOLOGY AND THE LAW (J.D. Peters, K.S. Fineberg, D.A. Kroll, V. Collins, eds.) (Health Administration Press, Ann Arbor, Mich.) (1983) at 190–91.
2. N. C. ADMIN. CODE §.1202(e).

Reimbursing Nurses and Developing a Health Policy

Dear Editors:

I found the three articles on problems in nurse reimbursement, published in the December issue, to be quite confusing. Two completely different issues do not seem to be separated: the issue of what constitutes nursing, and the issue of whether direct reimbursement of nurses will affect nursing functions or cost containment in health care.

The issue of reimbursement seems fairly simple to me. Direct reimbursement would certainly improve the nurse's professional standing, and would probably improve nursing in the same way that any direct relationship between the work performed and the pay received would. The disadvantage of direct reimbursement would be inferior nursing care of patients who are uninsured or who receive partial insurance (i.e., Medicaid). What would happen if the typical hospital-based nurse were to bill directly for services performed (e.g., distribution of medications, dressing changes)? As already occurs with physician-delivered care, one can imagine that the nurse might pay less attention to the wails of pain of the uninsured, and more attention to the psychosocial needs of insured patients.

The second and unrelated issue is whether there should be an expansion of state certified nursing practices.

This latter issue is separate from issues of direct reimbursement and requires a careful analysis and an understanding of the needs of the American populace. It should be resolved according to what we consider to be the proper training of someone licensed to perform primary care. Nurses undergo a comparatively short period of book and classroom training versus the amount of hands-on apprenticeship, at least in comparison with the average physician. What does society want? Certainly, it is cheaper to deliver primary care if one reduces the amount of training needed to practice primary care. One could argue that it would be better to expand nursing practices so that more, cheaper, and admittedly poorer care is delivered, in order to enfranchise those for whom there is no care at all.

My view, however, is that primary care is already suffering from a lack of training of the currently licensed participants. Reducing that level of training is certainly not going to decrease the number of missed diagnoses or inappropriate treatments rendered.

The goal, as I see it, should be to improve overall health statistics in the United States to the level already achieved in other industrialized nations (e.g., neonatal mortality, infant mortality, level of immunization, life expectancy) without increasing the proportion of the Gross National Product devoted to health care. How this should be achieved, and whether nurse practitioners should be involved in it, does not seem to have been addressed amidst the polemics in the December issue.

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The editors respond

We agree that the issue of third party reimbursement for nursing services is a complex one. The competing professional, economic, and societal interests involved in this area motivated Law, Medicine & Health Care *to publish the three articles at the same time, with an aim of stimulating discussion of this controversial topic.*

We do not agree, however, that our authors ignored the issue of quality of care. Both Professor Hershey and Ms. Baker addressed this issue, obviously taking very different positions.

Incidentally, the second issue that you identify—the scope of nursing practice—was covered by two articles in the February issue of Law, Medicine & Health Care.

Jane Greenlaw, R.N., M.S., J.D.
Associate Editor

Note to Readers

Law, Medicine & Health Care welcomes readers' comments and opinions on articles and columns. Please submit your letters typewritten and double-spaced, and provide your current affiliation, address, and phone number. Letters may be edited for reasons of space and clarity. Send letters to: *Law, Medicine & Health Care*, 765 Commonwealth Ave., Boston, MA 02215.