September 2008

Andrew Nugent, MD, FACEP
Vice Chair of Emergency Medicine at the University of Iowa Hospitals and Clinics
President, Iowa Chapter of the American College of Emergency Physicians.

Prepared Statement for the Iowa Board of Nursing:

Members of the Board, thank you for allowing me to speak to you concerning your proposed amendments to sub rules 6.2(6), 6.4(3) and 6.4(4), which pertain to nurse administered anesthetics. 2 minutes is an awfully short period of time in which to discuss a topic which will so drastically change physician and nursing practice. I have previously submitted several articles for your review which bear scientific proof of the safety and efficacy of deep sedation performed in Emergency Departments by well qualified teams of Emergency Nurses and physicians. In fact, at this time, there are zero peer reviewed papers which suggest that deep sedation performed by these teams is a dangerous practice to our patients. By enacting poorly thought out regulations such as these amendments, you are in fact endangering the life and well being of our patients.

If you choose to enact these amendments, hospitals will be forced into one of two bad choices. The first is to ban the administration of these agents in the Emergency Department altogether; this will result in unnecessary pain, delay in care and an increase in poor outcomes for our patients, in particular for those with joint dislocations which are time dependent upon their reduction.

The second option is to allow ED physicians to administer the medications without the aid of a nurse. This will add complexity to the procedure for the physician, and ultimately removes an important safety mechanism in the form of the nurse who ensures that the medications are given in the correct manner and in the dosage specified by the physician. Nurses do more than simply inject patients with medication. They are our extra hands, eyes and ears as well as our partners in ensuring that patient safety and well being are maintained.

I would ask that you review your reasoning behind not only these amendments, but also the original position paper on Propofol. As a group, emergency physicians feel that it is appropriate to be concerned about the indiscriminate use of anesthetic agents, however, to use a blanket resolution to outlaw their use despite appropriate safety considerations is inappropriate and not scientifically defensible.

One last point, it is not altogether entirely clear that the Board of Nursing has the jurisdiction to so closely regulate emergency nurses in this matter. The professional organization which represents emergency nurses, the ENA, has stated unequivocally that administering anesthesia agents in the presence of a trained physician is within the scope of practice for an emergency nurse. This is a well thought out, researched position that is backed by all the available scientific literature and should be respected by the Board of Nursing.

UNIVERSITY of IOWA
CARVER COLLEGE
OF MEDICINE

University of Iowa Health Care

*Iowa Emergency Medicine Residency Program*

*Hans R. House, M.D., Director*
*Roy J. and Lucille A.*
*Carver College of Medicine*
*200 Hawkins Drive – C43 GH*
*Iowa City IA 52204-1009*
*319-384-6511* ***Tel***
*319-353-7508* ***Fax***
*Hans-house@uiowa.edu*
www.uihealthcare.com/*emergencymedicine*

September 5, 2008

Lorinda Inman
Executive Director
Iowa Board of Nursing
400 SW 8th Street, Suite B
Des Moines, IA 50309-4685

Re: Proposed Nursing Practice Amendments

Dear Ms. Inman:

Good evening to the members of the board. My name is Dr. Hans House. I come before you tonight to voice my fervent opposition to the proposed amendments. I am an Emergency Physician at the University of Iowa and head of the Emergency Medicine Residency Training program there. I also speak on behalf of ER docs across the state.

The proposed amendments, if passed, will seriously hamper our ability to practice our profession and provide timely, safe, and effective care for our patients. Other state nursing boards have proposed similar restrictions, only to reject them after further consideration. I would like to take my time before you tonight to highlight the experiences of a couple of nearby states.

In October 2005, the Minnesota Board of Nursing ruled that **it is within the scope of practice** of a registered nurse to administer medications classified as anesthetics for purposes other than anesthesia. The board heard extensive testimony that these agents are widely used in settings such as Emergency Departments and they were shown abundant outcomes data proving the safety and efficacy of these medications. The key element in the board's decision is that "nursing practice includes both independent and **delegated medical functions** which may be performed in collaboration with other health team members." The board concluded that "restricting RN's from administering . . . [these medications] . . . may result in the delay of care, increased pain, and inefficient use of the skills of a CRNA." (see Appendix 1: Minnesota Statement of Accountability)

The South Dakota Board of Nursing restricted the use of Propofol in July 2004 but rescinded the decision one year later after being shown ample evidence of its safe use in ED's for procedural sedation. In 2005, North Dakota determined that **it is within the scope of practice** of RN's to administer these medications. And just a few months ago (July 2008) Wyoming's State Board of Nursing adopted the **Procedural Sedation Consensus Statement** endorsed by ACEP, ENA, ANA, and others. This Consensus statement is included your reference material.

Thank you,

Hans R. House, MD, FACEP
Associate Chair for Education
Residency Program Director
Department of Emergency Medicine
University of Iowa

Michael Miller, MD
Emergency Physician – St. Luke's Hospital, Cedar Rapids, IA
Member, Board of Directors, Iowa Chapter American College of Emergency Physicians

Text of oral testimony to the Iowa Board of Nursing
September 10, 2008

I am speaking on behalf of Iowa ACEP, St. Luke's Hospital, ECIAC and my own family. As an Emergency Physician with over a decade of experience from the smallest Iowa hospitals to the University of Iowa, I know **your** decision today will painfully and excruciatingly affect **your** loved ones.

Imagine your spouse is severely injured in a car accident on I-80, awake and in extreme pain. The volunteer EMS service calls the helicopter as your loved one needs an emergent airway. There is no safe medication available for the flight nurse to use and they die.

Your mother is in the ED with a dislocated hip and is in excruciating pain. She develops avascular necrosis as it takes 3 hours to get to an OR for an anesthesiologist to sedate her for relocation.

Your child has a displaced, cold, ankle fracture but cannot receive a safe sedative for relocation and ***feels every second*** of the relocation.

You dislocate your shoulder. The physician has to use high doses of less safe medications like morphine and versed to allow your relocation. Now you stop breathing, drop your blood pressure, and are given reversal medications resulting in an intractable seizure. You are intubated; kept in a Phenobarbital coma and left permanently impaired.

These are just a few examples of the unnecessary harms your proposed amendments will cause on a daily basis throughout the state. Currently, every hospital has in place sedation protocols that provide the best and safest care to our patients.

**Text of Oral Testimony to the Iowa Board of Nursing**
September 10, 2008

Gary T. Hemann, DO from West Des Moines, Iowa
Emergency Physician, and Chair, Department of Emergency Medicine
Mercy Medical Center – Des Moines
President Elect – Iowa Chapter American College of Emergency Physicians (IA-ACEP)

- Representing myself and my group, and providing comment in opposition to the proposed amendments and sub-rules to the Standard of Nursing Practice, which restricts the use of certain medications.

- We believe the Iowa Board of Nursing action in September 2007, limiting the nursing scope of practice and not allowing the trained registered nurse to administer propofol was a mistake. Proceeding with the actions outlined in the proposed sub-rules to include other medications imposes even more restriction on our professional practice, and most importantly affects the ability to provide timely, quality care for our patients.

- Our trained ER nurses are effectively removed from the role of valued assistant. The medical literature has clearly identified that procedural sedation, provided by the team of ER doctors and nurses is safe and effective. ER doctors have had extensive training and experience in moderate and deep sedation, which includes a variety of medications for sedation and analgesia. We are trained in advanced airway management, intubation, and ventilatory support. We have an excellent safety record in all of these areas, in no small part because of our past training, but also because we have an impeccable nursing staff. References have been provided in earlier letters to the Board. The proposed amendments, however, undermine the expertise of the emergency physician and nurse.

- Your administrative code identifies minimum standards for the registered nurse, to include assisting and "executing the regimen prescribed by the physician." Procedural sedation is a physician-directed aspect of patient care. It falls in the realm of physician credentialing at the hospital at which he practices. It is governed by the rules and regulations of the medical staff. Therefore, we believe it is inappropriate to amend the Nursing Practice Standards and restricting a nurse from giving specific medications even when appropriately prescribed by, and given in the presence of the qualified physician.

- It is prudent for the Board to continue to advance the cause of those minimum standards, qualifications and educational experiences for any nurse that assists the qualified physician with procedural sedation, and I support the spirit and intent of the language in the sub-rule that identifies certifications or courses of study, and a review of pharmacology

- Respectfully, I request that the Board reconsiders it prior decision concerning propofol administration: rescind that sub-rule and vote against further restrictions on the specific medications named in this proposed amendment to the nursing standards and scope of practice.

- Lastly, I would ask you to once again review that Procedural Sedation Consensus Statement I provide in my letter to each of you individually, dated August 18, 2008. Should you need another copy, I have them available this evening. Thank you kindly.

Thomas Benzoni, DO, FACOEP
Emergency Physician - Mercy Medical Center, Sioux City, IA
Member - Iowa Chapter, American College of Emergency Physicians (Iowa ACEP)
Member, Board of Directors, Iowa Medical Society (IMS)

Prepared Statement for Iowa Board of Nursing
September 10, 2008

Disclaimers; I speak only for myself and IA-ACEP. I do not speak for IMS

Members of the Iowa Board of Nursing:

I would ask your attention be directed for a few minutes to some concerns we have discussed at the State level in ACEP and in conversations with other concerned persons and bodies. My remarks will address potential pitfalls and unintended consequences of your enacted and proposed restrictions on nurses in Iowa handling medications intended to help patients tolerate brief painful procedures performed by qualified physicians and nurses in Iowa's Emergency Departments.

I would point out 3 areas:
1. The State using its power to make advertising tomes into medical standards
2. The creation of a new cause of action against nurses and hospitals by making a new standard of nursing practice.
3. The potential creation of a monopoly without proper public hearing.

Your proposal uses the language contained in the Physicians' Desk Reference (PDR) to give voice to restrictions on who can handle these medications (anesthesiologists). The FDA intends this language as guidance to drug companies to constrain what the sales forces may say to promote the drug, not to regulate the practice of medicine. Use of the PDR as a regulatory guide would mean that a nurse would have to be conversant in the indications in the PDR and refuse to give any medication for any purpose not approved by the FDA for promotion by the sales force. This practice of non-indicated use of medications is well-accepted and time honored.

There is a blatant fallacy in your proposal that, by trickery of language, can be read in two ways. These agents do indeed have a reversal agent; an agent is not a drug but any item that mitigates a potential adverse effect: here, a Bag-Valve-Mask (BVM). Believe me, if our ENA-RN's cannot wield a BVM, we have greater problems than you can solve. If "agent" is read to mean a drug, then I am frightened about what a plaintiff's attorney will do with this new standard you have created. A nurse may not, by this logic, give any agent that lacks a drug he/she can administer, apparently autonomously. There goes virtually all medications. Indeed, most of the medications we administer lack a specific reversal agent, drug or device!

Finally, this Board appears to be granting exclusive rights to perform certain procedures to specific groups. That is called the granting of a monopoly and is a carefully orchestrated function of the State. It is an authority I feel certain this Board does not possess, does not want, and does not intend.

In closing, let me remark on the most important facet: professionalism. Without this concept, we might as well pack it up and go home, our heads hung in shame. This group is charged with oversight of professionals, not tradesmen. A professional is told by his/her association that by dint of possession of knowledge and demonstrated training that they possess a skill, and by rights ought to be able to exercise that skill to the help of their patients. To the extent that a professional is placed in a double bind by any State Agency, to that extent that Agency is acting in the way of a Trades Board (e.g., Electrical Board.) By simple extension, then, to the extent that these regulations are promulgated is the extent to which they are invalid; this Board is chartered to aid Professionals, not govern skilled trades.

I am certain you will do the right thing and withdraw these proposed regulations and their ilk.

Thank you.

Theodore A. Koerner MD MPH
Medical Director, Eastern Iowa Emergency Physician Services, Wapiti Medical Group
Emeritus Faculty, University of Iowa College of Medicine, Iowa City IA
Member – Board of Directors, Iowa Chapter American College of Emergency Physicians

COMMENTS MADE BEFORE THE IOWA BOARD OF NURSING DURING A PUBLIC HEARING ON SEPTEMBER 10, 2008

On behalf of the nurses and physicians that staff the emergency rooms of the hospitals of rural Iowa and the Iowa Chapter of the American College of Emergency Physicians, I wish to make the following comments in OPPOSITION to the proposed restrictions on the administration of propofol and other procedural sedatives by emergency room nurses.This opposition is based on my eleven years experience practicing emergency medicine in more than 25 rural Iowa hospitals, as well as a review of the scientific literature.

First, there is no scientific basis for the assumption that staff nurses cannot administer propofol safely, even in rural emergency departments. Last year Engel, Coyner and Charles reported the results of an extensive study of the incidence of complications in procedural sedation with propofol by emergency physicians and nurses in rural emergency departments. This study was a well-designed prospective study over more than 3 years, involving 308 consecutive patients. The only complications observed were transient hypotension and hypoxia in less than 2% of the patients. No patient required intubation or anesthesia consultation and no patient aspirated. This study showed that propofol is safe and effective for sedation during procedures carried out by rural emergency physicians and nurses. (Annals of Emergency Medicine 50, S122-23, 2007)

Second, the requirement that procedural sedation be done only under the supervision of a CRNA or anesthesiologist is utterly impractical in the rural emergency setting. This requirement can only lead to restriction and delay in procedures that greatly comfort patients and even save their lives. In many of the rural Iowa hospitals in which I work there is no CRNA or anesthesiologist available over the weekend or at night. In the hospitals where such staff is available on-call, there are delays of 20-60 minutes in waiting for their arrival. Such delays where Rapid Sequence Induction for intubation is required, risk respiratory arrest and where orthopedic manipulation is required, prolongs the agony that is relieved by definitive treatment.

Finally, the requirement that a CRNA or anesthesiologist be legally inserted into the rural ER setting undermines the essential organizing principal of rural emergency medicine, namely that all staff be empowered to be "Jacks-and-Jills-of-all-trades." It is this spirit and this spirit alone that makes up for the lack of resources otherwise available in rural ERs. Most rural Iowa hospitals could find better ways to spend their limited budgets than on redundant services. The proposed rules changes by IBON will create the equivalent of what strong railroad unions demanded in the 1950s, namely, brakeman for trains that have automatic brakes.

I wish to thank the Iowa Board of Nursing for the opportunity to speak this evening.