American Society of Anesthesiologists®

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August 17, 2026

The Honorable Muriel Bowser
Mayor of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004

The Honorable Ayanna Bennett, MD, MSPH, FAAP
Director, DC Health
899 North Capitol Street NE
Washington, DC 20002

Dear Mayor Bowser,

The undersigned medical and specialty organizations represent physicians who deliver critical medical and surgical care to District patients every day. We understand you have been asked to consider opting out of the Medicare physician supervision requirement for nurse anesthetists. We strongly urge you to preserve that important patient-safety guardrail. Eliminating that requirement would reduce physician involvement in anesthesia care without improving access, lowering costs, or enhancing quality for District patients.

No Demonstrated Need for Opt-Out in Washington, D.C.

Unlike many states that have pursued opt-out based on alleged shortages in rural or frontier communities, Washington, D.C. is a fully urban jurisdiction served by major hospitals, academic medical centers, and physician training programs. No evidence has been presented demonstrating that physician supervision requirements are limiting access to anesthesia services in the District. Therefore, opting out would remove an existing patient-safety guardrail without solving an identified access problem.

Washington, D.C. currently maintains an important patient-safety guardrail through physician involvement in anesthesia care. This essential safeguard is maintained by many states, including every state bordering the District of Columbia. Anesthesiology is the practice of medicine, and eliminating physician oversight in anesthesia care removes an important patient-safety guardrail without any demonstrated benefit to patients.

Opt-Out Has Not Demonstrated Improvements in Access, Cost, or Quality

More than two decades of experience with state opt-out policies have failed to demonstrate the promised improvements in access to care, cost savings, or quality. The evidence is remarkably consistent. Since 2016, seven peer-reviewed studies examining the relationship between opt-out policies and anesthesia access have found no meaningful evidence that opt-out increases access to anesthesia services.[i,ii,iii,iv,v] One 2021 *Journal of Rural Health* study concluded that states adopting opt-out policies have not realized increased health care access or reduced health care costs.[vi] Similarly, a 2023 study found no evidence that granting CRNAs practice independence increased utilization of CRNAs or meaningfully changed anesthesia service delivery.[vii]

The evidence also undermines the common claim that opt-out improves access in underserved areas. The federally funded Graduate Nurse Education Demonstration Project found that 96 percent of CRNA graduates reported practicing in urban settings, suggesting that expanding CRNA autonomy does not necessarily translate into greater availability of anesthesia services in rural or underserved communities.[viii]

Opt-out has likewise failed to produce meaningful financial savings. Because Medicare generally pays the same total amount for anesthesia services regardless of whether care is provided through a physician-led anesthesia care team or a CRNA-only model, opt-out does not generate savings for Medicare beneficiaries, taxpayers, or the District government. When facilities replace physician involvement with a nurse-only model, patients generally pay the same while losing access to the additional medical expertise, risk assessment, perioperative medical management, and clinical oversight provided by anesthesiologists.

Physician-Led Anesthesia Care Improves Patient Safety

Anesthesiologists do far more than administer anesthesia. As physicians, they diagnose and manage complex medical conditions, assess and optimize patients before surgery, develop individualized perioperative care plans, and lead the response to life-threatening emergencies when complications arise. Their expertise helps identify risks before they become complications and ensures that patients receive comprehensive medical management before, during, and after surgery. These responsibilities require medical education and training that extend well beyond the technical delivery of anesthesia.

Anesthesiologists complete medical school and residency training focused on evaluating complex patients, managing coexisting disease, and responding to rapidly evolving medical emergencies. For patients and healthcare facilities, the value is not measured solely by training hours, but by more accurate risk assessment, earlier intervention, fewer preventable complications, and improved outcomes when emergencies occur.

Anesthesiology is widely recognized as one of medicine's greatest patient-safety success stories. In *To Err Is Human*, the Institute of Medicine identified anesthesiology as a model for systematic improvements in patient safety.[ix] Yet anesthesia remains a complex medical service requiring physician expertise before, during, and after surgery. Independent peer-reviewed research has not demonstrated that eliminating physician involvement improves outcomes, while one study found that the presence of a physician anesthesiologist prevented 6.9 excess deaths per 1,000 cases involving an anesthesia-related or surgical complication.[x] Washington, D.C. should not remove this longstanding patient-safety guardrail without clear evidence that doing so would benefit patients.

Real-World Examples Highlight the Risks of Reduced Physician Oversight

Recent California investigations identified serious deficiencies at facilities that reduced physician involvement in anesthesia care and blurred distinctions between physician and non-physician roles. These findings underscore the patient-safety risks associated with weakening physician oversight without any demonstrated benefit to patients.[xi,xii,xiii,xiv,xv,xvi]

D.C. Voters Prefer Physician-led Anesthesia Care

District voters overwhelmingly support physician involvement in anesthesia care. A March 2024 survey of registered voters in Washington, D.C. found that 85% of voters believe nurse anesthetists should be overseen by an anesthesiologist, and 70% support maintaining anesthesiologist oversight requirements in District law.[xvii]

No Compelling Case for Opt-Out in Washington, D.C.

Washington, D.C. should not lower its patient-safety standards in search of a solution to a problem that has not been shown to exist. The District has not demonstrated an anesthesia access problem that would justify reducing physician involvement in patient care. Opt-out has not produced the promised improvements in access, cost, or quality, yet it would remove an established patient-safety guardrail and disregard the public's preference for physician-led anesthesia care. Given the absence of a demonstrated need, the burden should rest with proponents of opt-out to provide clear and convincing evidence that

such a significant policy change can be implemented safely. No credible, peer-reviewed research has made that case.

We therefore respectfully urge you to reject any request to opt out of the Medicare physician supervision requirement for nurse anesthetists and to preserve physician-led anesthesia care for District patients.

Medical Society of the District of Columbia
District of Columbia Society of Anesthesiologists
District of Columbia Society of Oral and Maxillofacial Surgeons
District of Columbia Academy of Anesthesiologist Assistants
American Medical Association
American Society of Anesthesiologists
American College of Surgeons
American Association of Oral and Maxillofacial Surgeons
American Society of Ophthalmologists
American Society of Plastic Surgeons
American College of Radiology
American Academy of Anesthesiologist Assistants

cc: Tomas Talamante, Chief of Staff, Executive Office of the Mayor

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[i] Sun EC, Miller TR, Halzack NM. In the United States, "Opt-Out" States Show No Increase in Access to Anesthesia Services for Medicare Beneficiaries Compared with Non-"Opt-Out" States. A&A Case Reports. 2016; 6(9):283-5.
[ii] Sun EC, Dexter F, Miller TR. The Effect of "Opt-Out" Regulation on Access to Surgical Care for Urgent Cases in the United States: Evidence from the National Inpatient Sample. Anesthesia & Analgesia. 2016; 122(6):1983-91.
[iii] Sun EC, Dexter F, Miller TR, Baker LC. "Opt Out" and Access to Anesthesia Care for Elective and Urgent Surgeries among U.S. Medicare Beneficiaries. Anesthesiology. 2017; 126(3):461-71.
[iv] Schneider JE, Ohsfeldt R, Li P, Miller TR, Scheibling C. Assessing the impact of state "opt-out" policy on access to and costs of surgeries and other procedures requiring anesthesia services. Health Econ Rev. 2017; 7(1):10.
[v] Feyereisen S, McConnell W, Puro N. Revisiting the effects of state anesthesia policy interventions: A comprehensive look at certified registered nurse anesthetist service provision in U.S. hospitals from 2010 to 2021. J Rural Health. 2025;41(2):1–11. doi: 10.1111/jrh.12879.
[vi] Feyereisen SL, Puro N, McConnell, W. Addressing provider shortages in rural America: The role of state opt-out policy adoptions in promoting hospital anesthesia provision. J Rural Health. 2021; 37(4):684-691.
[vii] Chen AJ, Munnich EL, Parente ST, Richards MR. Provider turf wars and Medicare payment rules. J. Public Econ. 2023; 218(C).
[viii] The Graduate Nurse Education Demonstration Project: Final Evaluation Report, Centers for Medicare and Medicaid Services. August 2019. https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf (p.95).
[ix] In 2000, the Institute of Medicine identified anesthesiology and its professional organizations as the leading example of systematic improvements in patient safety and quality of care. To Err is Human: Building a Safer Health System. Institute of Medicine. 2000.
[x] Silber JH, Kennedy SK, Even-Shoshan O, Chen W, Koziol LFL, Showan AM, Longnecker DE: Anesthesiologist direction and patient outcomes. Anesthesiology 2000; 93: 152-a63.
[xi] Carlson K. (2024, April 18). Stanislaus County hospital is removed from the Medicare program over health, safety issues. The Modesto Bee.
[xii] Carlson K. (2024, May 29). Complaints at Modesto hospital under investigation by California agency. What's the concern? The Modesto Bee.
[xiii] Carlson, K. (2024, June 10). Modesto hospital shaken by California probe into anesthesia providers. What to know. The Modesto Bee.
[xiv] Statement of Deficiencies and Plan of Correction (OMB No. 0938-0391): Stanislaus Surgical Hospital. February 5, 2024. Pg. 290 of 377. Department of Health and Human Services, Centers for Medicare & Medicaid Services. “Based on observation, interview and record review, the hospital failed to provide anesthesia services in a well-organized manner when: 1. Certified Registered Nurse Anesthetists (CRNAs) were appointed to the Medical Staff by the

Governing Body, were considered 'independent practitioner' and provided anesthesia services 'just like [a physician] anesthesiologist'. Appointing CRNAs to the Medical Staff as independent practitioners' and with full prescriptive, diagnostic and therapeutic authority was not in accordance with hospital GB bylaws, Medical Staff Bylaws, Rules and Regulations and California state law." Available at https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx

[xv] Statement of Deficiencies and Plan of Correction (OMB No. 0938-0391). Doctors Medical Center. May 31, 2024. Pg. 369-370 of 406. Department of Health and Human Services, Centers for Medicare & Medicaid Services. "Based on interview and record review, the hospital failed to provide anesthesia services consistent with needs and resources when the hospital granted Certified Registered Nurse Anesthetists (CRNA) prescriptive authority and the ability to diagnose and treat patients without a treatment regimen ordered by a physician while providing anesthesia services and was not consistent with scope of practice laws and standards of practice for CRNAs." Available at https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx

[xvi] California Department of Public Health All Facilities Letter. Reminder of Certified Registered Nurse Anesthetist (CRNA) Requirements. September 6, 2024. Available at https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-24-22.aspx

[xvii] The individuals interviewed in the survey were randomly selected from the latest list of registered voters in Washington, D.C. and the results represent a cross-section of voters across all wards. The margin of error associated with a study of this size is +/-4.9%