Why We Oppose Authorizing Anesthesiologist Assistants (AAs)

Frequently Asked Questions

1. ***"Isn't this just about expanding the anesthesia workforce?"***
    a. **No, this is about creating the *right* workforce, just *more* providers.**
    b. Expanding scope for AAs does **not** increase access to care in rural or underserved areas, does **not** solve workforce maldistribution, and does **not** improve quality or safety.
    c. **Only three counties** in Kansas have the anesthesiologist density and supervision infrastructure necessary to support the AA model. The remaining counties—where access challenges are greatest—cannot utilize AAs at all.
    d. Authorizing AAs would divert scarce clinical training capacity away from CRNAs, ultimately shrinking Kansas's CRNA workforce overtime and undermining the very system that currently sustains anesthesia access statewide.
    e. **Retort:**
    If workforce expansion were the true goal, policymakers would focus on strengthening and retaining providers who already practice where the need exists—not introducing a profession that, by design, cannot.

2. ***"If these 3 counties represent 45% of the state population, shouldn't we bring in AA's?"***
    a. **No—because those counties are already fully served by CRNAs.**
    b. Authorizing AAs in those limited urban areas would monopolize training sites and anesthesiologist supervision, choking off CRNA education pipelines.
    c. The downstream effect would be **severe workforce shortages** across the remaining 102 counties—**impacting 55% of Kansans**—within the next decade.
    d. **Retort:**
    You do not fix urban abundance by sacrificing rural access.

3. ***"Can't AA's train CRNAs? Why does AA licensure reduce the CRNA workforce?"***
    a. **AAs require less training and education than CRNAs.** They are prepared exclusively for a dependent assistant role.

b. **CRNAs are doctoral-prepared anesthesia professionals trained for independent clinical decision-making.**
c. It would **be inappropriate—and unethical—for AAs to train CRNAs**, as AAs are not licensed or educated to practice independently. In fact, the existence of bridge programs that allow AAs to become CRNAs underscores the clear hierarchy between the professions, not equivalence.
d. **CRNAs must make independent decisions every day** regarding preoperative evaluation, anesthetic prescription and administration, and postoperative recovery—**decisions that AAs are simply not trained or licensed to make**. CRNAs are the keystone to rural care in Kansas.
e. **Retort**
   A dependent provider cannot train an independent one—and Kansas cannot afford to confuse the two.

4. ***"But AAs are supervised—doesn't that improve safety?"***
   a. **Supervision does not equal safety. Evidence does.**
   b. There is **no credible evidence** that AA involvement improves outcomes compared to CRNAs. In contrast, decades of peer-reviewed literature show **equivalent anesthesia outcomes** between CRNAs and anesthesiologists across case types.
   c. Supervision models also **fail in real-world settings**, especially in emergencies, off-hours, and rural facilities—exactly where anesthesia services are most critical for real-life Kansans!
   d. **Retort:**
      Safety comes from training, competence, and accountability—not from an insurance reimbursement checkbox.

5. ***"Why not let hospitals decide which providers they want?"***
   a. **Because licensure laws are about public protection, not hospital convenience.**
   b. Scope-of-practice decisions should be based on:
      i. Patient safety
      ii. Workforce needs
      iii. Cost efficiency
      iv. Access to care
      v. Not on which professional group has the strongest lobbying presence.

c. Hospitals already have access to a fully qualified anesthesia workforce without adding AAs.
d. **Retort:**
   Statewide healthcare policy should reflect the needs of Kansas patients—not the influence of groups concentrated in a few urban centers. Good policy follows evidence, not influence.

6. ***"Wouldn't competition lower costs?"***
   a. **No—AAs increase costs without increasing value.**
   b. AAs:
      i. Require mandatory anesthesiologist supervision
      ii. Cannot practice independently
      iii. Require 2 providers for 1 case
      iv. Increase administrative complexity
      v. Increase fraud risk
   c. CRNAs can provide the same anesthesia services **without requiring a supervising physician**, resulting in **lower overall costs**, especially in community hospitals and rural settings.
   d. **Retort:**
      True competition lowers costs by increasing efficiency—not by mandating redundancy.

7. ***"Aren't AAs trained specifically for anesthesia?"***
   a. **Yes—and so are CRNAs, with broader preparation and greater responsibility.**
   b. CRNAs:
      i. Have critical care nursing backgrounds
      ii. Complete doctoral-level anesthesia education
      iii. Are trained for autonomous clinical decision-making
      iv. Practice independently in most of Kansas
   c. AAs are trained for a **dependent role by design** and cannot function without supervision.
   d. **Retort:**
      When two providers can deliver the same care, the one who can do so independently is the more efficient public policy choice.

8. ***"Other states allow AAs—why shouldn't we?"***
    a. **Because policy should be evidence-based, not copy-and-paste.**
    b. States that authorize AAs often:
        i. Already face anesthesiologist oversupply
        ii. Have limited rural anesthesia needs
        iii. Lack robust CRNA practice protections
    c. Many states have **explicitly rejected AA licensure** after reviewing workforce data and access implications.
    d. **Retort:**
    Bad policy doesn't become good policy just because another state adopted it.

9. ***"Won't this improve access to anesthesia care?"***
    a. **No. AAs do not improve access—especially where it matters most.**
    b. AAs:
        i. Cannot practice without anesthesiologists
        ii. Do not work independently in rural hospitals
        iii. Are absent from critical access settings
    c. CRNAs already provide the backbone of anesthesia services in underserved areas.
    d. **Retort:**
    A provider who cannot practice where care is scarce does not improve access.

10. ***"Isn't opposition just professional turf protection?"***
    a. **No. This is about responsible workforce planning.**
    b. Opposition is grounded in:
        i. Redundancy of roles
        ii. Increased costs
        iii. No demonstrated safety benefit
        iv. No access improvement
        v. Disruption of existing care models
    c. CRNAs are not asking for exclusivity—only that the state avoid introducing an unnecessary, dependent role.

d. **Retort:**
   Protecting patients and taxpayers is not turf protection—it's good governance.

11. ***"Wouldn't AAs help anesthesiologists work at the top of their license?"***
    a. **CRNAs already do—and more effectively.**
    b. CRNAs:
        i. Practice autonomously
        ii. Reduce supervision burden
        iii. Allow anesthesiologists to focus on complex cases if desired
    c. AAs require **constant supervisory involvement**, limiting efficiency rather than enhancing it.
    d. **Retort:**
       If the goal is efficiency, dependency is the wrong design.