Legal Briefs

GENE A. BLUMENREICH, JD
AANA General Counsel
Fine & Ambrogne
Boston, Massachusetts

Surgeon's responsibility for CRNAs

CRNAs who are not supervised by anesthesiologists continue to seek assistance in assuring their hospitals, their surgeons or both that they are not required to be supervised by an anesthesiologist. No matter how many times they are discredited, the same misconceptions continue to circulate and to be used in efforts to restrict the practice of nurse anesthetists. These allegations seek justification on the basis of: State licensing laws, the rules of the Health Care Financing Administration (HCFA), risk management guidelines from insurance companies, surgical and anesthesia standards from the Joint Commission of Accreditation of Health Organizations (JCAHO) and statements concerning quality of care from the uninformed. Let us once again re-examine these misconceptions so that they can be abrogated once and for all.

State law

On occasion, surgeons have been misled into believing that they cannot supervise CRNAs under state law. *No state licensing statute requires nurse anesthetists to be supervised by an anesthesiologist.* In those states which have licensing laws dealing specifically with nurse anesthetists, the most frequent formulation is that the nurse anesthetist must be directed and/or supervised by a physician. In only one state (Georgia) does the statute contain any additional elements, and even there, the statute does not require the supervising physician to be an anesthesiologist.

In recent years, some state agencies have attempted to adopt regulations restricting the supervising physician to an anesthesiologist. Many of these attempts reflect a lack of familiarity with the quality of nurse anesthesia care, and the American Association of Nurse Anesthetists has been very successful in reversing these attempts.

In the health care field, courts seek the views of health care professionals in interpreting license laws, (See, *Chalmers-Francis u Nelson,* 6 Cal. (20) 402, 1936, *Bentley u Langley,* 249 SE 2d 481, (N.C. 1978) *Frank u South,* 175 Ky. 416, 1917). It is the height of irony that a physician, who knows that CRNA practice is well accepted, should be confused as to what the law allows. *The legal principles involved in determining a surgeon's liability for the acts of an anesthetist are the same whether a surgeon works with a CRNA or an anesthesiologist.* The cases are clear that surgeons are not liable simply because they supervise. A surgeon's liability is based on *control,* whether the surgeon works with CRNAs or anesthesiologists.

Health Care Financing Administration

Since 1982, the federal Medicaid system has been moving from a cost reimbursement to a negotiated rate model of health care reimbursement. As part of this process, HCFA determined that anesthesiologists were entitled to one rate of payment when they were actually providing the anesthesia and another (and lesser) rate when they were merely

supervising a nurse anesthetist who was giving the anesthesia.

For administrative convenience, HCFA determined that if the anesthesiologist was supervising no more than four concurrent surgeries (first proposed as "no more than two") and met certain additional requirements, the anesthesiologist would be reimbursed as if the anesthesiologist were engaging in direct patient care. These requirements were adopted solely for purposes of determining how to reimburse the anesthesiologist.

We have read, on several occasions, that anesthesiologists have claimed that HCFA requires that an anesthesiologist supervise no more than four concurrent procedures and must be present for induction and emergence. This is, of course, untrue. HCFA reimburses nurse anesthetists who administer anesthesia in hospitals where there are no anesthesiologists at all. *HCFA's rules are not "requirements," nor are they quality of care policies; they are merely guidelines adopted solely for the purpose of determining the amount of reimbursement.*

Joint Commission on Accreditation of Healthcare Organizations

JCAHO adopted standards for surgery and anesthesia which became effective on January 1, 1988. These standards require that anesthesia services be the responsibility of "licensed independent practitioners with appropriate clinical privileges." We were very concerned when the standards came out that "licensed independent practitioners with appropriate clinical privileges" meant anesthesiologists.

After contacting JCAHO, we received clarifications from both JCAHO's general counsel and from its president clearly stating that these references in the standards "do not mandate that accredited hospitals utilize anesthesiologists."

The standards do not require that the responsible licensed independent practitioner have privileges to actually administer anesthesia. Since the standards demand competence in what they are already doing, surgeons who now supervise or direct the practice of CRNAs would be expected to have no difficulty meeting the new standards." (Letter of Harold J. Bressler, JCAHO general counsel to Gene A. Blumenreich, May 14, 1987). In informal discussions, Dennis O'Leary, MD, president of JCAHO, has been even more insistent that neither JCAHO nor its standards require hospitals to have anesthesiologists.

Insurance companies

There have been a variety of problems regarding malpractice insurance carriers. One of these problems would sometimes arise after a hospital had been visited by the risk management group of a malpractice insurance carrier. Under the JCAHO standards for anesthesia which were in effect *prior* to January 1, 1988, it was stated that "in the absence of a staff anesthesiologist, a practicing consultant anesthesiologist should provide the specific guidelines [for anesthesia practice] based on an on-site assessment of the personnel, equipment, and overall anesthesia environment." *This requirement for a consulting anesthesiologist was deleted in the JCAHO standards which became effective on January 1, 1988.*

Some malpractice carriers, including St. Paul Fire & Marine, in the process of conducting their risk management services to hospitals would point out that a hospital had failed to have a visit from a consultant anesthesiologist as required by its JCAHO recognition. These hospitals would be encouraged to retain a consultant anesthesiologist to comply with JCAHO standards. In some cases, hospitals mistakenly believed that this required them to have an anesthesiologist.

Since the new standards have been adopted, there is no reason for risk management groups to recommend a visit by a consulting anesthesiologist. St. Paul and most others have ceased to advise it. However, in one case brought to our attention, a hospital thought it was required to hire an anesthesiologist based on a two-year-old risk management report. The hospital was unaware that the recommendation (which only called for a consultation) was based on an outdated JCAHO standard.

A second problem involving insurance has been restricted to physician-owned or physician-controlled insurance companies. Some of these, either out of malice or out of a mistaken belief that anesthesiologists provide higher care, began to adopt the anti-CRNA restrictions as expressed by the American Society of Anesthesiologists (ASA) in its nurse anesthesia bill. While the source is the same, actual restrictions have varied greatly. For example, one insurance company would not permit surgeons to work with CRNAs giving a general anesthestic unless they were supervised by an anesthesiologist (permitting regionals); another would not insure surgeons who worked with CRNAs who were not supervised by an anesthesiologist in giving regional anesthesia (permitting generals).

The ASA recently published a survey on physician-owned insurance companies under the title "The Cost of Professional Liability Insurance for Anesthesiologists." Despite the title, the subject of the study was more than just cost.

ASA tried to find out what anti-CRNA restrictions these insurance companies were following as

well. In addition to surcharges of anesthesiologists and surgeons who work with nurse anesthetists, some of the companies restrict the number of CRNAs who can be supervised by an anesthesiologist at any one time. (These ratios are the same 1:2 and 1:4 ratios that were originally considered by HCFA for reimbursement purposes, now reincarnated as quality of care requirements).

The study reported that 38 physician-controlled insurance companies had been surveyed. Of these, 24 companies reported that they insure surgeons who work with nurse anesthetists not supervised by an anesthesiologist. Only five reported that they charged an increased annual rate to surgeons. *There is no evidence and no justification for any insurance company to be charging a surgeon a premium or adopting any restrictive policy with regard to the supervision of CRNAs.* When challenged, none of these companies has ever claimed that their loss data showed that anesthesia administered by a nurse anesthetist is not every bit as safe as an anesthetic administered by an anesthesiologist.

Conclusion

Of course, one reason these insurance companies have not offered evidence is that evidence does not exist. (Cooper, *Quality of Anesthesia Care as a Function of Provider Alternatives* – from the 1988 Center for Health Economics Research [CHER] study and numerous quality of care studies available from the AANA which have previously been commented upon in this column).

It is remarkable that the quality of care issue continues when all the evidence shows that CRNAs give anesthesia with the same high degree of care as anesthesiologists. Nurse anesthetists have been providing high quality care for 100 years and have competed with anesthesiologists since anesthesiologists emerged as a medical specialty. After all these years, one would hope that anesthesiologists would let competition be determined by who gives better anesthesia care, instead of creating arbitrary and baseless obstacles which appeal to stereotypes rather than results.