



Physician Anesthesiologists • Wisdom • Expertise

*Ambassador*

# LSA Ambassador Program Toolkit



LSAHQ



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# **SECTION I: AMBASSADOR PROGRAM**

*What is the Ambassador Program?*

## SECTION I: AMBASSADOR PROGRAM

### *What is the Ambassador Program?*

#### Louisiana Society of Anesthesiologists Ambassador Program

December 7, 2015

Purpose: The purpose of the Louisiana Society of Anesthesiologists Ambassador (LSAA) Program is to improve bilateral communication between the LSA Board of Directors and the members of the LSA.

Qualifications: Ambassadors must be ABA Board Certified (or in process) Physician Anesthesiologists who are licensed to practice medicine in the State of Louisiana. LSAs must be members in good standing of the ASA and the LSA and participate in LSA PAC and ASAPAC.

Job Description: LSAs shall assist the Board of Directors in promoting the mission of the LSA. LSAs shall promote membership in ASA, LSA, ASAPAC and LSA PAC to physician anesthesiologists in their group and area. LSAs will be assigned members who they will communicate and work with on various LSA projects including legislative advocacy, public relations initiatives, member education and promoting involvement in the LSA and its activities.

Term: The term of LSAs shall be 2 years. There are no term limits.

Appointment: The LSA President shall appoint LSAs after approval of the LSA Board of Directors.

Number of LSAs: The number of LSA members shall determine the number of LSAs required. Ideally there should be one ambassador per every 15 – 20 LSA members. These numbers may increase depending on need. The current distribution of members suggests the following ambassador distribution and numbers:

- Shreveport/Bossier City – 4
- Alexandria – 1
- Northshore – 1
- Baton Rouge – 3
- New Orleans metro – 6
- Lafayette/Opelousas – 2
- Lake Charles – 1
- Monroe/Ruston – 1
- Houma/Thibodaux – 1

Conflict of interest: LSAs must disclose any conflicts of interests in discharging their duties

## **SECTION II: ABOUT LSA**

*LSA Leadership*

*LSA Bylaws*

*LSA Membership Stats*

## SECTION II: ABOUT LSA

### *LSA Leadership*

#### **President**

Kraig de Lanzac, MD  
Slidell Memorial Hospital  
Slidell, LA

#### **Secretary/Treasurer**

W. David Sumrall, MD  
Ochsner Medical Center  
New Orleans, LA

#### **Orleans District**

Khaled “Kal” Dajani, MD  
Ochsner Medical Center  
New Orleans, LA

#### **Jefferson District**

Kierstin Lund, MD  
Ochsner Medical Center  
New Orleans, LA

#### **Northshore District**

Matthew K. Miller, MD  
Slidell Memorial Hospital  
Slidell, LA

#### **Baton Rouge District**

VACANT

#### **Shreveport District**

Katherine Stammen, MD  
LSUHSC  
Shreveport, LA

#### **Northeastern (Monroe) District**

Ezekiel “Zeke” Wetzel, MD  
Monroe, LA

#### **Acadiana District**

Julie Broussard, MD  
Parish Anesthesia of Lafayette  
Lafayette, LA

#### **Southwestern District**

Ken Price, MD  
Imperial Health  
Lake Charles, LA

#### **Director at Large**

Joseph Koveleskie, MD  
Ochsner Clinic Foundation  
New Orleans, LA

#### **ASA Director- LA**

David Broussard, MD  
Ochsner Medical Center  
New Orleans, LA

#### **ASA Alternate Director**

Kraig de Lanzac, MD  
Slidell Memorial Hospital  
Slidell, LA  
STAFF

#### **Executive Director**

Janna Pecquet  
janna@lsa-online.org

#### **Membership Information**

member@lsa-online.org

#### **Lobbyist**

Randy Haynie  
rkhaynie@haynieandassociates.com

**LOUISIANA SOCIETY OF  
ANESTHESIOLOGISTS, INC.**

**BYLAWS**

REVISED 11/2015

**ARTICLE 1**

- 1.1 This Corporation shall be a non-profit corporation and shall have no capital stock. It shall be operated and maintained by such membership dues and assessments and endowments as the board of directors shall determine to be necessary or acceptable for the proper functioning of the corporation. Under no circumstances shall any of the net earnings or assets of the corporation inure or be distributed to the benefit of its members, directors, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article 2 hereof and the Corporation may indemnify its directors, officers, and employees with respect to actions taken in their capacities as such to the extent permitted under these Articles of Incorporation and the Louisiana Nonprofit Corporation Law.
- 1.2 The purpose of the Corporation shall be to advance the medical practice of anesthesiology and its related subspecialties and to safeguard the professional interests of the Members of the Society. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under section 501(c)(6) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) or (b) by a corporation, contributions to which are deductible under section 170(c)(2) of the Internal Revenue Code of 1954 (or the corresponding provision

of any future United States Internal Revenue Law).

- 1.3 Upon the dissolution of the corporation, the Board Of Directors shall, after paying or making provision for the payment of all of the liabilities of the corporation, dispose of all of the remaining assets of the corporation to such organization or organizations organized under section 501 (c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) as shall at that time have purposes substantially similar to those of the Corporation, as the Board of Directors shall determine.

**ARTICLE 2-PURPOSE**

**The purposes of this Society are:**

- 2.1 To associate and affiliate into one organization all the reputable doctors of medicine, osteopathy or other scientists in the state of Louisiana who are engaged in the practice of, or otherwise interested in the medical specialty of anesthesiology, critical care, pain management, or perioperative medicine.
- 2.2 To encourage specialization in this field and to make available to more people the benefits to be derived from the services of qualified anesthesiologists.
- 2.3 To advance the science and art of Anesthesiology and to stimulate interest and promote progress in the scientific and educational aspects of the specialty.
- 2.4 To seek the betterment of the individual members of this Society and to protect the member's interests within the structure of the Bylaws of this Society and the American Society of Anesthesiologists (ASA)
- 2.5 To uphold, adhere to and promote the aims, principles and purposes of the ASA, as set forth in the Bylaws of that organization.

- 2.6 To promote relations of the society with the public, other medical organizations, and hospitals.

### ARTICLE 3 - MEMBERSHIP

- 3.1 Membership in the Society is a privilege and not a right.

- 3.2 There shall be five classes of membership:

- 3.21 **Active member:**  
A physician who is engaged in the practice of, or who is especially interested in the medical specialty of anesthesiology, who has successfully completed a training program in anesthesiology, who has a degree of Doctor of Medicine, Bachelor of Medicine, or Doctor of Osteopathy, who is licensed to practice medicine, whose location of principal professional activity is in the state of Louisiana, and who is an Active member of the American Society of Anesthesiologists, shall be eligible to become an Active member.

- 3.22 **Resident member:**  
A physician in training in an accredited anesthesiology residency in the state of Louisiana shall be eligible to become a Resident member.

- 3.23 **Retired member:**  
A doctor of medicine who shall have been an active member of this Society in good standing for a period of at least ten years and who shall have attained the age of 65 years, or shall have become permanently disabled or shall have ceased the practice of medicine, shall be eligible to become a Retired member, provided, however, that the Board of Directors may at its discretion modify the time and age requirements, and that Retired membership status shall terminate upon resumption of professional activity.

- 3.24 **Affiliate member:**  
A physician or other scientist who is especially interested in the field of anesthesiology, but who does not fulfill

the requirements for inclusion in other categories.

- 3.25 **Honorary member:**

A doctor of medicine or scientist who shall have rendered years of faithful service to this Society, or who has made a significant contribution to anesthesiology, or who has attained exceptional eminence in anesthesiology, shall be eligible to become an Honorary member.

- 3.3 **Application for membership**

Application for membership in the Society shall be submitted to the Secretary. Applications may be required to contain a copy of the applicant's license to practice medicine in the state of Louisiana. If the applicant meets the requirements for membership, the member shall be notified by mail or electronically if preferred. Each applicant for membership in this Society, who is not a member of the ASA, Inc., shall at the time make application for such membership, with the exception of applicants of Honorary Membership.

- 3.4 **Rights and Privileges**

Active members are entitled to all rights and privileges of this Society. All other categories of members are entitled to participate in the functions and activities of this Society, including membership on committees, but are not eligible for election to office and have no right to vote, except at meetings of committees on which they serve.

- 3.5 Upon receipt of written notice from the American Society of Anesthesiologists, that a member of this Society is not a member of the ASA, the Secretary of this Society shall give written notice to such member that he will be dropped from membership in this Society unless he regains membership in the American Society of Anesthesiologists and gives evidence thereof to the Secretary within sixty days. Upon expiration of this sixty-day grace period, having received no evidence of return to membership in the American Society of Anesthesiologists, the

- Secretary shall drop such member from the membership rolls of this Society and shall notify him thereof.
- 3.51 A member of the American Society of Anesthesiologists whose application for membership in this Society is denied, may appeal.
- 3.511 The member shall forward his written notice of appeal to the Secretary, who shall refer the matter to the ad hoc Judicial Committee. The ad hoc Judicial Committee shall be chaired by the Immediate Past-President of the Society and composed of five Active members in accordance with these Bylaws.
- 3.512 The ad hoc Judicial Committee shall request the Secretary to furnish a written statement detailing the reasons for denial of membership, and shall request the applicant to furnish a written statement detailing his grounds for appeal, and shall make such other investigations as it deems necessary and proper.
- 3.513 The ad hoc Judicial Committee shall afford the member the opportunity to be heard in his own behalf and shall then make a written report to the Board of Directors of the Society stating its findings of fact and its recommendation.
- 3.514 The Board of Directors of the Society shall review the findings and recommendations of the ad hoc Judicial Committee and shall make its ruling, which shall be final.
- 3.52 A member of this Society may be censured, suspended, or expelled for any valid cause including but not limited to:
- A. Revocation or suspension of license to practice medicine by a regularly constituted state authority.
  - B. Conviction in a court of law of a felony or any offense involving moral turpitude.
  - C. Conduct unbecoming a physician.
  - D. Any cause or act, which is detrimental to this Society.
- E. Failure to abide by the provisions of these Bylaws.
  - F. Violations of the standards of professional conduct or ethics as may be set forth in statements of the American Society of Anesthesiologists.
- 3.523 An ad hoc Membership Committee shall be convened by the President of the Society to investigate any cause or claim for censure, suspension, or expulsion which comes to the Society's attention, and determine if the matter shall be pursued.
- 3.522 If the ad hoc Membership Committee determines that the matter will be pursued, it shall prepare a notice which will set forth the matter in question with sufficient particularity so that the member will be cognizant of the question to be inquired about and which will inform the member that he will have an opportunity to be heard in his own defense before the ad hoc Judicial Committee. At the same time he will be notified of the date, time, and place of the hearing.
- 3.523 The ad hoc Membership Committee shall mail copies of this notice to the member involved and to the Chairman of the ad hoc Judicial Committee and may forward additional reports on the matter to the ad hoc Judicial Committee as it deems appropriate with copies of same to the member involved.
- 3.524 The ad hoc Judicial Committee shall investigate as it deems proper, and shall give the member involved at least thirty days notice of the date, time, and place of the hearing. At the hearing the member shall have the opportunity to speak in his own defense, present his written statement, and produce documents and witnesses; he is entitled to legal counsel. Should the member fail to appear at the hearing without prior approval of the Committee, the hearing may continue in his absence. The Committee may consider the matter on the basis of the notice and reports from the ad hoc Membership Committee; other documentation; written

statements from the member involved;  
and such other investigations as it deems  
necessary and proper.

3.525 The ad hoc Judicial Committee shall make  
a written report to the Board of Directors  
stating the matters set forth in the notice of  
the Membership Committee, the findings of  
fact of the ad hoc Judicial Committee, and the  
recommendations of the Judicial Committee.  
The findings of fact by the ad hoc Judicial  
Committee shall be considered conclusive by  
the Board of Directors.

3.526 At the next meeting of the Board of  
Directors following receipt of the ad hoc  
Judicial Committee's report, the Board shall  
consider and act upon same, determining,  
by resolution, whether the member shall be  
disciplined and the nature of the disciplinary  
action, if any. The decision of the Board is  
final.

3.527 Suspension of a member shall be for a definite  
period of time and may, in the sole discretion  
of the Board of Directors, be commuted.  
During the period of suspension the member  
is not entitled to exercise any of the rights  
or privileges of membership in the Society,  
and shall be deemed not a member in good  
standing. If he/she holds elected office, the  
position shall be declared vacant. Expulsion  
of a member shall terminate all rights and  
privileges as a member, and any position  
in this Society held by such person shall be  
declared vacant.

3.528 A member who has been expelled from  
membership as provided in these Bylaws  
may make application for reinstatement  
provided he/she does so in the same manner  
as provided for an original application for  
membership, and provided a year has elapsed  
since the date the member was expelled, or  
since rejection of his prior application for  
reinstatement.

3.529 Any member disciplined in any degree in this  
Society, having exhausted all means of appeal  
in this Society, shall have the right to appeal

from the final decision of this Society to the  
Judicial Committee of the American Society  
of Anesthesiologists. Such appeal must be  
made within thirty days of the final action of  
the Society.

#### ARTICLE 4 - DUES

4.1 Dues shall be determined annually in the  
amount necessary to confer the proposed  
budget for the following year. Any  
assessment can be announced at any regular  
meeting of the Society.

4.11 Retired and Honorary Members shall not be  
charged dues or assessments.

4.12 Resident Members shall pay Annual dues of  
\$25.00

4.13 Active Members shall pay full dues and  
assessments.

4.14 Affiliate Members shall pay one-half of the  
Annual Dues only.

4.2 Dues shall be due and payable on January 1 of  
each year.

4.21 Unpaid dues become delinquent on July  
1st of the following calendar year. Unpaid  
assessments become delinquent on the  
first day of the third month after they are  
announced. A delinquent member shall  
be notified immediately that he will be  
expelled from the Society unless payment  
of the delinquent account is received within  
two months. A member expelled for non-  
payment of annual dues or assessments  
may be reinstated by paying the dues or  
assessments in arrears.

4.3 The Executive Committee may, at its  
discretion, modify or waive any requirement  
for payment of any dues or assessment  
by request. Any such request from a  
member shall remain privy to the Executive  
Committee.

## ARTICLE 5 - MEETINGS

- 5.1 The Society shall hold an Annual Meeting at which policy may be determined. A scientific program may be presented. Elections of officers and other business, which may properly come before such a meeting, may be conducted. The time and place of the Annual Meeting shall be determined by the Board of Directors.
- 5.2 Special and interim meetings of the Society may be called at a time and location designated by the Board of Directors.
- 5.3 The Secretary shall mail notice to each member in good standing with the time, place, and purposes of all meetings.
- 5.4 Each Active member present and in good standing shall have one vote at a meeting of the Society. A quorum shall consist of those present. A majority of those Active members in good standing present and voting shall be required for passage of any motion or resolution, or enactment of any other action, except as otherwise provided by these Bylaws or by the rules of order in force at that meeting.
- 5.5 Any member may submit a proposition or resolution for vote at the annual meeting. The proposition must be submitted to the President of the Society in writing at least 30 days before the meeting. During the new business segment resolutions and propositions may be accepted from the floor for vote at the discretion of the meeting chairman.
- 6.03 The LSA Board shall submit nominations for elected office to the Secretary thirty days prior to the announced election in accordance with these Bylaws for officers whose term is expired or whose office is vacant. In addition to those members nominated by the Board, any member in good standing may submit a nomination for office either in writing or electronically to the Secretary for consideration.
- 6.04 The officers shall be elected by the voting members of this Society. The candidate receiving the majority of votes of the members voting shall be elected; should no candidate receive a majority on the first ballot, the candidate receiving the least votes shall be removed from consideration, and another ballot taken, this procedure being repeated until one candidate has been elected.
- 6.05 The candidate elected as ASA Alternate Director shall also automatically serve as a Delegate to the House of Delegates of the American Society of Anesthesiologists.
- 6.06 The term of office of the elected officers of this Society shall be as follows.
- 6.07 The President, President-Elect, Immediate Past President, and Secretary-Treasurer shall serve for two years, from the close of the ASA Annual Meeting at which they were elected until the close of the second following ASA Annual Meeting.
- 6.08 The ASA Director, and ASA Alternate Director shall serve for three years as specified by the American Society of Anesthesiologists.

## ARTICLE 6 - ELECTION OF OFFICERS

- 6.01 The elected officers of the Society shall be a President, President-Elect, Secretary-Treasurer, ASA Director, and ASA Alternate Director.
- 6.02 Only active members in good standing shall be eligible to be elected to and hold office in the Society.
- 6.09 Any member elected to fill a vacant office shall serve from the time of his election to the normal expiration of that office's term.
- 6.10 Vacant office shall be filled by the normal election process following the occurrence of the vacancy, provided that, in the interim, the

President of the Society may appoint any qualified member to fill the vacancy if she/he deems it necessary, such appointment being subject to confirmation by the Board of Directors.

## ARTICLE 7 - DUTIES OF OFFICERS

- 7.01 The President shall have general supervision and direction of the affairs of the Society; she/he shall serve as Chairman of the Board of Directors and Chairman of the Executive Committee; she/he shall preside at meetings of the Board of Directors, the Executive Committee, and at any LSA meetings; she/he shall fill vacant office as prescribed in the Bylaws; she/he shall appoint the chair and members of all committees except as otherwise provided herein or by the Society; she/he shall deliver a report to the Board of Directors and the membership of the Society at the close of her/his term of office; and she/he shall perform such other duties as custom, necessity, and parliamentary usage require, or as otherwise provided in the Bylaws or directed by the Board of Directors or by the Society.
- 7.02 The President-Elect shall assist the President in the performance of her/his duties; she/he shall assume the duties of the President in her/his absence; she/he shall perform such duties directed by the President, the Board of Directors, or the Society; and she/he shall automatically assume the office of President should it become permanently vacant, until elections can be duly conducted.
- 7.03 The Immediate Past President shall provide continuity between administrations, and contribute her/his knowledge and experience to the officers and members of the Society.
- 7.04 The Secretary-Treasurer shall perform the duties designated in the Bylaws of the American Society of Anesthesiologists for the secretary of a component society; she/he shall correspond with directors of training centers in the state of Louisiana to

gain information needed to assist eligible individuals to become Resident members and then to progress to Active membership when qualified; she/he or her/his designee shall serve as recording secretary at the meetings of the society, its Board of Directors, and its Executive Committee; she/he shall receive, disburse, manage and account for all the funds of the Society; and she/he shall perform all the other usual duties of a secretary and of a treasurer of a society, and such other duties provided in the Bylaws or directed by the President, the Board of Directors, or the Society.

- 7.05 The ASA Director from Louisiana shall represent the Society on the ASA Board of Directors and at the House of Delegates of the American Society of Anesthesiologists as official representative of the Louisiana Society of Anesthesiologists; she/he shall perform the duties designated in the Bylaws of the American Society of Anesthesiologists for a Director of a component society; and she/he shall perform such other duties provided in these Bylaws or directed by the President, the Board of Directors, or the Society.
- 7.06 The ASA Alternate Director shall assist the ASA Director; she/he shall attend such meetings as the ASA Director attends to the extent allowed; she/he shall assume the duties of the Director in her/his absence; she/he shall automatically assume the office of the Director should it become vacant, until elections can be duly conducted; and she/he shall perform such other duties directed by the President, the Board of Directors, or the Society.
- 7.07 The Delegates, selected by the LSA Board, shall represent this Society in the House of Delegates of the American Society of Anesthesiologists; they shall counsel whenever possible with the officers and Board of Directors of this Society on all matters pending in the House of Delegates to ascertain that actions taken by them are in accordance with the best interests and desires of this Society; they shall attend each meeting

of the House of Delegates of the American Society of Anesthesiologists, and such other meetings as are customary for Delegates to attend, or make certain this Society if fully represented thereat; and they shall perform such other duties directed by the President, the Board of Directors, or the Society.

## ARTICLE 8 - BOARD OF DIRECTORS

- 8.01 The Board of Directors of the Society shall be composed of the President, President-Elect, Immediate Past-President, Secretary-Treasurer, ASA Director, ASA Alternate Director, any member holding an office on the Administrative Council of the ASA, Directors from the Louisiana Districts, and a Member-At-Large. Other members may be invited to attend such as Legislative Committee Chair, but these members shall not have a vote in official LSA matters. Resident members who hold national office and a resident component representative may also attend in a non-voting capacity.
- 8.02 Each member of the Board shall have one vote and members of the Board must cast their own vote. Vote may be electronic, in person or via telephone as agreed on by the members of the Board prior to the vote. Members may only act in one capacity for the purpose of voting. In other words, members of the Board holding two offices such as Director and Past-President shall have only one vote on the Board. Simple majority of certified members of the Board shall rule.
- 8.03 A quorum shall be composed of at least a majority of the Board members. A quorum must be present to conduct the business of the Board.
- 8.04 The Board shall be composed of Directors from the established Louisiana Districts. Nominations will be accepted for Louisiana District Directors and if the position is contested, an election will be called in accordance with these Bylaws. If the position is uncontested, the President shall appoint the Director to the LSA Board of Directors.

- 8.05 The term of the Louisiana Directors shall be two years with the term starting at the conclusion of the ASA Annual Meeting.
- 8.06 The Louisiana Districts are as such:
- a. Orleans composed of Orleans Parish members
  - b. Jefferson composed of members in areas including but not limited to Metairie, River Ridge, Kenner, Gretna, Harahan, Harvey, Marrero, LaPlace, Luling and Plaquemines
  - c. Northshore composed of members in areas including but not limited to Slidell, Covington, Mandeville, Madisonville, Hammond, Ponchatoula, Pearl River, Bogalusa
  - d. Baton Rouge composed of members in areas including but not limited to Baton Rouge, Zachary
  - e. Acadiana composed of members in areas including but not limited to Lafayette, Opelousas, New Iberia, Erath, Eunice, Mamou, Houma, Thibodaux, Morgan City
  - f. Southwest and Central Louisiana composed of members in areas including but not limited to Lake Charles, Alexandria and Pineville.
  - g. Shreveport composed of members in areas including but not limited to Shreveport and Bossier City
  - h. Northeastern composed of members in areas including but not limited to Monroe, West Monroe, Ruston, Bastrop
- 8.07 The Board of Directors shall manage the business and financial affairs of this Society, and in the interim between meetings of the Society, may act upon matters which would otherwise require special meetings of the Society, except for those functions restricted in the Bylaws to the Society as a whole.
- 8.08 The Board of Directors is charged and entrusted as follows: it shall have the power to delegate its authority to officers or committees of the Society as it sees fit; it shall determine the amount of the annual assessment; it may inspect any and all financial and other records and accounts of

the Society; and it shall have final authority concerning censure, suspension, expulsion, or other matters relating to membership in this Society, subject to the provisions of the Bylaws.

- 8.09 All actions of the Board shall be reported by the President or her/his designee to the membership of the Society at its Annual Meeting, where such action by the Board is subject to modification or revocation by the membership by a majority vote of those voting.
- 8.10 The Board of Directors shall meet no less than two times each year either in person, electronically or via teleconference at a time to be determined by the President. Other meetings may be called by the President, with the approval of the Executive Committee of the Board of Directors.
- 8.11 The Executive Committee of the Board of Directors shall be composed of the President, the President-Elect, the Immediate Past President, the Secretary-Treasurer, ASA Alternate and ASA Director.
- 8.12 The Executive Committee shall act in the interim between meetings of the Board of Directors upon specific matters which would ordinarily require special meetings of the Board of Directors.
- 8.13 The Executive Committee shall expedite, execute, and administer the previous actions and directives of the Board of Directors and the Society. The Executive Committee has no policy making power, and functions only under direction of the Board of Directors; its actions are subject to review and approval by the Board of Directors.
- 8.14 Meetings of the Executive Committees shall be held upon call of the President or at the request of any two members. Any three members of the Executive Committee shall constitute a quorum, a majority of which can do business.

- 8.15 The Executive Committee shall submit a report of its activities at each meeting of the Board of Directors.

## ARTICLE 9 - COMMITTEES

- 9.01 The Standing and Special (ad hoc) Committees of this Society shall be composed of members of this Society, appointed by the President unless otherwise provided in these Bylaws.
- 9.02 The terms of office of the chairmen and members of Standing Committees shall be for the term of office of the President appointing them, unless otherwise provided by the Bylaws, the Board of Directors, or the Society.
- 9.03 The Standing Committees continue from year to year, and the President shall announce their membership at the time of his taking office unless otherwise provided in these Bylaws. Committee or Committee positions may be left dormant if there is not sufficient interest or need demonstrated. The Standing Committees of the Society shall be:
  - a) The Committee on Constitution, Bylaws, and Rules, which shall be composed of a chairman and at least two members; it shall recommend amendments to the Bylaws to insure consistency with the actions of the policy-making bodies of this Society; and it shall prepare amendments which it considers advisable to facilitate the work and best interest of this Society.
  - b) The Committee on Public Relations, which shall be composed of a chairman and at least two members shall promote relations of the Society with the public, other medical organizations, and hospitals; it shall supervise dissemination of information concerning anesthesiology to the public and to the membership; it may utilize professional assistance to the extent approved by the Board of Directors.
  - c) The Committee on Governmental Affairs, which shall be composed of a chairman

and at least two members; it shall serve as a liaison between this Society and the American Society of Anesthesiologists and its committees in matters related to governmental and legislative affairs; it shall monitor legislative and regulatory activities at all levels of government and report to the Society and its officers as needed on these activities; it shall with guidance from the Society and its leadership, provide advice and guidance to governmental, legislative, and regulatory bodies in hope of educating them and influencing their actions in the best interests of the Society; and it may utilize professional assistance in these functions to the extent approved by the Board of Directors.

- d) Finance and Budget Committee shall be composed of five members, each of whom shall have been an active member of the Society for at least five years. The Secretary-Treasurer shall serve as chairman. The Committee shall review the annual budget to be submitted by the President. It shall establish an annual budget, a dues structure, and select appropriate investments for surplus funds for approval by the Executive Committee and shall assist other committees.

9.04 Special (ad hoc) Committees of the Society may be convened at the direction of the President and/or the LSA Board of Directors. These committees include but are not limited to:

- a) The Committee on Education and Research, which shall be composed of a chairman and at least two members; it shall plan, prepare, and secure all scientific programs for the Society. Final approval must be approved by the Board of Directors of the Society. The committee will review all applications for research grants and make recommendations to the Board of Directors for final approval
- b) The Membership Committee, which shall be composed of a chairman and at least three members; it shall conduct investigations

and make decisions by majority vote on applications for Active and Resident membership in the Society; it shall conduct investigations for all other categories of membership and submit recommendations on such applications to the Board of Directors, except as otherwise provided in these Bylaws; and it shall encourage qualified persons to apply for membership in the Society. It may act as a liaison between physicians desiring to practice anesthesiology in the state of Louisiana and institutions seeking services of anesthesiologists.

- c) The Nominating Committee, which shall consist of a chairman (Immediate Past-President) and at least three members in good standing; it shall nominate one candidate for each office in which there is a vacancy to be filled, or in which the current officer's term is due to expire before the Society would meet again.
- d) The Judicial Committee shall consist of five Active members in good standing. Membership shall be approved by the Executive Committee. The Immediate Past-President shall serve as Chair of the Judicial Committee once convened. The Judicial Committee shall hear and consider, and at its discretion attempt to adjudicate, all questions of ethics, discipline, professional relationship, and the rights and standings of members of this Society; it shall conduct investigations and hold appropriate hearings as provided in these Bylaws. In matters involving alleged violations of standards of professional conduct, the decision of the Judicial Committee that no violation occurred shall be final. Neither the Executive Committee nor the Board of Directors shall take any action upon matters within the jurisdiction of the Judicial Committee until the recommendations of the Judicial Committee have been received, and thereafter the action taken by the body having ultimate authority is final and conclusive as to all parties concerned.

## **ARTICLE 10 - RESIDENT PHYSICIAN'S SECTION**

- 10.01 The Resident Physicians Section of this Society shall be composed of those who are Resident members of this Society.
- 10.02 The Resident Physicians' Section may enact Bylaws and Rules as it feels necessary and proper for the conduct of its business. Resident Physicians' Section Bylaws are subject to approval by the Board of Directors.
- 10.03 The members of the Resident Physicians' Section may be assessed annually in an amount and manner which the Resident Physicians' Section may determine; the Secretary-Treasurer of the Louisiana Society of Anesthesiologists may assist in the collection of this assessment.
- 10.04 The Resident Physicians' Section may hold an Annual Meeting at a time and place approved by the Executive Committee of the Louisiana Society of Anesthesiologists; the Resident Physicians' Section may elect its officers at this Annual Meeting and conduct other business as needed.
- 10.05 The elected officers of the Resident Physicians' Section shall include a representative to the Louisiana Society of Anesthesiologists Board of Directors, who shall serve as a non-voting member of that Board.
- 10.06 All activities of the Resident Physicians' Section shall be under the auspices of the Louisiana Society of Anesthesiologists.
- 10.07 The Resident Physicians' Section shall submit a written report of its activities at each meeting of the Louisiana Society of Anesthesiologists Board of Directors.
- 10.08 All actions of the Resident Physicians' Section shall be subject to the approval of the Louisiana Society of Anesthesiologists Board of Directors.

## **ARTICLE 11 - FUNDS AND EXPENDITURES**

- 11.01 Funds of the Society are derived from the annual assessment of dues as provided for in these Bylaws, from any special assessments authorized by the Board of Directors, and from such other sources as may be approved by the Board of Directors.
- 11.02 Expenditures of funds of this Society may be made at the discretion of the Board of Directors.
- 11.03 Checks issued by the Society must bear the signature of the Secretary-Treasurer or the President.
- 11.04 The financial accounts and records of the Society shall be audited annually as directed by the Board of Directors.

## **ARTICLE 12 - PARLIAMENTARY AUTHORITY**

- 12.01 Questions of parliamentary procedure and order shall be determined by such book or manual of parliamentary law or rules of order as shall be selected by the President in advance of a meeting, subject to rejection by two-thirds vote of those present at that meeting.
- 12.02 The President may appoint a Parliamentarian from the membership of the Society whose duties shall be to assist and advise the President in parliamentary matters.
- 12.03 The Bylaws of the American Society of Anesthesiologists shall be adopted and utilized as needed in application to the requirements of this Society, and no provision or action of the Bylaws of this Society, or other actions of this Society, shall have effect if found to be in conflict with the Bylaws of the American Society of Anesthesiologists.

### **ARTICLE 13 - REFERENDUM**

- 13.01 Any matter which affects this Society may be referred to the Active members of the Society for a general vote, being submitted to them upon a two-thirds vote of the total membership of the board of Directors, or upon a written request signed by at least fifteen percent of the Active members of this Society.
- 13.02 Voting on the question shall be determined by a majority vote at a Annual Meeting of the Society, or by a two-thirds vote of the Active members in good standing responding to an electronic or mail ballot, if such ballot shall be authorized by the Board of Directors.

### **ARTICLE 14 - AMENDMENTS**

- 14.01 These Bylaws may be amended or suspended at the annual meeting of the Society by a two-thirds vote of the Active members in good standing present.

## SECTION II: ABOUT LSA

### *LSA Membership Stats*

#### MEMBERSHIP HISTORY

2009

Actives 267

Residents 13

Dues changed from \$250 to \$350 per year (2010-??)

2010

Actives 269

Residents 29

2011

Actives 226

Residents 25

2012

Actives 222

Residents 19

2013

Actives 258

Residents 69

2014

Actives 243

Residents 84

2015

Actives 301

Residents 59

**SECTION III:  
LOUISIANA GOVERNMENT**

*Governor John Bel Edwards*

*2016 Louisiana House of Representative  
Health and Welfare Committee*

*2016 Louisiana State Senate  
Health and Welfare Committee*

## JOHN BEL EDWARDS



### Governor John Bel Edwards

#### Biographical Data

(ED – words); Democrat; Catholic (09/16/1966);  
Married (Donna Hutto); Children (Samantha  
Bel, Sarah Ellen, and John Miller)

#### Career/Education

Governor (2016 to present)  
Louisiana State Representative (2008-2016)  
Edwards and Associate Law Firm (1999-2016)  
US. Army Infantry Office, 82nd Airborne Division (1988-1996)  
Louisiana State University Paul M. Law Center (J.D.) (1999)  
United States Military Academy at West Point (B.S.) (1988)  
Amite High School (1984)

#### State Office

State Capitol, 4th Floor  
P.O. Box 94004  
Baton Rouge, LA 70804  
(225) 342-7015  
(225) 342-7099 Fax  
<http://gov.louisiana.gov>

The election of John Bel Edwards in November 2015 was as improbable as it was historic. For only the second time in more than four decades, Louisiana elected a governor of the same party as the sitting president. It was also the first time in seven years that a Democrat was elected to a statewide office. But more telling was Edwards' journey from an unknown candidate to one who was at best a long shot against U.S. Sen. David Vitter, and finally to an unstoppable force who defied the odds.

Running on a promise to always be honest, as dictated by the West Point Honor Code, Edwards was able to capture an impressive amount of the rural vote, winning parishes that were previously lost by President Barack Obama and U.S. Sen. Mary Landrieu. He locked down the Democratic Party's endorsement early, and the unions followed suit, culminating in an unlikely victory for a man who went from freshman lawmaker to minority leader in his first year in the state House. In the end, he bested Vitter with 56 percent of the vote.

The historical footnotes did not stop when Edwards was inaugurated on January 11, 2016. That's when he became the 37th Democrat to assume the post since 1812, the second with the last name of Edwards (see former Governor Edwin), and only the fifth governor to take the oath alongside a lieutenant governor from another party. Although he also became the fourth former state representative to be installed in the office, Edwards is actually the only one ever to be elected directly from Louisiana's lower chamber.

Just hours before being sworn in, Edwards likewise became the first governor in modern times to see his choice for speaker not seated. He had backed Representative Walt Leger of New Orleans, a fellow Democrat, but the House went with Representative Taylor Barras, a Republican from New Iberia. After Barras was sworn in, Edwards noted in his inauguration speech, "Louisiana is an example to the rest of the country that diversity is a source of strength, not division. That is why I am confident that regardless of party we can band together to rebuild Louisiana. The status quo is not sustainable in a state that is anything but ordinary."

And that sums up Edwards' early challenge as a Democratic governor. He'll have to work with a Republican Legislature and carve out unique ways to reach compromises. For a man who beat all the odds in the 2015 governor's race, it's a challenge he accepted head-on in his first days in office. Within the first two weeks of the new Edwards administration, a four-year policy skeleton had already been put in place, with promises to tackle incarceration rates in his second year.

But it was year one that was best defined in his first few days. His administration immediately announced a \$750 million budget shortfall for the remainder of the 2015-2016 fiscal year and a \$1.9 billion gap for the 2016-2017 fiscal year. Faced with economic challenges "bigger than our state has ever seen," Edwards proposed increasing the state's 4-cent sales tax by a penny and boosting the cigarette tax by 22 cents. He also suggested overhauling corporate and personal income tax brackets.

If that wasn't an aggressive enough agenda in year one, Edwards also kicked off his term by starting the process to expand Medicaid. He also charged a Republican Legislature with increasing the minimum wage, passing a new equal pay statute, making college more affordable, and combating poverty.

## Background

John Bel Edwards was born on September 16, 1966, in Amite. He comes from old political stock; his great-grandfather, grandfather and father were all popular sheriffs in Tangipahoa Parish. His family proved so popular that his younger brother Daniel, who inspired the governor to be an infantryman, is the fourth generation to wear the badge. Not to be outdone, his older brother Frank is police chief in Independence and he has a sister-in-law who is a judge.

Edwards graduated as valedictorian from Amite High School in 1984. With the goal of attending law school, Edwards was late to apply for West Point, but he was aided by recommendations from former U.S. Sens. Russell Long and J. Bennett Johnston. He married his high school sweetheart along the way, the former Donna Hutto, who was on the dance squad while Edwards was the football team's quarterback.

In 1988, Edwards received a bachelor's degree in engineering. His time at West Point was life altering. He was on the Dean's List and, as some of his most memorable campaign commercials would remind voters, he served as vice chairman of the panel that enforced the West Point Honor Code.

Edwards was an Airborne Ranger who commanded his own rifle company in the 82nd Airborne Division in the 1990s. It was a fighting division, and still is, with soldiers proudly wearing the famous "AA" — "All-American" — patches on their shoulders. Edwards received his first orders for a combat mission as an Airborne Ranger in 1994, but never actually saw combat as democratic rule was returned to Haiti.

While he initially expected to pull a 20-year hitch in the Army, Edwards became a civilian just two years later to spend more time with his family and to open a private practice in Amite. In 2008, he ran for a seat in the state House of Representatives and prevailed. He became the only freshman lawmaker to chair a committee — the Veterans Affairs Committee — and was selected as the chairman of the House Democratic Caucus. The first time Edwards ever had to raise money on a large scale was in 2011, when he toured the state helping House Democrats maintain their seats. While Democrats lost their majority that year, it was only because several representatives switched parties. During that election cycle, Democrats actually held onto every challenged seat.

On February 21, 2013, Edwards announced that he would run for governor in 2015.

## Outlook

Balancing the budget and matching Louisiana's revenues with its expenses will be the governor's top priority in his first term. John Bel Edwards says he plans to do so by telling the public the truth about the state's financial condition, adding, "You're going to see honest budgeting, you're going to see responsible budgeting from me."

In year two Edwards says he plans to turn his attention to sentencing reforms and incarceration rates. But throughout his term he'll have to find ways to work with a Republican-led Legislature that is promising to be anti-tax and further to the right than earlier iterations of the House and Senate.

*"The breeze of hope that got us here today will also drive a current of change as mighty as the Mississippi. But this river can't flow unless the breeze continues. We must put action before idleness, unity before party, and citizenship before self in order to put Louisiana first."*

*"Like you, I've been here through good times and bad. We are not a perfect state, but we are a resilient one. Following shared sacrifice, there will be shared prosperity. I am bullish on our future. Louisiana's best days are certainly ahead, and I want you to be as excited and optimistic as I am."*

*"Remember, after Katrina we battled back and, in fact, we still celebrated Mardi Gras. After the Red River flooded, families still gathered at the state fair. After the oil spill, we didn't give up fishing for oysters and shrimp. The sugar cane still grows in Louisiana. Tourists still flock to the French Quarter. And new industries continue to emerge."*

*"If there are two things we'll never run out of in Louisiana — it's gumbo and gumption."*

- John Bel Edwards, Inauguration speech, January 11, 2016

### Statewide Election-General<sup>1</sup>

2015	John Bel Edwards	56%
	David Vitter	44%

### Statewide Election-Primary

2015	Scott Angelle	19%
	Jay Dardenne	15%
	John Bel Edwards	40%
	David Vitter	23%
	Others	3%

### SECTION III: STATE LEGISLATURE

#### *2016 Louisiana House of Representative Health and Welfare Committee*

**Hoffmann, Frank A. (Chair)**

District: 15 Party: R  
204 North 3rd Street Suite A  
West Monroe, LA 71291  
(318)362-4130  
hoffmanf@legis.la.gov

**Willmott, Thomas P. (Vice-Chair)**

District: 92 Party: R  
2002 20th Street Suite 204-A  
Kenner, LA 70062  
(504)465-3479  
willmott@legis.la.gov

**Bagley, Larry**

District: 7 Party: R  
671 Hwy. 171 Suite E  
Stonewall, LA 71078  
(318)925-9588  
bagleyl@legis.la.gov

**Cox, Kenny R.**

District: 23 Party: D  
781 Hwy. 494  
Natchitoches, LA 71457  
(855)844-8583  
coxk@legis.la.gov

**Cromer, Gregory**

District: 90 Party: R  
P.O. Box 2088  
Slidell, LA 70459  
(985)645-3592  
cromerg@legis.la.gov

**Edwards, Ronnie**

District: 29 Party: D  
5905 Hooper Rd.  
Baton Rouge, LA 70811  
(225)356-6200  
edwardsr@legis.la.gov

**Falconer, Reid**

District: 89 Party: R  
4990 Highway 22 Suite E  
Mandeville, LA 70471  
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falconerr@legis.la.gov

**Hensgens, Bob**

District: 47 Party: R  
407 Charity Street  
Abbeville, LA 70510  
(337)893-5035  
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**Jackson, Katrina R.**

District: 16 Party: D  
1051 Kansas Lane  
Monroe, LA 71203  
(318)362-5123  
jacksonk@legis.la.gov

**Johnson, Mike**

District: 8 Party: R  
2250 Hospital Dr. Suite 248  
Bossier City, LA 71111  
(318)741-2790  
johnsonmi@legis.la.gov

**Johnson, Robert A.**

District: 28 Party: D  
P.O. Box 467 Marksville  
Marksville, LA 71351  
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johnsoro@legis.la.gov

**LeBas, H. Bernard**

District: 38 Party: D  
115 Southwest Railroad Ave.  
Ville Platte, LA 70586  
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**Magee, Tanner**

District: 53 Party: R  
7833 Main St.  
Houma, LA 70360  
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**Miller, Dustin**

District: 40 Party: D  
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Opelousas, LA 70570  
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**Moreno, Helena**

District: 93 Party: D  
643 Magazine St. Suite 302  
New Orleans, LA 70130  
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morenoh@legis.la.gov

### SECTION III: STATE LEGISLATURE

#### *2016 Louisiana State Senate Health and Welfare Committee*

**Mills, Fred (Chairman)**

District: 22 Party: R  
800 S. Lewis St. Suite 203  
New Iberia, LA 70560  
(337) 365-8484  
millsf@legis.la.gov

**Barrow, Regina**

District: 15 Party: D  
4811 Harding Blvd  
Baton Rouge, LA 70811  
(225) 359-9400  
barrowr@legis.la.gov

**Boudreaux, Gerald**

District: 24 Party: D  
2900 Moss Street Suite B  
Lafayette, LA 70501  
(337) 267-7520  
boudreauxg@legis.la.gov

**Brown, Troy**

District: 2 Party: D  
P.O. Box 974  
Napoleonville, LA 70390  
(985) 369-3333  
brownte@legis.la.gov

**Chabert, Norby**

District: 20 Party: R  
P.O. Box 2417  
Houma, LA 70361  
(985) 858-2927  
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**Claitor, Dan**

District: 16 Party: R  
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Baton Rouge, LA 70802  
(225) 342-7602  
claitord@legis.la.gov

**Colomb, Yvonne**

District: 14 Party: D  
1520 Thomas H. Delpit Drive, Suite 226  
Baton Rouge, LA 70802  
(225) 342-9700  
dorseyy@legis.la.gov

**Erdey, Dale**

District: 13 Party: R  
P.O. Box 908  
Livingston, LA 70754  
(225) 686-2881  
erdeyd@legis.la.gov

**Luneau, Jay**

District: 29 Party: D  
711 Washington Street  
Alexandria, LA 71301  
(318) 484-2288  
luneauj@legis.la.gov

**SECTION IV:  
LOUISIANA CRNA STATUTE  
AND RELATED MATERIALS**

*Louisiana CRNA Statute*

*Summary of CRNA Pain Case*

*2015 Proposed CRNA rule change  
CRNA rule change “final”*

## SECTION IV: LOUISIANA CRNA STATUTE AND RELATED MATERIALS

### *Louisiana CRNA Statute*

#### 930. Anesthetics; authority to administer; penalty

A. No registered professional nurse shall administer any form of anesthetic to any person under their care unless the following conditions are met:

(1) The registered nurse has successfully completed the prescribed educational program in a school of anesthesia which is accredited by a nationally recognized accrediting agency approved by the United States Department of Health, Education, and Welfare.

(2) Is a registered nurse anesthetist certified by a nationally recognized certifying agency for nurse anesthetists following completion of the educational program referred to in Paragraph (1) of this Subsection and participates in a continuing education program of a nationally approved accreditation agency as from time to time required which program shall be recognized as the Continuing Education Program for Certified Registered Nurse Anesthetists; and

(3) Administers anesthetics and ancillary services under the direction and supervision of a physician or dentist who is licensed to practice under the laws of the state of Louisiana.

B.(1) No registered professional nurse licensed in the state of Louisiana who has been employed to administer anesthetics for six months prior to October 1, 1976, shall be required to meet the requirements set forth in Paragraphs (1) and (2) of Subsection A herein, and such registered professional nurse may continue to administer anesthetics provided that such employment is continuous in the state of Louisiana and is not broken for a period of more than one year. However, any registered professional nurse licensed in this state who is employed to administer anesthetics after October 1, 1976, shall be required to meet the requirements of this Section.

(2) No registered professional nurse licensed in the state of Louisiana administering parenterally a sedative, hypnotic, or analgesic drug in the course of her employment under the supervision and control of a physician or dentist shall be required to meet the requirements set forth in Paragraphs (A)(1) and (2) of this Section.

(3) The requirements set forth in Paragraphs (1) and (2) of Subsection A herein, shall not apply to a graduate nurse anesthetist awaiting certification results, provided that the application for certification is made as soon as possible upon completion of the prescribed educational program in a school of anesthesia and provided further that this is the initial attempt for passage of the certification exam.

(4) The requirements set forth in Paragraphs (1) and (2) of Subsection A of this Section shall not apply to an emergency situation as determined by the appropriate supervising physician or dentist.

(5) No registered professional nurse who on and after October 1, 1976 possesses a permit, a temporary license or a permanent license to practice nursing in Louisiana in accordance with the provision of the Nurse Practice Act and who is duly enrolled as a bona fide student pursuing a course in a nurse anesthesia school which is approved by a nationally recognized accrediting body and whose graduates are acceptable for certification by a nationally recognized certifying body shall be required to meet the requirements set forth in Paragraphs (1) and (2) of Subsection A, herein insofar as the administering of anesthetics is confined to the educational requirements of the course and under direct supervision of a qualified instructor.

C. Whoever is found guilty of violating the provisions of this Section shall be fined not more than one thou-

sand dollars, or imprisoned for not more than six months, or both.

D. Nothing herein shall prohibit the injection of local anesthetic agents under the skin or application of topical anesthetic agents by a registered nurse when prescribed by a physician or dentist who is licensed to practice in this state; however, this provision shall not permit a registered nurse to administer local anesthetics perineurally, peridurally, epidurally, intrathecally, or intravenously. This Subsection shall not be applicable to certified registered nurse anesthetists provided for in Subsection A of this Section.

E. Nothing herein shall prohibit the administration of a digital block or a pudendal block by an advanced practice registered nurse who has been trained to administer such procedure in accordance with a collaborative practice agreement.

F. Notwithstanding any laws to the contrary, a certified registered nurse anesthetist shall not be required to have a collaborative practice agreement or prescriptive authority to provide anesthesia care, including the administration of medications, anesthetics, and ancillary services necessary for the delivery of care within his scope of practice under the direction and supervision of a physician or dentist who is licensed to practice under the laws of the state of Louisiana.

G.(1) The Louisiana Legislature hereby finds that:

(a) Certified Registered Nurse Anesthetists (CRNAs) have been selecting and administering anesthesia in Louisiana and the United States for over one hundred years.

(b) The specialty of nurse anesthesia was established in the late 1800s as the first clinical nursing specialty.

(c) Nursing took the lead in formalizing anesthesia practice as a specialty and in providing for specialty education and credentialing in anesthesia practice. During World War I, nurse anesthetists trained both physicians and nurses to provide anesthesia services both at home and abroad.

(d) Nurse anesthetists alone provided the overwhelming majority of anesthetics up until World War II.

(e) Nurse anesthetists receive rigorous clinical and academic training, requiring a bachelor's degree from an accredited school of nursing and one year of professional nursing experience in an acute care setting prior to being considered for entrance to an accredited twenty-four to thirty-six month nurse anesthesia educational program.

(f) CRNAs administer the majority of anesthetics in Louisiana and all of the anesthetics in many parts of the state.

(g) Multiple studies have demonstrated that CRNAs are safe, accessible, and cost-effective providers of anesthetics.

(h) CRNAs are critical providers of quality anesthesia services in the health care delivery system in this state.

(i) An adequate supply of CRNAs in Louisiana is vital to continued access to safe, cost-effective health care for the citizens of Louisiana.

(j) Anesthesiologist assistants (AAs) are not presently authorized to train or practice in Louisiana and are only recognized in eight states.

(k) Less than six hundred AAs exist in the United States while over thirty thousand CRNAs are licensed and

authorized to practice in every state in the United States.

(l) CRNAs receive a much higher level of education and training than do AAs.

(m) After thirty years of existence, only two AA schools exist in the United States while there are ninety-nine CRNA schools.

(n) CRNAs are trained and legally authorized to administer all types of anesthetics in all settings while AAs are limited by the type of anesthetics they can administer and the settings in which they are authorized to perform their services.

(2) It is hereby declared that CRNAs are an essential provider of safe, accessible, and cost-effective anesthesia care to the citizens of Louisiana. It is further declared that a sufficient supply of CRNAs in Louisiana is affected with the public interest. It is hereby declared to be the legislative intent to encourage a sufficient ongoing supply of CRNAs in this state and to discourage the creation and authorization of providers of anesthesia not otherwise presently trained and licensed to provide anesthesia. Specifically, it is the intent of the legislature to prevent the introduction of AAs into Louisiana until such time that they are deemed to be viable providers of anesthesia services. The purpose of this Subsection is to carry out that policy in the public interest, providing for the repeal of any provision that provides otherwise.

(3) No health care provider or other person, other than a certified registered nurse anesthetist, physician, dentist, perfusionist, or other explicitly authorized provider, shall select or administer any form of anesthetic to any person either directly or by delegation unless explicitly authorized by this Title.

Acts 1976, No. 200, §1. Amended by Acts 1977, No. 131, §1; Acts 1983, No. 322, §1; Acts 2001, No. 721, §1; Acts 2003, No. 1094, §1, eff. July 2, 2003; Acts 2004, No. 279, §1.

## SECTION IV: LOUISIANA CRNA STATUTE AND RELATED MATERIALS

### *Summary of CRNA Pain Case*

Court of Appeal of Louisiana, First Circuit.  
SPINE DIAGNOSTICS CENTER OF BATON  
ROUGE, INC. v. LOUISIANA STATE BOARD OF  
NURSING through LOUISIANA DEPARTMENT  
OF HEALTH AND HOSPITALS, and August J.  
Rantz, III.  
No. 2008 CA 0813.  
Decided: December 23, 2008

Before PETTIGREW, McDONALD, and HUGHES,  
JJ. John P. Wolfe, III, Chad A. Sullivan, Tiffany  
N. Thornton, Michael M. Thompson, Rebecca H.  
Klar, Baton Rouge, LA, for Plaintiffs-Appellees,  
Spine Diagnostics Center of Baton Rouge, Inc.  
and The American Society of International Pain  
Physicians. Nicholas Gachassin, III, Lafayette,  
LA, for Defendant-Appellee, August J. Rantz,  
III. Christopher L. Whittington, Baton Rouge,  
LA, for Intervenor-Appellee, Louisiana Society  
of Anesthesiologists. E. Wade Shows, Jeffrey  
K. Cody, Baton Rouge, LA, for Defendant-2nd  
Appellant, Louisiana State Board of Nursing. Sheri  
M. Morris, Larry M. Roedel, Edward J. Walters,  
Jr., Michael A. Patterson, Baton Rouge, LA, for  
Intervenor-1st Appellant, Louisiana Association  
of Nurse Anesthetists. Dominic J. Gianna, New  
Orleans, LA, for American Association of Nurse  
Anesthetists, Amicus curiae. Stephen M. Pizzo,  
Guice A. Giambrone, III, Kelly A. Dugas, Metairie,  
LA, for Louisiana Association of Nurse Practitioners,  
Amicus Curiae. Rodney C. Braxton, Baton Rouge,  
LA, Alice L. Bodley Silver Spring, MD, for American  
Nurses Association, Louisiana State Nurses  
Association, and Louisiana Alliance of Nursing  
Organizations, Amici Curiae. Clark R. Cosse, III  
Baton Rouge, LA, for Louisiana Hospital Association,  
Amicus Curiae. Thomas G. Abram Chicago, IL, for  
National Council of State Boards of Nursing, Inc.,  
Amicus Curiae.

In the instant case, appellants challenge the trial  
court's judgment granting injunctive relief in favor  
of plaintiffs. Following this court's review of the  
record and relevant law, we affirm in part and reverse  
in part.

#### FACTS AND PROCEDURAL HISTORY

On March 24, 2005, August J. Rantz, III, a certified

registered nurse anesthetist ("CRNA"), submitted  
a petition for an advisory opinion to the Louisiana  
State Board of Nursing ("the LSBN"), which  
requested a response to the following query:  
Whether it is within the scope of practice for a  
CRNA to perform procedures involving the injection  
of local anesthetics, steroids and analgesics for pain  
management purposes, including, but not limited to,  
peripheral nerve blocks, epidural injections (62310),  
and spinal facet joint injections (64470 & 64472)  
when the CRNA can document education, training  
and experience in performing such procedures.  
After considering Rantz's petition, the LSBN's  
practice committee submitted a recommendation  
to the LSBN that it was within the scope of practice  
for CRNAs to perform such procedures under the  
direction and supervision of a physician.  
Prior to the LSBN's consideration of the practice  
committee's recommendation, Spine Diagnostics  
Center of Baton Rouge, Inc. ("Spine Diagnostics")  
filed a "Petition For Injunctive Relief And For  
Declaratory Judgment," seeking to enjoin the LSBN  
from adopting the committee's recommendation,  
to prevent Rantz from practicing interventional  
pain management, and to prevent Rantz from  
performing anesthesia-related management unless  
by physician order and under the direct and  
immediate supervision of a physician. Additionally,  
Spine Diagnostics prayed that the trial court issue  
a declaratory judgment finding that the practice  
of "pain management" constitutes the "practice  
of medicine." <sup>1</sup> At its December 7, 2005 board  
meeting, the LSBN amended the recommendation  
of the practice committee, and adopted the following  
statement:

That it is within the scope of practice for the  
CRNA to perform procedures under the direction  
and supervision of the physician involving the  
injection of local anesthetics, steroids and analgesics  
for pain management purposes, peripheral nerve  
blocks, epidural injections, and spinal facet  
joint injections when the CRNA can document  
education, training and experience in performing  
such procedures and has the knowledge, skills, and  
abilities to safely perform the procedures based on an  
order from the physician.

The statement was subsequently published on the  
LSBN's web site as well as in its quarterly publication,  
The Examiner.

Following the LSBN's adoption of the above

statement, Spine Diagnostics filed a first supplemental and amending petition, contending the LSBN was attempting to promulgate a “rule” within the meaning of the Louisiana Administrative Procedure Act (“LAPA”) that “has not been properly adopted and promulgated and should be declared invalid.”<sup>2</sup> Thereafter, at Spine Diagnostics’ request, the Louisiana State Board of Medical Examiners (“the LSBME”) issued an Advisory Opinion regarding interventional pain management by CRNAs. In its opinion, the LSBME indicated that CRNAs could provide anesthetics for acute pain associated with surgery, but opined that the procedures at issue for interventional pain management purposes constituted the practice of medicine that could only be performed by a physician.<sup>3</sup>

After a two-day hearing on Spine Diagnostics’ request for injunctive relief, the trial court took the matter under advisement. The court subsequently rendered judgment denying the request for injunctive relief, but noted that the request for declaratory judgment would proceed via ordinaria in accordance with the case management order. Thereafter, Spine Diagnostics filed a writ application with this court seeking review of that judgment. We granted certiorari for the limited purpose of reviewing the judgment denying Spine Diagnostics’ request for injunctive relief, insofar as that request alleged the LSBN had promulgated a “rule” within the intendment of the LAPA without following the procedural requirements therein.

In an unpublished decision rendered on December 28, 2006, this court reversed the trial court’s judgment and issued a preliminary injunction in favor of Spine Diagnostics. *Spine Diagnostics Center of Baton Rouge, Inc. v. Louisiana State Bd. of Nursing ex rel. Louisiana Dept. of Health and Hospitals*, 2006-0554 (La.App. 1 Cir. 12/28/06) (unpublished opinion), writs denied, 2007-0183, 2007-0217 (La.3/16/07), 952 So.2d 702, 703 (“Spine Diagnostics I”). In so doing, we noted, in pertinent part, as follows:

Thus, Spine Diagnostics has made a prima facie showing that the LSBN statement substantively expands the scope of practice for CRNAs into an area where they have not traditionally practiced, i.e., chronic or interventional pain management. Such a substantive expansion of the scope of practice clearly constitutes a rule within the meaning of

La. R.S. 49:951(6). Further, although the LSBN contends the statement is limited in scope, the actual language of the statement approved by the LSBN does not limit its application to Rantz alone, and is capable of being applied to every CRNA who has the requisite knowledge, skills, and abilities to perform the procedures at issue. CRNAs are able to freely access the statement insofar as it was published in *The Examiner* and on the LSBN’s website.

Given these circumstances, we find Spine Diagnostics has made a prima facie showing that the statement adopted by the LSBN insofar as it relates to chronic or interventional pain management is a rule within the meaning of the LAPA. Since it is undisputed that the requirements of the LAPA were not met, Spine Diagnostics is entitled to a preliminary injunction enjoining enforcement of the statement adopted by the LSBN at its December 7, 2005, board meeting, and enjoining Rantz from practicing chronic or interventional pain management procedures pursuant to the authority of that statement.

On June 29, 2007, Spine Diagnostics filed a second supplemental and amending petition, adding Raymond R. Smith, Jr., a CRNA who had admitted to performing interventional pain management procedures in violation of the Medical Practice Act, the Nurse Practice Act, and other general and equitable laws.<sup>4</sup> Spine Diagnostics also alleged that the LSBN attempted to circumvent this court’s December 28, 2006 ruling by urging House Bill 684 and Senate Bill 322.<sup>5</sup> On July 9, 2007, the Louisiana Association of Nurse Anesthetists (“LANA”) sought to intervene in this matter as of right. On October 15, 2007, LANA was permitted to intervene in the proceedings.

The trial on Spine Diagnostics’ request for declaratory judgment, permanent injunction, and contempt was held on November 29 and 30, 2007, and December 3, 2007. Thereafter, the trial court took the matter under advisement and, on January 10, 2008, rendered judgment in favor of Spine Diagnostics as follows:<sup>6</sup>

The Court ORDERS, ADJUDGES and DECREES, the following in connection with the declaratory judgment:

1. The statement issued by the LSBN substantively expands the scope of practice for CRNAs into an area where they have not traditionally practiced, i.e. chronic or interventional pain management.

2. The practice of interventional pain management is not within a CRNAs scope of practice.
3. The practice of interventional pain management is solely the practice of medicine.

4. The opinion issued by the LSBN is an effort to substantively expand CRNA scope of practice and is an improper attempt at rule making.

IT IS FURTHER ORDERED, ADJUDGED and DECREED that in connection with the permanent injunction:

1. A permanent injunction issue prohibiting the LSBN from enforcing the statement.
2. A permanent injunction issue prohibiting August Rantz, III from performing chronic interventional pain procedures in connection with the LSBN statement.
3. The LSBN shall remove the advisory opinion from its website.
4. The LSBN shall post the judgment of this Court on its website and publish it in the LSBN publication, The Examiner.

IT IS FURTHER ORDERED, ADJUDGED and DECREED that

1. LSBN is taxed with all costs associated with these proceedings;
2. LSBN is taxed with all expert costs and fees;
3. LSBN is taxed \$7,500.00 in litigation costs pursuant to LA R.S. 49:965.1(A);
4. LSBN is taxed with costs of all deposition transcripts.

It is from this judgment that the LSBN and LANA have appealed.<sup>7</sup>

In its appeal, the LSBN assigns the following specification of errors:

1. The Trial Court erred in ruling that Spine Diagnostics met its burden of proof to obtain a permanent injunction enjoining the Nursing Board's Advisory Opinion on the basis that it constituted a "rule" which should have been promulgated in accordance with the LAPA.
2. The Trial Court erred in ruling that Spine Diagnostics had met its burden of proof to obtain a permanent injunction enjoining the Nursing Board's Advisory Opinion on the basis that it substantively expands the scope of practice for CRNAs into an area where CRNAs have not traditionally practiced, i.e., chronic or interventional pain management.
3. The Trial Court erred in ruling that Spine Diagnostics had met its burden of proof to obtain a mandatory injunction requiring the removal of the

Advisory Opinion from its website and ordering publication of the judgment on the Nursing Board's website and in its quarterly publication, The Examiner.

4. The Trial Court erred in declaring the practice of injecting local anesthetics, steroids and analgesics for chronic pain management under the direction and supervision of a physician to be beyond the traditional scope of practice for CRNAs.

5. The Trial Court erred in declaring the practice of injecting local anesthetics, steroids and analgesics for chronic pain management under the direction and supervision of a physician to be solely the practice of medicine.

6. The Trial Court erred in awarding Spine Diagnostics up to \$7,500 in reasonable litigation expenses pursuant to La. R.S. 49:965.1 and other fees/costs for its expert witnesses and the taking of depositions.

Similarly, LANA sets forth the following on appeal for our review:

1. The trial court committed legal error in declaring the practice of injecting local anesthetics, steroids and analgesics for chronic pain management pursuant to a physician's order beyond the scope of CRNA practice.
2. The trial court committed legal error in declaring the practice of injecting local anesthetics, steroids and analgesics for chronic pain management pursuant to a physician's order to be solely the practice of medicine.
3. The trial court erred in finding the Nursing Board's advisory opinion is an improper attempt at rule-making.
4. The trial court erred in finding that the Nursing Board advisory opinion substantively expands the scope of practice for CRNAs into an area where CRNAs have not traditionally practiced, i.e. chronic or interventional pain management.

#### LAW OF THE CASE DOCTRINE

On appeal, the LSBN and LAIMA both argue that the advisory opinion issued by the LSBN in response to Rantz's petition was nothing more than a declaratory order, which is provided for in La. R.S. 49:962, not a rule within the meaning of the LAPA.<sup>8</sup> Thus, they assert, the trial court erred in finding that the LSBN's advisory opinion was an improper attempt at rule-making. In response, Spine Diagnostics contends that the LSBN and LANA are attempting to relitigate issues previously decided

by this court. Spine Diagnostics maintains that these arguments are pretermitted by the law of the case doctrine as they have been briefed, argued, and decided by this court.

Pursuant to the law of the case doctrine, an appellate court generally will not, as part of a subsequent appeal, reconsider its earlier ruling in the same case. *Spruell v. Dudley*, 2006-0015, p. 4 (La.App. 1 Cir. 12/28/06), 951 So.2d 339, 342, writ denied, 2007-0196 (La.3/23/07), 951 So.2d 1106. In *Louisiana Land and Exploration Company v. Verdin*, 95-2579, pp. 3-4 (La.App. 1 Cir. 9/27/96), 681 So.2d 63, 65, writ denied, 96-2629 (La.12/13/96), 692 So.2d 1067, cert. denied, 520 U.S. 1212, 117 S.Ct. 1696, 137 L.Ed.2d 822 (1997), this court discussed the law of the case doctrine and its application as follows:

The law of the case principle is a discretionary guide which relates to (a) the binding force of a trial judge's ruling during the later stages of trial, (b) the conclusive effects of appellate rulings at trial on remand, and (c) the rule that an appellate court ordinarily will not reconsider its own rulings of law on a subsequent appeal in the same case. It applies to all prior rulings or decisions of an appellate court or the supreme court in the same case, not merely those arising from the full appeal process. Re-argument in the same case of a previously decided point will be barred where there is simply a doubt as to the correctness of the earlier ruling. However, the law of the case principle is not applied in cases of palpable error or where, if the law of the case were applied, manifest injustice would occur.

The reasons for the law of the case doctrine is to avoid relitigation of the same issue; to promote consistency of result in the same litigation; and to promote efficiency and fairness to both parties by affording a single opportunity for the argument and decision of the matter at issue.

When an appellate court considers arguments made in supervisory writ applications or responses to such applications, the court's disposition on the issue considered usually becomes the law of the case, foreclosing relitigation of that issue either at the trial court on remand or in the appellate court on a later appeal. However, where a prior disposition is clearly erroneous and will create a grave injustice, it should be reconsidered. [Citations omitted.]

In considering this doctrine and its applicability herein, we note that the arguments and issues raised

by the LSBN and LANA in this regard appear to be indistinguishable from those presented to the trial court in the original request for injunctive relief and again to this court in the writ application in *Spine Diagnostics I*. In fact, a review of our opinion in *Spine Diagnostics I* reveals this court previously considered the ISBN's authority to issue declaratory orders and advisory opinions pursuant to La. R.S. 49:962, thoroughly reviewed arguments concerning La. R.S. 37:930 as it relates to this issue, and concluded that the LSBN's statement, insofar as it relates to chronic or interventional pain management, was a rule that required compliance with the procedural requirements of the LAPA. Although ably argued on appeal, a review of the instant record reveals that this court's previous ruling was without error. Thus, by operation of the law of the case doctrine, we decline review of these issues on appeal.

#### SCOPE OF PRACTICE ISSUE

The central issue to be decided in this appeal is whether procedures involving the injection of local anesthetics, steroids and analgesics for pain management purposes, peripheral nerve blocks, epidural injections, and spinal facet joint injections are within the scope of practice of CRNAs or whether these procedures are considered the practice of medicine and can only be performed by a physician licensed to practice medicine in Louisiana. The issue before us is *res nova*.

The statutory provisions governing practice by a CRNA are found in La. R.S. 37:390. Louisiana Revised Statutes 37:930(A) provides that CRNAs are authorized to administer local anesthetics under the direction and supervision of a physician.<sup>9</sup> In 2004, the Louisiana Legislature statutorily recognized the importance of CRNAs in providing anesthetics to Louisiana residents when it added paragraph (G) to La. R.S. 37:930. This provision provides, in pertinent part, as follows:

G. (1) The Louisiana Legislature hereby finds that:

(a) Certified Registered Nurse Anesthetists (CRNAs) have been selecting and administering anesthesia in Louisiana and the United States for over one hundred years.

(e) Nurse anesthetists receive rigorous clinical and academic training, requiring a bachelor's degree from an accredited school of nursing and one year of professional nursing experience in an acute care setting prior to being considered for entrance to an

accredited twenty-four to thirty-six month nurse anesthesia educational program.

(f) CRNAs administer the majority of anesthetics in Louisiana and all of the anesthetics in many parts of the state.

(g) Multiple studies have demonstrated that CRNAs are safe, accessible, and cost-effective providers of anesthetics.

(h) CRNAs are critical providers of quality anesthesia services in the health care delivery system in this state.

(i) An adequate supply of CRNAs in Louisiana is vital to continued access to safe, cost-effective health care for the citizens of Louisiana.

(n) CRNAs are trained and legally authorized to administer all types of anesthetics in all settings while AAs [Anesthesiologist assistants] are limited by the type of anesthetics they can administer and the settings in which they are authorized to perform their services.

On appeal, the LSBN and LANA argue that Spine Diagnostics failed to prove by a preponderance of the evidence that the LSBN's statement expands the scope of practice for CRNAs into areas where CRNAs have not traditionally practiced. Noting an overlap between various practitioners, including nurses, and the practice of medicine, the LSBN and LANA contend that interventional pain management is not solely the practice of medicine. Moreover, they maintain that had the legislature intended to exclude CRNAs from performing interventional pain management procedures, language concerning the restriction could have simply been added to La. R.S. 37:930 to accomplish same.

To the contrary, Spine Diagnostics asserts that the evidence presented at the trial on the merits supports the trial court's ruling that the LSBN's statement expands the scope of practice for CRNAs into an area not traditionally practiced. Spine Diagnostics argues that (1) CRNAs do not have an established history of performing interventional pain management procedures; (2) CRNAs do not have the education, training, or accreditation to safely and effectively perform these procedures; (3) studies demonstrate decreased safety, competency, and efficacy when these procedures are performed by CRNAs; (4) CRNAs have no regulatory mechanism or process to assess their competency, training, or education; (5) no verifiable need exists for CRNAs in

this area of practice; and (6) CRNA practice in this area will negatively impact public health and safety. As previously mentioned, this matter was tried over three days before the trial court. After hearing from the witnesses and considering the documentary evidence presented by the parties, the trial court entered a declaratory judgment finding that the statement issued by the LSBN expanded the scope of practice for CRNAs into an area where they have not traditionally practiced, i.e., chronic or interventional pain management. The trial court further declared that the practice of chronic or interventional pain management is not within the scope of practice of a CRNA, but rather is solely the practice of medicine. Appellate courts review a trial court's decision to grant or deny a declaratory judgment using the abuse of discretion standard. *Mai v. Floyd*, 2005-2301, p. 4 (La.App. 1 Cir. 12/6/06), 951 So.2d 244, 245. Factual findings made by the trial court are reviewed using the manifest error or clearly wrong standard. *Rosell v. ESCO*, 549 So.2d 840, 844 (La.1989).

The trial court also issued a permanent injunction prohibiting the LSBN from enforcing its statement and prohibiting Mr. Rantz from performing chronic interventional pain procedures in connection with the LSBN statement and a mandatory injunction ordering the LSBN to remove the statement from its website, post the judgment of the trial court on its website, and publish the judgment in its publication, *The Examiner*.

The issuance of a permanent injunction takes place only after a trial on the merits, in which the burden of proof must be founded on a preponderance of the evidence. *State Machinery & Equipment Sales, Inc. v. Iberville Parish Council*, 2005-2240, p. 4 (La.App. 1 Cir. 12/28/06), 952 So.2d 77, 81. A mandatory injunction, so named because it commands the doing of some action, similarly cannot be issued without a hearing on the merits. The jurisprudence has established that a mandatory preliminary injunction has the same basic effect as a permanent injunction, and therefore may not be issued on merely a prima facie showing that the party seeking the injunction can prove the necessary elements; instead, the party must show by a preponderance of the evidence at an evidentiary hearing that he is entitled to the preliminary injunction. *Concerned Citizens for Proper Planning, LLC v. Parish of Tangipahoa*, 2004-0270, p.

7 (La.App. 1 Cir. 3/24/05), 906 So.2d 660, 664. The standard of review for the issuance of a permanent injunction is the manifest error standard. *Cathcart v. Magruder*, 2006-0986, p. 18 (La.App. 1 Cir. 5/4/07), 960 So.2d 1032, 1041. Under this standard, the issue to be resolved by a reviewing court is not whether the trier of fact was right or wrong, but whether the fact finder's conclusion was a reasonable one. *Stobart v. State through Dept. of Transp. and Development*, 617 So.2d 880, 882 (La.1993). Thus, if the trial court's findings are reasonable in light of the record reviewed in its entirety, this court may not reverse, even if convinced that had it been sitting as trier of fact, it would have weighed the evidence differently. *Parish of East Feliciana ex rel. East Feliciana Parish Police Jury v. Guidry*, 2004-1197, p. 15 (La.App. 1 Cir. 8/10/05), 923 So.2d 45, 53, writ denied, 2005-2288 (La.3/10/06), 925 So.2d 515. The trial court heard from many medical experts regarding the scope of practice issue. Dr. Laxmaiah Manchikanti, the single most published author in the United States on interventional pain management techniques, was accepted by the court as an expert in interventional pain management with special expertise in credentialing, education, training, research, access, and scope of practice. Dr. Manchikanti developed the definition of interventional pain management that is accepted by the United States Congress today. He testified at length concerning the level of training needed to perform interventional pain management procedures, indicating that the health and safety of the patients warrants the enhanced skills of a duly licensed and trained medical physician. Dr. Manchikanti opined that interventional pain management procedures are not traditionally within the scope of practice for a CRNA. Dr. John Dombroski testified as an expert in the field of anesthesiology, internal medicine, and pain medicine, and was allowed to express an opinion with respect to the scope and practice of medicine in those areas of medicine as they interface with other healthcare professionals such as CRNAs. Dr. Dombroski stated unequivocally that CRNAs should not be allowed to be performing interventional pain management procedures as they have never had the proper training required to do so. He indicated that the patients deserve the best care possible, including a proper medical diagnosis and the correct assessment by a duly licensed and trained medical

physician.

The trial court also was provided testimony from Dr. Gabor Racz via deposition. Dr. Racz is an anesthesiologist who is currently working as a professor. He has taught both physicians and CRNAs. Dr. Racz is a highly decorated physician, having been listed in the "Best Doctors in America" and receiving the lifetime achievement award from the American Society of Interventional Pain Physicians. He is also the President of the World Institute of Pain. Dr. Racz testified that under no circumstances should a CRNA be allowed to perform interventional pain management procedures. He added that if CRNAs wish to do these procedures, they have every right to "avail themselves to the training, and whatever it takes to be an interventional pain physician." Dr. Racz opined that nurses do not practice to a physician level and that a medical diagnosis differs from a nursing diagnosis.

Dr. Frank Falco was accepted as an expert in the field of physical medicine. He is also board certified in rehabilitation, pain medicine, and sports medicine. Dr. Falco testified regarding the requirements of a pain medicine fellowship training program. He explained that the assessment of a chronic pain patient is very complex and is not "simply putting a needle in someplace and injecting some solution in that area." Dr. Falco noted further:

The pain fellow must understand based on a history tailored towards the pain patient and the physical examination, that is, a complete examination involving the neurological assessment, a musculoskeletal assessment, a psychological assessment, reviewing of all of the diagnostic data, the CT, the xray, the MRI, the electrodiagnostic studies, and then making a diagnosis based upon the evaluation and then laying out a treatment plan. We have three fellows in our ACGME Accredited Pain Medicine Fellowship. They are constantly supervised for the entire twelve months. They get four months of inpatient training.

When asked if CRNAs had any role to play in the chronic pain management arena, Dr. Falco responded that although CRNAs are excellently trained in providing anesthesia services for surgery under the direction of an anesthesiologist, "[t]hey do not have the training that allows them to include in their scope of practice the management of chronic complex pain." Dr. Falco opined that it would be

“practicing medicine with a license, without the proper training,” which could lead to significant complications not only from the procedures themselves, but also from the patients being mismanaged. Dr. Falco concluded that without going to medical school, CRNAs cannot receive the training needed to be able to competently perform these procedures.

Jack Neary, a CRNA from New Hampshire, testified that he performs interventional pain management procedures unsupervised. He acknowledged that he has no training in radiology or neurology. Mr. Neary noted further that he knows of no regulations or guidelines of any sort that apply nationally to institutions to assess the competency, ability, credentials or skill sets of CRNAs with respect to interventional pain management procedures. From his perspective, once a CRNA gets their certificate and the proper training, and feels comfortable with a procedure, they can do it. With regard to the scope of practice for CRNAs in New Hampshire, Mr. Neary testified that the New Hampshire Board of Nursing has found that certain interventional pain management procedures are within the scope of practice of a CRNA licensed in New Hampshire. Christine Langer testified regarding the educational requirements of a CRNA. Ms. Langer is an instructor who trains CRNAs at the Louisiana State University School of Nursing. She indicated she does not teach a section called “interventional pain management,” noting that the majority of her teaching focuses on training CRNAs for the hospital setting. Ms. Langer agreed that there is a distinct difference between acute pain treatment in a hospital or surgical setting and chronic interventional pain management. She also acknowledged that at the time a student acquires a CRNA certificate, absent anything else, no student in Louisiana is competent to perform interventional pain management procedures. Ms. Langer testified that she is not aware of any post-certification competency benchmarks for CRNAs related to interventional pain management procedures. She agreed that CRNAs cannot make medical diagnoses.

Barbara Morvant, the Executive Director for the LSBN, testified concerning the licensing and credentialing of CRNAs in Louisiana. She explained that in its role as a licensing agency, the LSBN credentials CRNAs for entry level practice, and provides for re-certification requirements in their

field of nurse anesthesia practice. The LSBN also investigates any complaints that may be filed against CRNAs. When asked specifically about the LSBN statement in question and whether the LSBN had any mechanism or system designed to verify or in any way assess whether a CRNA has the documented education, training, experience, knowledge, skills, and abilities to safely perform interventional pain management procedures, Ms. Morvant acknowledged that it has no such system in place. Jackie Rowles is the President-Elect of the American Association of Nurse Anesthetists and is a practicing CRNA in Indiana. She has been performing interventional pain management procedures for almost five years. Ms. Rowles agreed that she cannot make a medical diagnosis, only a nursing diagnosis. She explained, however, that when her patients come to her for treatment, they have already been seen by a physician and have a diagnosis. Ms. Rowles acknowledged that there are no guidelines for assessing the competency, skill set, abilities, or training needed for CRNAs to begin performing interventional pain management procedures. Rather, she opined that a CRNA should be allowed to perform these procedures once the CRNA has had the “necessary education, training, and feels like they have the necessary skills.”

Kathleen Wren, a CRNA with a Master of Science in nursing, testified regarding her twenty-three years of experience as CRNA, practicing in eight different states including Louisiana. During her career as a CRNA, she established three pain clinics and three rural hospitals, in Nebraska and Iowa. Her pain clinics provided anesthetic blocks for chronic pain patients. Ms. Wren stated that in her experience as a CRNA, the injection of steroids and analgesics for pain management purposes, including peripheral nerve blocks, epidural injections, and spinal facet joint injections, have always been a part of the practice of CRNAs in the states she practiced in, including Louisiana. However, Ms. Wren later admitted that she never practiced interventional pain management in Louisiana. In her opinion, it is within the scope of practice of a properly trained nurse anesthetist to perform interventional pain management procedures outside of the hospital setting. When asked whether she was aware of any certification beyond the CRNA licensing process or any type of regulatory process in place that would tell the public whether a particular CRNA has met a

threshold standard of competency, Ms. Wren stated that she believed that was a function of the LSBN. Rusty Smith, a CRNA in Louisiana, testified that he performs interventional pain management in Louisiana and has done so for several years. Mr. Smith indicated that while he has been performing epidural injections for chronic pain relief for approximately twenty years, it is just in the last four years of his practice that he has begun offering spinal facet joint injections related to chronic pain management. He does these procedures exclusively at an ambulatory surgery center in Vidalia, Louisiana. His largest referring physician for interventional pain management procedures is Dr. Russ Fairbanks. When a patient comes to him from Dr. Fairbanks, the patient has been examined and diagnosed. Mr. Smith indicated that when submitting codes to Medicare and Medicaid, he uses the diagnosis submitted by Dr. Fairbanks. When asked if he continued with these interventional pain management procedures even after learning of the preliminary injunction that was in place concerning the LSBN's statement, Mr. Smith stated that to his knowledge, the injunction was only against Mr. Rantz. In fact, Mr. Smith indicated that even after the preliminary injunction had been ordered, Ms. Morvant, the Executive Director of the LSBN, told him that there was nothing that would prevent him from continuing in his practice.

Dr. Fairbanks, accepted by the trial court as an expert in the field of orthopedics, testified regarding his relationship with Mr. Smith. According to Dr. Fairbanks, over the last five years he has referred approximately three or four patients a week to Mr. Smith for interventional pain management procedures.<sup>10</sup> Dr. Fairbanks testified that after he sees the patient and makes a diagnosis, he refers the patient to Mr. Smith who then works under his direction. However, Dr. Fairbanks admitted that he is not in the operating suite when Mr. Smith performs these procedures. In fact, Dr. Fairbanks indicated that there may even be times when he is not in the facility when the procedures are being performed. Dr. Fairbanks stated that he has never had any complaints from his patients regarding the treatment they have received from Mr. Smith. Although Dr. Fairbanks denied having any direct financial ties with Mr. Smith, he did acknowledge that he owns a percentage of the surgery center in Vidalia where Mr. Smith performs the procedures.

Dr. Fairbanks also noted that there is an interventional pain medicine physician in Natchez, Mississippi, which is only five miles from his surgery center in Vidalia.

We have thoroughly reviewed the record before us and find no abuse of discretion by the trial court in its declaratory judgment in favor of Spine Diagnostics finding that the statement issued by the LSBN expanded the scope of practice for CRNAs into an area where they have not traditionally practiced and finding that the practice of interventional pain management is not within the scope of practice of a CRNA, but rather is solely the practice of medicine. Moreover, with the foregoing legal precepts in mind, and having reviewed the evidence considered by the trial court below, we are satisfied that Spine Diagnostics met its burden of proof on the permanent injunction and the mandatory injunction. The trial court's judgment regarding same is reasonable, supported by the record, and not manifestly erroneous.

#### AWARD OF REASONABLE LITIGATION EXPENSES AND OTHER COSTS TO SPINE DIAGNOSTICS

The LSBN argues on appeal that the trial court erred in awarding Spine Diagnostics \$7,500.00 in reasonable litigation expenses pursuant to La. R.S. 49:965.1 plus an award for other fees/costs associated with expert witnesses and depositions. Spine Diagnostics argues that pursuant to La. Code Civ. P. art. 1920,<sup>11</sup> the trial judge has great discretion in awarding costs and its judgment should not be disturbed absent an abuse of discretion. See *MCI Telecommunications Corp. v. Kennedy*, 2004-0458, p. 11 (La.App. 1 Cir. 3/24/05), 899 So.2d 674, 681. Based on applicable law and jurisprudence, we reverse that portion of the judgment that awarded Spine Diagnostics any fees/costs in excess of the \$7,500.00 provided for in La. R.S. 49:965.1. Spine Diagnostics' request for litigation expenses and the trial court's award were based on La. R.S. 49:965.1(A). It provides, in pertinent part, as follows:

When a small business files a petition seeking: .  
(2) judicial review of the validity or applicability of an agency rule, . the petition may include a claim against the agency for the recovery of reasonable litigation expenses. If the small business prevails and the court determines that the agency acted

without substantial justification, the court may award such expenses, in addition to granting any other appropriate relief.

“Reasonable litigation expenses” are defined as “any expenses, not exceeding seven thousand five hundred dollars in connection with any one claim, reasonably incurred in opposing or contesting the agency action, including costs and expenses incurred in both the administrative proceeding and the judicial proceeding, fees and expenses of expert or other witnesses, and attorney fees.” La. R.S. 49:965.1(D)(1) (Emphasis added.); *State ex rel. Louisiana Riverboat Gaming Com’n v. Louisiana State Police Riverboat Gaming Enforcement Div.*, 99-2038, p. 4 (La.App. 1 Cir. 9/22/00), 768 So.2d 284, 286, writ denied, 2000-2926 (La.1/5/01), 778 So.2d 598. To qualify for this relief, a “small business” must meet the criteria defined by the Small Business Administration in Section 13 of the Code of Federal Regulations, Part 121. La. R.S. 49:965.1(D)(2). A physician’s office with annual receipts of less than \$9 million is considered a “small business” under the applicable regulation. 13 C.F.R. § 121.201.<sup>12</sup> At the hearing on the preliminary injunction, Dr. John Burdine, owner of Spine Diagnostics, testified that Spine Diagnostics’ annual receipts total less than \$9 million per year. A review of the record before us reveals that this testimony was not contradicted. Thus, Spine Diagnostics meets the eligibility requirements set forth in the statute.

Because La. R.S. 49:965.1 provides for an award for reasonable litigation expenses, it is penal in nature. It is a well-settled rule of statutory construction that penal statutes must be strictly construed and their provisions shall be given a genuine construction according to the fair import of their words, taken in their usual sense, in connection with the context and with reference to the purpose of the provision. *Doc’s Clinic, APMC v. State ex rel. Dept. of Health and Hospitals*, 2007-0480, p. 32 (La. App. 1 dr. 11/2/07), 984 So.2d 711, 732, writ denied, 2007-2302 (La.2/15/08), 974 So.2d 665. Pursuant to the clear language of this statute, any award for reasonable litigation expenses is limited to \$7,500.00 and is inclusive of any and all costs, fees, and expenses associated with opposing or contesting the agency action. Thus, there can be no award over and above the \$7,500.00 for other expert fees and deposition costs such as those awarded by the trial court in this matter. Accordingly, we affirm the

\$7,500.00 award for litigation expenses and reverse that portion of the judgment awarding “all costs associated with these proceedings;” “all expert costs and fees;” and “costs of all deposition transcripts.”

## CONCLUSION

For the above and foregoing reasons, we reverse that portion of the trial court’s judgment awarding “all costs associated with these proceedings;” “all expert costs and fees;” and “costs of all deposition transcripts.” In all other respects, we affirm. All costs associated with this appeal are assessed equally against the Louisiana State Board of Nursing and the Louisiana Association of Nurse Anesthetists.

AFFIRMED IN PART; REVERSED IN PART.

## FOOTNOTES

- <sup>1</sup> The Louisiana Society of Anesthesiologists has intervened in the litigation praying for the same relief sought by Spine Diagnostics.
- <sup>2</sup> We note it was not necessary that Spine Diagnostics exhaust all administrative remedies prior to seeking injunctive relief in connection with its action for declaratory judgment. See La. R.S. 49:963(E).
- <sup>3</sup> In the opinion, the LSBME noted, in pertinent part, as follows: . the injection of local anesthetics, steroids and analgesics, peripheral nerve blocks, epidural injections and spinal facet joint injections, when used for interventional pain management of patients suffering from chronic pain, constitute the practice of medicine, are not delegable by a physician to a non-physician by physician prescription, direction or supervision, and may only be performed in this state by a physician licensed to practice medicine in Louisiana.
- <sup>4</sup> Spine Diagnostics subsequently moved to voluntarily dismiss Mr. Smith from this action, without prejudice. Judgment granting said dismissal was signed by the trial court on October 25, 2007.
- <sup>5</sup> According to the record, Senate Bill 322 was proposed as an attempt to amend La. R.S. 37:930(A) (3) relative to the practice of nursing to provide that it is within the scope of practice of a CRNA to perform certain pain management procedures, including peripheral nerve blocks, epidural injections, and spinal facet joint injections, when the CRNA can document education, training, and experience in performing such procedures.

6. On January 17, 2008, the trial court signed an amended judgment, which was identical in substance to the judgment rendered on January 10, 2008. According to the record, the amended judgment was necessary only to correct a clerical error because the original judgment indicated it had been signed on January 10, 2007, when in fact the judgment had been rendered on January 10, 2008.

7. Both the LSBN and LANA originally sought to suspensively appeal the trial court's judgment. However, the trial court denied the requests for suspensive appeals, and instead granted both parties devolutive appeals. Amici Curiae briefs on behalf of the American Association of Nurse Anesthetists, the Louisiana Association of Nurse Practitioners, the American Nurses Association, the Louisiana Alliance of Nursing Organizations, the Louisiana Hospital Association, and the National Council of State Boards of Nursing, Inc. have also been filed for this court's review.

8. Louisiana Revised Statutes 49:962 provides as follows: Each agency shall provide by rule for the filing and prompt disposition of petitions for declaratory orders and rulings as to the applicability of any statutory provision or of any rule or order of the agency. Declaratory orders and rulings shall have the same status as agency decisions or orders in adjudicated cases.

9. Louisiana Revised Statutes 37:930(A) provides as follows: A. No registered professional nurse shall administer any form of anesthetic to any person under their care unless the following conditions are met: (1) The registered nurse has successfully completed the prescribed educational program in a school of anesthesia which is accredited by a nationally recognized accrediting agency approved by the United States Department of Health, Education, and Welfare. (2) Is a registered nurse anesthetist certified by a nationally recognized certifying agency for nurse anesthetists following completion of the educational program referred to in Paragraph (1) of this Subsection and participates in a continuing education program of a nationally approved accreditation agency as from time to time required which program shall be recognized as the Continuing Education Program for Certified Registered Nurse Anesthetists; and (3) Administers anesthetics and ancillary services under the direction and supervision of a physician or dentist who is licensed to practice under the laws of the state of

Louisiana. [Emphasis added.]

10. We note that Mr. Smith did not testify during trial as to the number of interventional pain management procedures he performed. However, after the trial on the merits, there was a contempt hearing concerning a subpoena duces tecum that Mr. Smith had failed to respond to prior to trial. The motion for contempt against Mr. Smith was ultimately dismissed, and the parties entered into a stipulation that from 2004 to 2007, Mr. Smith performed a total of twelve interventional pain management procedures at the ambulatory surgical center in Vidalia.

11. Article 1920 provides as follows: Unless the judgment provides otherwise, costs shall be paid by the party cast, and may be taxed by a rule to show cause. Except as otherwise provided by law, the court may render judgment for costs, or any part thereof, against any party, as it may consider equitable.

12. Effective August 26, 2008, 13 C.F.R. 121.201 was amended to provide that a physician's office must now have annual receipts of less than \$10 million to be considered a "small business."

- See more at: <http://caselaw.findlaw.com/la-court-of-appeal/1124615.html#sthash.dh8rH3hy.dpuf>

## SECTION IV: LOUISIANA CRNA STATUTE AND RELATED MATERIALS

### 2015 Proposed CRNA rule change

Additionally, the proposed rule changes to LAC 46:XXXIII.313 allow for two things: 1) Mobile and Portable Dentistry Permits are required for the owner of any mobile or portable dentistry unit, but the permits are only issued to Louisiana licensed dentists. Federally Qualified Health Centers (FQHCs) are allowed to provide mobile and portable dentistry, but need not be owned by a dentist. Thus, although FQHCs are allowed to do mobile or portable dentistry, they cannot get permits because they are typically not owned by dentists. The change allows the permit to be issued to a Louisiana licensed dentist who practices in a FQHCs mobile or portable clinic, even if he or she is not the owner; and 2) the changes exempt dentists from all of the requirements of the mobile and portable permits if their sole mobile or portable practice consists of only making dentures or mouth guards.

#### II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

After the proposed rule changes become effective to LAC 46:XXXIII.313, the Louisiana State Board of Dentistry estimates receiving applications for approximately 3 new Federally Qualified Health Centers (FQHCs) mobile or portable permits per year. Each new FQHC mobile or portable permit costs \$250.00 and thereafter each dentist will be charged a renewal fee of \$400.00 for the mobile or portable permit upon renewal of his or her Louisiana dental license. The Board estimates annual revenues of approximately \$750 upon adoption of the proposed rule change with revenues growing to approximately \$1,800 by FY 18 for both new FQHC mobile or portable permits and the renewal of FQHC mobile or portable permits.

#### III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed changes to LAC 46:XXXIII.313 will affect any Louisiana licensed dentist who works for a Federally Qualified Health Center (FQHC) mobile or portable clinic. The dentist will be required to pay a fee of \$250 for a new mobile or portable permit and a renewal fee of \$400. The renewal fee will be charged at the time the dentist is required to renew his or her license, which occurs biennially.

#### IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change will allow FQHCs to provide mobile and portable dentistry services under the care of a licensed dentist. Eligible clients may realize greater access to services by utilizing mobile and portable dentistry services provided through FQHCs. The proposed rule change will also allow certain dentists to operate mobile or portable practices consisting of making dentures or mouth guards without paying for specific licensure to do so.

Arthur F. "Rusty" Hickham  
Executive Director  
1510#093

John D. Carpenter  
Legislative Fiscal Officer  
Legislative Fiscal Office

### NOTICE OF INTENT

#### Department of Health and Hospitals Board of Nursing

#### Licensure as an Advanced Practice Registered Nurse and Authorized Practice (LAC 46:XLVII.4507 and 4513)

Notice is hereby given in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 37:918, that the Louisiana State Board of Nursing (LSBN) is amending two

Sections in Chapter 45 of its rules: §§4507 and 4513. The proposed Rule changes will allow the Louisiana State Board of Nursing the ability to provide an opportunity for APRNs that have acquired licensure by alternative methods to go before the board and explain and/or justify why the Louisiana State Board of Nursing should extend licensure opportunities to him/her. It will also allow the Louisiana State Board of Nursing the ability to clarify exemption of CRNAs from the requirement to have a collaborative practice agreement to provide anesthesia care and ancillary services to patients in a hospital or other licensed surgical facility.

### Title 46

#### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XLVII. Nurses: Practical Nurses and Registered Nurses

#### Subpart 2. Registered Nurses

#### Chapter 45. Advanced Practice Registered Nurses

#### §4507. Licensure as Advanced Practice Registered Nurse

##### A. Initial Licensure

1. The applicant shall meet the following requirements:

a. - b.ii. ...

c. any deviation from Subparagraph 1.b shall be submitted to the board for review and approval;

d. submission of a completed application on a form furnished by the board;

e. submission of evidence of current certification in the respective advanced practice nursing role and population focus by a nationally-recognized certifying body approved by the board;

f. submission of a non-refundable fee as specified in LAC 46:XLVII.3341;

g. submission to criminal history record information as specified in LAC 46:XLVII.3330;

h. after initial licensure, applicants seeking licensure for advanced practice in an additional specialty and/or functional role shall meet the requirements stated in LAC 46:XLVII.4507.A.1.a-d;

i. if there is a gap equal to or greater than two years between the completion of the graduate or post graduate program as delineated in LAC 46:XLVII.4507.A.1.b and the application for initial licensure, the applicant must provide additional verification of competency as requested by the board and may be required to appear before the board (or its committee) for further consideration before licensure or a temporary permit may be granted.

A.2. - F.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Nursing, LR 22:281 (April 1996), amended LR 27:724 (May 2001), LR 29:580 (April 2003), LR 31:1340 (June 2005), LR 31:2015 (August 2005), LR 32:247 (February 2006), LR 37:3027 (October 2011), LR 40:61 (January 2014), LR 42:

#### §4513. Authorized Practice

A. - D.10. ...

11. Limitation

a. - b. ...

c. Exclusion. Nothing herein shall require a CRNA to have a collaborative practice agreement to provide anesthesia care and ancillary services to patients in a hospital or other licensed surgical facility.

i. Anesthesia care shall be within the scope of practice of CRNAs as delineated by the American Association of Nurse Anesthetists and includes:

(a). the administration, selection, and prescribing of anesthesia related drugs or medicine during the perioperative period necessary for anesthesia care; and

(b). prescribing diagnostic studies, legend and controlled drugs, therapeutic regimens, and medical devices and appliances necessary for anesthesia care.

ii. Ancillary services provided by CRNAs:

(a). shall include services within the scope of practice of CRNAs as delineated by the American Association of Nurse Anesthetists in which the individual CRNA possesses the knowledge, skills, and abilities to competently perform;

(b). shall be pursuant to a consult for the service by a licensed prescriber if the services are not directly related to anesthesia care; and

(c). may include prescribing diagnostic studies, legend and controlled drugs, therapeutic regimens, and medical devices and appliances for assessment, administration or application while the patient is in the hospital or other licensed surgical facility in the state of Louisiana.

iii. Nothing herein shall provide for services by a CRNA which are otherwise prohibited by law.

11.d. - 14.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918(K) and R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 10:598 (August 1984), amended by the Department of Health and Hospitals, Board of Nursing, LR 22:283 (April 1996), amended by the Department of Health and Hospitals, Board of Nursing and Board of Medical Examiners, LR 22:981 (October 1996), LR 25:1245 (July 1999), LR, amended by the Department of Health and Hospitals, Board of Nursing, 27:727 (May 2001), amended by the Department of Health and Hospitals, Board of Nursing and Board of Medical Examiners, LR 28:487 (March 2002), repromulgated LR 28:1205 (June 2002), amended by the Department of Health and Hospitals, Board of Nursing, LR 31:2023 (August 2005), LR 33:1870 (September 2007), LR 40:63 (January 2014), LR 40:2249 (November 2014), LR 42:

#### **Family Impact Statement**

The proposed additions and/or changes to the rules of the board, Louisiana State Board of Nursing should not have any known or foreseeable impact on any family as defined by R.S. 49.972(D) or on family formation, stability and autonomy. Specifically, there should be no known or foreseeable effect on:

1. the stability of the family;
2. the authority and rights of parents regarding the education and supervision of their children;
3. the functioning of the family;
4. a family's earnings and budget;
5. the behavior and personal responsibility of the children; or
6. the family's ability or that of the local government to perform the function as contained in the proposed Rule.

#### **Poverty Impact Statement**

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described on R.S. 49:973.

#### **Provider Impact Statement**

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

#### **Public Comments**

Interested persons may submit written comments on the proposed Rule to Karen C. Lyon, 17373 Perkins Road, Baton Rouge, LA 70810, or by facsimile to (225) 755-7585. All comments must be submitted by 5 p.m. on or before November 10, 2015.

Karen C. Lyon  
Executive Director

#### **FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES**

##### **RULE TITLE: Licensure as an Advanced Practice Registered Nurse and Authorized Practice**

##### **I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)**

Other than publication costs associated with the proposed rule changes, which are estimated to be \$656 in FY 16, it is not anticipated that state or local governmental units will incur any other costs or savings as a result of promulgation of the proposed rule. The proposed changes provide definitions and clarifications of the current exclusion for Certified Registered Nurse Anesthetists (CRNA) from being required to have a collaborative practice agreement in order to provide anesthesia care and ancillary services to patients in a hospital or other licensed surgical facility. The proposed changes will also require an Advanced Practice Registered Nurse (APRN) to define any deviation from stated licensure requirements during the initial licensure phase. These deviations shall be submitted to the board for review and approval. This rule does not require an increase or decrease in workload responsibilities to the Board.

##### **II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The proposed rule change will not affect state or local governmental revenue collections.

##### **III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

The proposed rule change is not anticipated to result in costs and/or economic benefits to any person or non-governmental groups.

##### **IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

The proposed rule change may allow certain APRNs to acquire licensure via an alternative method that is generally not

recognized by national, state and/or local boards. Any such licensure would require review and approval by the board.

Karen C. Lyon  
Executive Director  
1510#062

John D. Carpenter  
Legislative Fiscal Officer  
Legislative Fiscal Office

## NOTICE OF INTENT

### Department of Health and Hospitals Board of Practical Nurse Examiners

#### Types of Licensure (LAC 46:XLVII.1703)

The Board of Practical Nurse Examiners proposes to amend LAC 46:XLVII.1703, in accordance with the provisions of the Administrative Procedure Act, R.S. 950 et seq., and the Practical Nursing Practice Act, R.S. 37:961-979.

The purpose of the proposed Rule change to Section 1703 is to ensure that the practical nurse graduate possess the knowledge, skill and ability to engage successfully in the clinical setting.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XLVII. Nurses: Practical Nurses and Registered Nurses

##### Subpart 1. Practical Nurses

#### Chapter 17. Licensure

##### §1703. Types of Licensure

###### A. - A.1. ...

2. be permitted to write the examination up to four times within a period of two years from the date of being made eligible;

3. re-enter and successfully complete the entire practical nursing program without advance credits if the fourth writing is unsuccessful before being allowed to take the practical nursing examination again;

###### B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:969, 37:971 and 37:972.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Practical Nurse Examiners, LR 3:199 (April 1977), amended LR 10:341 (April 1984), LR 10:915 (November 1984), amended by the Department of Health and Hospitals, Board of Practical Nurse Examiners, LR 18:1129 (October 1992), repromulgated LR 18:1263 (November 1992), amended LR 28:2355 (November 2002), LR 42:

#### Family Impact Statement

The proposed amendments to LAC 46:XLVII.Subpart 1 should not have any impact on family as defined by R.S. 49:972. There should not be any effect on: the stability of the family; the authority and rights of parents regarding the education and supervision of their children; the functioning of the family; family earnings and family budget; the behavior and personal responsibility of children; and/or the ability of the family or local government to perform the function as contained in the proposed Rule.

#### Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, it is anticipated that the proposed amendments will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

#### Provider Impact Statement

The proposed amendments should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known foreseeable effect on:

1. Is there an effect on the staffing level requirements or qualifications required to provide the same level of service? There will be no effect on the staffing level requirements or qualifications required to provide the same level of service.

2. Is there a total direct and indirect effect on the cost to the providers to provide the same level of service? There is not a direct or indirect effect on the cost to the providers to provide the same level of service.

3. What is the overall effect on the ability of the provider to provide the same level of service? There is no effect on the ability of the provider to provide the same level of service.

#### Public Comments

Interested persons may submit written comments until 4 p.m., November 9, 2015, to M. Lynn Ansardi, RN, Board of Practical Nurse Examiners, 131 Airline Drive, Suite 301 Metairie, LA 70001.

M. Lynn Ansardi, RN  
Executive Director

### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Types of Licensure

#### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The only anticipated costs to the board associated with the implementation of the proposed Rule change will be to publish the Rule in the Louisiana Register at approximately \$164.00 and to mail notices to affected applicants informing them of the Rule change at approximately \$1,000.00 in FY 16. No other state or local governmental units will be affected.

#### II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule change may slightly decrease revenue collected by this state agency but will not have an effect on revenues collected by other state agencies or local governmental units.

#### III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The only person(s) affected by this Rule change would be applicants for licensure who do not pass the practical nursing examination in the time allotted. They will have to re-enroll and repeat the entire practical nursing program before applying again to take the practical nursing examination.

**SECTION IV: LOUISIANA CRNA STATUTE AND RELATED MATERIALS**  
***CRNA rule change “final”***

c. exclusion. Nothing herein shall require a CRNA to have a collaborative practice agreement to provide anesthesia care and ancillary services to patients in a hospital or other licensed surgical facility:

- i. Anesthesia care includes modalities associated with the delivery of anesthesia. Anesthesia Care provided by a CRNA shall be in accord with the educational preparation of that CRNA in compliance with R.S.37:930(A)(3) and includes
  - a. The administration, selection, and prescribing of anesthesia related drugs or medicine during the perioperative period necessary for anesthesia care; and
  - b. Prescribing diagnostic studies, legend and controlled drugs, therapeutic regimens, and medical devices and appliances necessary for anesthesia care.
- ii. Ancillary services provided by CRNAs shall be in accordance with R.S.37:930(A)(3):
  - a. Shall include services provided by a CRNA in accord with the educational preparation of that CRNA;
  - b. Shall be pursuant to a consult for the service by a licensed prescriber if the services are not directly related to anesthesia care; and
  - c. May include prescribing diagnostic studies, legend and controlled drugs, therapeutic regimens, and medical devices and appliances for assessment, administration or application while the patient is in the hospital or other licensed surgical facility in the State of Louisiana.
- iii. Nothing herein shall provide for services by a CRNA, which are otherwise prohibited by law.

## **SECTION V: MEDICARE OPT-OUT SUMMARY**

### ***Medicare Opt-Out***

## SECTION V: MEDICARE OPT-OUT SUMMARY

### *Medicare Opt-Out*

#### MEDICARE OPT-OUT BACKGROUND AND RELATED ACTIVITY

On November 13, 2001, the Bush Administration published a final rule regarding the Medicare and Medicaid anesthesia Conditions of Participation (COP) for hospitals, critical access hospitals (CAHs) and ambulatory surgical centers (ASCs). The rule retains the current requirement for physician supervision of nurse anesthetists, but allows state governors to opt-out of this requirement under certain circumstances.

To opt-out, a governor must first consult with the medical and nursing boards regarding access to and the quality of anesthesia services in the state. If opting-out is consistent with state law, and if the governor determines that it is in the best interests of the citizens of the state to opt-out, the governor must advise the Centers for Medicare & Medicaid Services (CMS) in writing. The opt-out becomes effective upon submission of the request. A governor may retract this action at any time.

The American Society of Anesthesiologists strongly opposes gubernatorial opt-outs.

#### Current Opt-Out States

- Iowa (December 2001)
- Nebraska (February 2002)
- Idaho (March 2002)
- Minnesota (April 2002)
- New Hampshire (June 2002)
- New Mexico (November 2002)
- Kansas (March 2003)
- North Dakota (October 2003)
- Washington (October 2003)
- Alaska (October 2003)
- Oregon (December 2003)
- Montana (January 2004)
- South Dakota (March 2005)
- Wisconsin (June 2005)
- California (July 2009)
- Colorado (September 2010)\*
- Kentucky (April 2012)

## **SECTION VI: KEY LSBME STATEMENTS**

### ***LSBME Statements on Pain and Regional Anesthesia***

## SECTION VI: KEY LSBME STATEMENTS

### *LSBME Statements on Pain and Regional Anesthesia*

**Louisiana State Board of Medical Examiners**  
630 Camp Street, New Orleans, LA 70130  
(504) 568-6820

#### \*\*\* STATEMENT OF POSITION \*\*\*

#### **INTERVENTIONAL PAIN MANAGEMENT PROCEDURES ARE NOT DELEGABLE June 2006**

**SUMMARY.** It is the opinion of the Louisiana State Board of Medical Examiners (the “Board”) that the injection of local anesthetics, steroids and analgesics, peripheral nerve blocks, epidural injections and spinal facet joint injections, when used for purposes of interventional pain management, constitute the practice of medicine, are not delegable by a physician to a non-physician by prescription, direction or supervision and may only be performed in this state by a Louisiana licensed physician. This guidance is provided by the Board to assist Louisiana physicians in the course of their professional practices.

**STATEMENT OF POSITION.** In recent months, the Board has received several requests for advisory opinions as to the legality, under applicable state law<sup>1</sup> of physician delegation, through prescription or order, of certain interventional pain management procedures to certified registered nurse anesthetist (“CRNAs”). CRNAs provide anesthetics and ancillary services and may administer local anesthetics perineurally, peridurally, epidurally, intrathectically, or intravenously, when prescribed by a physician and performed under physician direction and supervision.<sup>2</sup> In conformity with their education, training and scope of practice CRNAs, as a profession, were established to, for many years have, and currently remain essential providers of anesthesia for surgery and acute pain associated with surgery, under physician direction and supervision.

In contrast, physicians specializing in the management of chronic pain utilize some or all of these same procedures— injection of local anesthetics, steroids and analgesics, peripheral nerve blocks, epidural injections and spinal facet joint injections—as diagnostic tools to assess the cause of a patient’s chronic pain, as therapeutic modalities of treatment, and as a basis upon which to recommend additional treatment, including the need for surgical intervention and repeated or additional treatments. Due to the risk of death, paralysis, cerebral vascular accidents and infection attendant to these procedures, they are typically performed in a hospital or ambulatory surgery setting to afford patients the full range of life-saving measures that may result from an untoward event. They are also usually performed in combination with fluoroscopy and x-ray, neither of which CRNAs are formally trained to diagnose and interpret, but both of which are essential to insure proper needle and anesthetic placement for the safety of the patient.

<sup>1</sup> LA. REV. STAT. §§37:1261, *et seq.*

<sup>2</sup> LA. REV. STAT. §§37:930A (3), 37:930D.- When used in this manner by physicians specializing in the treatment of chronic pain, these procedures are referred to as “interventional pain management.”

<sup>3</sup> LA. REV. STAT. ANN. §37:1261(1), defines the ‘practice of medicine,’ to include:

[T]he diagnosing, treating, curing, or relieving of any bodily...disease, condition, infirmity, deformity, defect, ailment, or injury in any human being...whether by the use of any drug, instrument or force...or of what other nature, or any other agency or means....

<sup>4</sup> “No person shall practice medicine as defined herein [the Medical Practice Act] until he possesses a duly recorded license issued under this Part or a permit or registration as provided for herein.” LA. REV. STAT. ANN. §37:1271.

When used for interventional pain management purposes such procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inferences and judgments drawn from patient response to the anesthetic or other agent being administered. In such instances, it is not the procedures—but the purpose and manner in which such procedures are utilized—that demand the ongoing application of direct and immediate medical judgment, which constitutes the practice of medicine, and which may only be performed in this state by a Louisiana licensed physician.

While a CRNA may utilize these procedures on the order of and under physician direction and supervision for surgical cases and acute pain associated with surgery, for a physician to permit a CRNA, or any non-physician for that matter, to employ them to diagnose, manage or treat chronic pain patients would necessarily permit the CRNA to exercise independent medical judgment, perform diagnostic testing, render diagnoses, and provide

treatment or recommendations for treatment of patients suffering with chronic pain. Such determinations are essentially diagnostic and treatment decisions that can have critical implications for the patient are reserved solely to those licensed to practice medicine in this state and, in the Board's view, are not delegable by a physician to a non-physician by physician prescription, direction or supervision.<sup>4</sup>

The Board's opinion is not and cannot be altered by representations that a particular CRNA has received postdoctoral training in such areas or has performed such activities in this or another state. A non-physician may have education, training and, indeed, expertise in such area but expertise cannot, in and of itself, supply authority under law to practice medicine.

For these reasons, it is the opinion of the Board that the injection of local anesthetics, steroids and analgesics, peripheral nerve blocks, epidural injections and spinal facet joint injections, when used for interventional pain management of patients suffering from chronic pain, constitute the practice of medicine, are not delegable by a physician to a non-physician by physician prescription, direction or supervision, and may only be performed in this state by a physician licensed to practice medicine in Louisiana.

#### **LOUISIANA STATE BOARD OF MEDICAL EXAMINERS**

Louisiana State Board of Medical Examiners

630 Camp Street, New Orleans, LA 70130

(504) 568-6820

\*\*\* STATEMENT OF POSITION \*\*\*

Administration of Regional Anesthesia

August 24, 1984

Reviewed March 20, 2001

The administration of regional anesthesia (including intrathecal, extrathecal, epidural and peridural nerve injections) constitutes the practice of medicine as defined by La. Rev. Stat. 37:1262(1). Such procedures may therefore be performed only by a physician duly licensed by the Board under La. Rev. Stat. 37:1261-91, or under the personal direction and immediate (on-premises) supervision of a physician. A physician who directs and supervises a nonphysician in the administration of regional anesthesia must have adequate and appropriate training and experience in the performance of the procedure and a thorough knowledge of the potential untoward effects of the procedure and the anesthetic agents used therein, and in the proper management of such untoward effects. In any event, the physician is and remains responsible for the performance and results of regional anesthesia procedures.

In making this statement, the Board makes no distinction between initial injection and reinjection.

Louisiana State

**Section VII:**  
**REFERENCE ARTICLE ON LOUISIANA**  
**ANESTHESIA WORKFORCE**

*Draft of Journal of LSMS Article  
on anesthesia workforce on LA*

## **BACKGROUND**

### **Providers of Anesthesia Services**

#### Anesthesiologists

Anesthesiologists are physicians who have completed four years of medical school and obtained a doctorate of medicine (M.D.). After completion of medical school, physicians must complete a four-year residency training program in anesthesiology. Upon successful completion of residency training, an anesthesiologist must sit for both written and oral examinations to obtain board certification by the American Board of Anesthesiology. Anesthesiologists may also pursue fellowship training in the subspecialty fields of anesthesiology, critical care, and pain management. In addition to perioperative care, anesthesiologists practice as consultants and primary providers of care in intensive care and pain management settings. With regard to perioperative care, anesthesiologists practice as consultant medical specialists, both as solo practitioners and as leaders of the anesthesia care team.

#### Mid-Level Providers

There are two types of mid-level anesthesia providers in the United States. They include certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants (AAs).

A CRNA is a registered nurse (RN) who receives specialized training in the delivery of anesthesia. This training program is of at least 24 months duration and a master's degree is granted at the conclusion. Upon completion of their training, CRNAs must pass a national certification exam in order to practice. CRNAs may deliver anesthesia only under the direction or supervision of a physician, either an anesthesiologist or the physician

performing the procedure that requires anesthesia. Currently CRNAs are the only type of mid-level anesthesia provider practicing in the State of Louisiana. Regulatory oversight of CRNA practice, including scope of

practice, is by the Louisiana State Board of Nursing. There are approximately 90 schools of nurse anesthesia in the United States. The one school present in the State of Louisiana will be without an academic affiliation and cannot currently accept new students.

The second type of mid-level provider is an anesthesiologist assistant. AAs are analogous to physician's assistants except that an AA receives specialized training in the delivery of anesthesia rather than training for the delivery of primary care. The training program for AAs is at least 24 months in duration and AAs earn a master's degree upon completion. An AA must pass a national certification exam covalidated by the National Board of Medical Examiners in order to practice. Applicants for acceptance into AA training programs must possess a bachelor's degree with required basic science courses typical of a pre-medical curriculum. Anesthesiologist assistants may deliver anesthesia only under the supervision of an anesthesiologist. Nationally the regulatory oversight of AA practice, including scope of practice, falls under each state's medical board or comparable body. In a recent opinion rendered by the Louisiana State Board of Medical Examiners (January 2001), the practice of AAs is now recognized under the provision for delegatory authority of physicians to qualified professionals. There are currently no AAs practicing in the State of Louisiana. Presently, there are two training programs for AAs in the United States with additional AA training programs in development.

## Practice Models for Delivery of Anesthesia Services

### Anesthesia Care Team

The Anesthesia Care Team (ACT) refers to the practice model in which an anesthesiologist directs or supervises the administration of anesthesia by a mid-level provider. The anesthesiologist acts as the perioperative physician directing medical care before, during, and after surgery. The mid-level provider typically administers anesthesia according to the plan set forth by the anesthesiologist. The anesthesiologist: 1) is present for all critical points of the anesthetic and surgical procedure, 2) performs routine interval monitoring of the patient while under anesthesia, and 3) remains immediately available to respond to any concerns or emergencies. The advantage of the ACT is that it allows patients access to physicians that are highly skilled and trained in the field of anesthesiology. The ACT is the most efficient use of available physician manpower and has been consistently shown to provide safe patient care. The ACT model is the predominant model for utilization of anesthesia services (based on number of patients cared for) in Louisiana and the United States. Nationally, CRNAs and AAs are used interchangeably as mid-level providers within the anesthesia care team model. Both CRNAs and AAs are recognized by the Health Care Financing Administration, and reimbursement for services provided within the anesthesia care team are identical.

### Anesthesiologist – Solo Practitioner

The second most common model of anesthesia delivery nationally is that of an anesthesiologist directly administering anesthesia intraoperatively as well as providing perioperative medical management. This model does not use a mid-level anesthesia provider. The anesthesiologist may be part of a group that does utilize the anesthesia care team model as well as physician-only care. The advantage of having an anesthesiologist as the sole provider of anesthesia service is that it provides patients with continuous access to physicians highly skilled and trained in the field of anesthesiology. The disadvantage of this model of practice is that the anesthesiologist is limited to providing care to only one patient at a time. Consequently, there may not be enough anesthesiologists to provide solo anesthesia care for all patients presenting for surgical or obstetric procedures.

### Certified Registered Nurse Anesthetist – Solo Practitioner

The least common model of anesthesia delivery nationally is that of a certified registered nurse anesthetist directly administering anesthesia intraoperatively and participating in perioperative care under the supervision of the patient's surgeon and/or primary care physician. In this model, CRNAs practice without the supervision of an anesthesiologist. This model increases the available pool of anesthesia providers. The disadvantage with this model is that the only person with specific training in the administration of anesthesia is limited in their medical background and training. According to a study published in the July 2000 edition of *Anesthesiology*, Silber, *et al.*(1) found that the adjusted odds ratios for death and failure-to-rescue were greater in Medicare patients when care was not directed by an anesthesiologist. The study concluded that this corresponded to 2.5 excess deaths/1,000 patients and 6.9 excess failures-to-rescue (deaths) per 1,000 patients with complications. Both 30-day mortality rate and mortality rate after complications (failure-to-rescue) were lower when anesthesiologists directed anesthesia care. The results of this study suggest that surgical outcomes in Medicare patients are associated with anesthesiologist direction, and may provide insight regarding potential approaches for improving surgical outcomes.

The services of anesthesiologists, like other medical specialists, are not provided at all medical facilities. The CRNA – solo practitioner model utilizes CRNAs as substitute providers in locations without the benefit of an anesthesiologist's services.

## **Current Anesthesia Delivery in Louisiana**

The delivery of anesthesia services will be described in both the metropolitan and the rural areas. This division was made because healthcare delivery in the rural areas is a major concern, and the rural areas are noted to be of particular concern with regard to delivery of anesthesia services.

### Metropolitan Areas

According to the U.S. Census Bureau, Louisiana has eight metropolitan areas with a total metropolitan population of 3,286,863. The areas are New Orleans, Baton Rouge, Shreveport/Bossier City, Lafayette, Houma, Lake Charles, Monroe, and Alexandria. These metropolitan areas include all or part of 24 parishes and serve as the referral sites for most of the state's patients requiring complex medical and surgical treatment. The overwhelming majority of procedures requiring anesthesia services are performed within these metropolitan areas. In addition, the model of anesthesia delivery in the metropolitan areas is overwhelmingly the anesthesia care team.

### Rural Areas

Approximately 25% of Louisiana's citizens live in non-metropolitan areas (this includes 40 "non-metropolitan" parishes as defined by the U.S. Office of Management and Budget). Any assessment of the State's healthcare needs must account for the citizens that reside in the rural areas and depend on rural hospitals for their basic healthcare needs. In order to ensure inclusion of any smaller facilities and because of the overlapping of portions of many rural parishes into metropolitan areas it was necessary to consider each parish in terms of its population and consider any hospitals in the 54 least populated parishes. The analysis of anesthesia delivery in the least populated parishes (described in detail below) revealed a mix of practice models. The predominant model (in terms of procedures utilizing anesthesia services) was again found to be the anesthesia care team model.

There were some facilities that utilized CRNAs acting as the sole providers of anesthesia services under the supervision of the operating physician. In addition, there were a small number of facilities that utilized anesthesiologists (physicians) as the sole providers of anesthesia and perioperative medical management.

## **METHODOLOGY**

### **Sources of Data**

In performing this analysis several sources of data were used: 1) U.S. Census Data, 2) The American Hospital Directory (featuring the American Hospital Association Survey Data), 3) The Louisiana Hospital Association Hospital Directory, 4) The Louisiana State Center for Health Statistics – Division of Health Information, 1998 LA Vital Statistics, 5) The American Association of Nurse Anesthetists (AANA) "Fact Sheet" for Louisiana, and 6) The LSUHSC Louisiana Rural Hospital Operating Room (OR) Utilization Survey.

Data obtained from the U.S. Census was accepted as factual and used for population analysis. Data from

the American Hospital Directory was cross-referenced with data from the Louisiana Hospital Association Hospital Directory to ensure that all hospitals within a given parish were identified. Data from the 1998 LA Vital Statistics (live births) was cross-referenced with obstetric activity reported by facilities to verify data collected by the LSUHSC Louisiana Rural Hospital OR Utilization Survey. In addition, the 1998 LA Vital Statistics (live births) was utilized to obtain the total number of live births in Louisiana and to calculate percent of total live births in Louisiana. Data from the AANA “Fact Sheet” was cross-referenced with data collected by the LSUHSC Louisiana Rural Hospital OR Utilization Survey and any discrepancies were noted.

The AANA “Fact Sheet” presents data noted to be derived from several sources. The details and/or methodology by which the data was obtained for the AANA 1999 Membership Survey, The AANA Demographic Survey 2000, and the 1997 Study of CRNA/Anesthesiology Distribution could not be obtained as this information was designated as “proprietary” by AANA representatives.

The LSUHSC Louisiana Rural Hospital OR Utilization Survey was conducted in the fall of 2000. The survey was performed to obtain specific information regarding the utilization of operating rooms and anesthesia services within the rural areas of Louisiana. The survey was necessary because there was no source of data regarding the number of ORs available, the number of ORs utilized, the number of surgical procedures, or the model of anesthesia delivery within the rural parishes of Louisiana.

The LSUHSC Louisiana Rural Hospital OR Utilization Survey focused on parishes with a population less than 100,000 (according to U.S. Census Bureau estimates for 7/1/1999) in order to capture all rural facilities. Of the 64 total parishes in Louisiana, 54 parishes have a population less than 100,000. Data collected from the hospitals in the 10 largest parishes was limited to total number of OR procedures, and is used only as a reference value for calculating percent of total services provided in Louisiana.

### **LSUHSC Louisiana Rural Hospital OR Utilization Survey**

Hospital facilities in Louisiana were identified using the American Hospital Directory and were cross-referenced with the Louisiana Hospital Association Hospital Directory. This process identified a total of 195 facilities, including general, psychiatric, specialty, long-term care and military facilities. We also reviewed U. S. Census Bureau population estimates for 1999 in the State of Louisiana and identified 54 of the 64 parishes with a population of less than 100,000. The largest parish included was Tangipahoa with a population of 98,285. The smallest parish not included was Terrebonne with a population of 105,128. We contacted all facilities in the 54 least populated parishes and identified the hospitals that offered surgical and obstetric services (i.e., those which utilized anesthesia services). The only facility utilizing anesthesia services that did not participate in the survey was the Bayne-Jones Army Community Hospital in Vernon Parish. We interviewed OR directors, supervisors, hospital administrators or their designees who had direct knowledge and statistics regarding OR and/or OB utilization and staffing. When necessary, obstetric information was collected from OB directors and/or supervisors, or their designees who had direct knowledge and statistics. Interviewees were asked to provide information regarding OR utilization and surgical activity over at least six continuous months within the last two calendar years. Interviewees were asked to provide surgical activity exclusive of gastrointestinal endoscopic procedures, which in smaller facilities are frequently performed in operating rooms but rarely utilize anesthesia services. Three LSUHSC physicians who identified themselves as LSUHSC representatives, without identifying themselves as anesthesiologists, conducted the telephone interviews. The interviews were based on a standardized questionnaire (attachment 1). In addition as part of the standard interview, all respondents were questioned with regard to any other facilities in their area at which patients received surgical services. This data was used to help ensure that all facilities utilizing anesthesia services were identified and included in the survey. The data collected from the 54 parishes with a population less than 100,000 was placed into spreadsheets and population, OR utilization, and anesthesia

utilization were analyzed.

Facilities located in the 10 parishes with a population of greater than 100,000 were also contacted, and those offering surgical service were asked to provide the annual number of surgical procedures performed. The standard questionnaire, used for the 54 least populated parishes, was not used for facilities in these 10 parishes. The standard questionnaire was not used because the main focus of the survey was health care delivery in rural parishes. In addition, it became readily apparent that metropolitan facilities were reluctant to share detailed information.

## **ANALYSIS**

The total population of Louisiana is 4,372,035. The total population within the 54 parishes (each with a population less than 100,000) is 1,889,006. Therefore these 54 parishes represent 43.2% of the total population of Louisiana.

The total number of parishes in Louisiana is 64. Of these 64 parishes, only 47 parishes contained hospitals offering surgical and anesthesia services. Of the 54 least populated parishes, hospitals offering surgical and anesthesia services are located in 37 parishes.

The total number of hospitals located in Louisiana is 195. Of these 195 hospitals, 117 offer surgical and anesthesia services. In the 54 least populated parishes a total of 56 hospitals offer surgical and anesthesia services. In the 10 most populated parishes a total of 61 hospitals offer surgical and anesthesia services.

The total number of surgical procedures performed annually in the 117 hospitals offering services was reported to be 423,202. In the 56 hospitals providing services in the 54 least populated parishes a total of 74,672 surgical procedures were reported. This represents 17.6% of all surgical procedures performed annually in Louisiana.

The total number of live births in Louisiana during 1998 was 67,100. This data was included because each live birth represents a potential obstetric anesthesia encounter (e.g. labor epidural and/or surgical delivery). In the 54 least populated parishes there were a total of 13,060 live births. This represents 19.5% of the total live births in Louisiana. According to the LSUHSC survey, 2700 live births were reported in facilities where CRNAs may practice using the CRNA – solo practitioner model. If each expectant mother received anesthesia services, this figure would represent 4.0% of the potential obstetric anesthesia encounters in Louisiana.

As mentioned in the introduction, the focus of this assessment is the 54 parishes, each with a population less than 100,000. As such, the detailed data regarding OR utilization and anesthesia services in those 54 parishes was obtained. Within these 54 least populated parishes we analyzed anesthesia delivery with regard to practice model, number of facilities, number of procedures utilizing anesthesia services, and number of operating rooms utilizing anesthesia services on a daily basis.

In the 54 parishes, the most commonly occurring model of practice ***by number of facilities*** was certified registered nurse anesthetist – solo practitioner, accounting for 23 of 56 hospitals (41.1%). The next most common model of practice was the anesthesia care team (ACT) accounting for 20 of 56 hospitals (35.7%). Anesthesiologists providing services in a solo practitioner model accounted for 4 of the 56 hospitals (7.1%). And finally, in 9 of 56 hospitals (16.1%) a mixture of the ACT, anesthesiologist – solo practitioner, and CRNA – solo practitioner models of anesthesia delivery were utilized.

In the 54 parishes there are 179 operating rooms available in the 56 hospitals. On an average daily basis,

114 operating rooms were utilized at any given time. The most commonly occurring model of practice **by number of operating rooms** was the ACT, accounting for 80 of 114 operating rooms (70.2%). The next most common model was CRNA – solo practitioner accounting for 27 of 114 operating rooms (23.7%). Anesthesiologists providing services in a solo practitioner model accounted for 7 of 114 operating rooms (6.1%). For hospitals using a mixture of practice models, operating rooms were allocated to one of the above practice models based on detailed information collected during the survey.

In the 54 parishes there were 74,547 surgical procedures in the 56 hospitals. The most commonly occurring model of practice **by number of procedures** was the ACT accounting for 52,508 of 74,547 procedures (70.4%). The next most common model was CRNA – solo practitioner, accounting for 17,308 of 74,547 procedures (23.2%). Anesthesiologists providing services in a solo practitioner model accounted for 4,731 of 74,547 procedures (6.3%). For hospitals using a mixture of practice models, procedures were allocated to one of the above practice models based on detailed information collected during the survey. The American Association of Nurse Anesthetists (AANA) provided data which purports to address anesthesia delivery in parishes with a population of 10,000 to 91,000 that have no physician anesthesiologists (24 parishes included). Their data claims that CRNAs practicing as solo practitioners provide anesthesia for 120,889 cases in these 24 parishes. Our analysis of rural OR utilization (described in this paper) demonstrates that this data is erroneous. We contacted the AANA in an effort to analyze their data and understand the methodology of data collection, however we were told that this information was proprietary and we could not have access to that information.

The data collected by the LSUHSC survey was compared with information provided by the AANA. The following discrepancies were found with regard to the 24 parishes described as “CRNA only”;

- 1). Of the 24 parishes described as “CRNA only” by the AANA, 3 parishes had no hospitals providing surgical or obstetric services, and at least 10 parishes were found to have practicing anesthesiologists. This leaves at most 11 of the 24 parishes described by the AANA as “CRNA only” with CRNAs as the sole providers of anesthesia services. In fact, of the 64 parishes in Louisiana LSUHSC identified a maximum of 13 parishes in which CRNAs were the sole providers of anesthesia services.
- 2). The AANA estimates a total of 120,889 “anesthesia cases” provided by CRNAs as solo practitioners in these 24 parishes. The LSUHSC data indicates that there are fewer than 20,000 total procedures performed annually in the 24 parishes designated by the AANA as “CRNA only”. In fact, there are only 13 parishes in Louisiana in which CRNAs are the sole providers of anesthesia services, and in these 13 parishes fewer than 10,000 cases are performed annually.
- 3). The population of the 13 parishes where CRNAs appear to be the sole providers of anesthesia services is 310,022. This is 7.1% of the total population of Louisiana. Although 7.1% of the population resides in these parishes, this does not translate into 7.1% of the anesthetic cases performed in Louisiana. The cases requiring anesthesia services in these 13 parishes represent approximately 2.3 % of the total cases requiring anesthesia in Louisiana.
- 4). In the 13 parishes in which CRNAs are the sole providers of anesthesia services there are approximately 14 individual operating rooms which need to be covered on a daily basis.
- 5). In the 13 parishes in which CRNAs are the sole providers of anesthesia service the total number of live births was 1,908. This represents 2.8% of the total live births in Louisiana.

## **SUMMARY**

There is an average of 423,202 surgical procedures requiring anesthesia services performed annually in Louisiana. The overwhelming majority (82.4%) of these procedures are performed in the 10 parishes with a population greater than 100,000. If the procedures were divided into metropolitan and rural sites (as defined by the U.S. Office of Management and Budget), 90.9% of the surgical cases in Louisiana requiring anesthesia

services are performed in metropolitan areas. Unquestionably, the overwhelmingly predominant model of anesthesia delivery in the metropolitan areas is the anesthesia care team.

In the 54 parishes each with a population less than 100,000 there are 74,672 surgical procedures performed annually which require anesthesia services. Either the anesthesia care team or an anesthesiologist (as a solo practitioner) provides anesthesia services for the majority of procedures (76.8%) in the least populated parishes. Approximately 17,308 procedures were performed in the 54 least populated parishes utilizing the CRNA – solo practitioner model. This represents 4.1% of all surgical procedures requiring anesthesia services in Louisiana.

In the 54 least populated parishes there were a total of 13,060 live births. This represents 19.5% of the total live births in Louisiana. A total of 2700 live births were reported in facilities where CRNAs may practice using the CRNA – solo practitioner model. If each expectant mother received anesthesia services, this figure would represent 4.0% of the potential obstetric anesthesia encounters in Louisiana.

In summary, approximately 4.1% of the total number of obstetric and surgical cases in Louisiana are performed by CRNAs who may be practicing solo in the 54 least populated parishes.

## **CONCLUSION**

The collection and analysis of data related to OR utilization and the delivery of anesthesia services is essential to making sound healthcare policy decisions for the State of Louisiana. Accurate data on anesthesia services is also needed to help guide the development of training programs in the State of Louisiana. The overwhelming majority of anesthetics for surgical and obstetric procedures in the State of Louisiana are provided utilizing the anesthesia care team approach. As described, both anesthesiologist assistants and certified registered nurse anesthetists provide care and are used interchangeably under the medical direction of an anesthesiologist within the anesthesia care team model. The need for continued training of physician anesthesiologists is apparent and increasing medical student interest in the medical specialty of anesthesiology is encouraging. When considering the options for mid-level anesthesia providers within the State, the data presented in this article supports the training and utilization of both CRNAs and AAs. In light of the well publicized shortage of registered nurses both nationally and within the State, options for mid-level anesthesia providers which draw from a more diverse, yet equally qualified pool, should be given strong consideration.

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2. As published in the Journal of the Louisiana State Medical Society  
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## **SECTION VIII: IMPORTANT LINKS**

### ***Important Links***

## Important Links

Louisiana Society of Anesthesiologists	<a href="http://www.lsahq.org">www.lsahq.org</a>
American Society of Anesthesiologists	<a href="http://www.asahq.org">www.asahq.org</a>
ASA VA Comment	<a href="http://www.SafeVAcare.org">www.SafeVAcare.org</a>
Louisiana State Board of Medical Examiners	<a href="http://www.lsbme.org">www.lsbme.org</a>
Louisiana State Board of Nursing	<a href="http://www.lsbm.state.la.us">www.lsbm.state.la.us</a>
American Board of Anesthesiology	<a href="http://www.theaba.org">www.theaba.org</a>
Louisiana House of Representatives	<a href="http://www.house.louisiana.gov">www.house.louisiana.gov</a>
Louisiana State Senate	<a href="http://www.senate.la.gov">www.senate.la.gov</a>
Department of Health and Hospitals	<a href="http://www.dhh.louisiana.gov">www.dhh.louisiana.gov</a>
American Academy of Anesthesiologist Assistants	<a href="http://www.anesthetist.org">www.anesthetist.org</a>
American Association of Nurse Anesthetists	<a href="http://www.aana.com">www.aana.com</a>
Louisiana Association of Nurse Anesthetists	<a href="http://www.lacrna.org">www.lacrna.org</a>

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