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M E M O R A N D U M

September 9, 2014

TO: Kaiser Permanente Nurse Anesthetist Association (KPNAA)

FROM: Andrew T. Kugler

RE: CRNA Scope of Practice in California

This memo analyzes certain scope of practice issues as they apply to Certified Registered Nurse Anesthetists (CRNAs) in California. CRNAs are both registered nurses and anesthesia specialists, who must complete an undergraduate degree in nursing or a related field and 2-3 years of post-graduate education that includes an average of 2,500 hours of clinical work and administration of about 850 anesthetics.[1] They must also pass a national certification exam and complete a continuing education program every two years.[2] Only nurses who comply with these requirements can identify themselves as CRNAs, a credential that signifies advanced training, education and competence necessary to provide anesthesia services.

Nationally, CRNAs administer approximately 32 million anesthetics to patients each year, working in collaboration with other qualified health care providers in hospitals, surgical centers and office settings.[3] CRNAs administer anesthesia for surgical, diagnostic and therapeutic procedures, as well as for pain management associated with obstetrical labor and delivery, acute and chronic pain, and other conditions.

CRNA Scope of Practice

In California, CRNA practice is primarily governed by two statutes – the Nursing Practice Act, which contains the statutory scope of practice for all nurses (including

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[1] California Business & Professions Code ("B&P Code") § 2826(a); *see* www.aana.com/ceandeducation/becomeacrna/Pages/Education-of-Nurse-Anesthetists-in-the-United-States.aspx.

[2] *Id*.

[3] *See* www.aana.com/ceandeducation/becomeacrna/Pages/Questions-and-Answers-Career-Possibilities-in-Nurse-Anesthesia.aspx.

CRNAs),[4] and the Nurse Anesthetists Act, which contains provisions specific to CRNAs.[5] With respect to scope of practice, the Nursing Practice Act begins by stating:

> [N]ursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the legislature in amending this section…to provide clear legal authority for functions and procedures which have common acceptance and usage. It is the legislative intent to also recognize the existence of overlapping functions between physicians and registered nurses to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses.[6]

The Act then goes on to list four separate functions that nurses may perform, including "the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist…."[7]

Over the years, there has been much debate over how this statutory language applies to the administration of anesthesia by CRNAs. However, California courts recently put that debate to rest. Giving the statutory language its plain meaning, the courts held that Section 2725(b)(2) clearly authorizes CRNAs to administer medications (including anesthesia) necessary to implement a treatment regimen "ordered" by a physician.[8] The courts also made clear that CRNAs do not have to be supervised by a physician when administering anesthesia.[9] This conclusion is consistent with the repeated position of the California Board of Registered Nursing (BRN).

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[4] B&P Code §§ 2700 *et seq.*
[5] B&P Code §§ 2825 *et. seq.*
[6] B&P Code § 2725(a).
[7] B&P Code § 2725(b).
[8] *California Society of Anesthesiologists v. Superior Court* (2012) 204 Cal.App.4th 390, 403 ("CSA Case"), attached as Exhibit A. The trial court opinion is attached as Exhibit B.
[9] CSA Case, 204 Cal.App.4th at 408. The CSA Case involved CSA's challenge to Governor Schwarzenegger's decision to have California opt out of a federal requirement that CRNAs be supervised by physicians in order for facilities to receive Medicare reimbursement. The federal law allows a state to opt out of that requirement if, among other things, the state's own law does not require physician supervision of CRNAs. CSA challenged Governor Schwarzenegger's opt out decision, arguing that California law requires physician supervision. Both the trial court and Court of Appeal found definitively that California law contains no such requirement.

Indeed, the BRN has repeatedly stated that CRNAs in California can be Licensed Independent Practitioners (LIPs) as that term is defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[10] Similarly, the Court of Appeal in the CSA Case recognized that since "CRNAs administer anesthesia under the authority of their own licenses as independent practitioners, the Nurse Anesthetists Act also provides that CRNAs 'shall be responsible for [their] own professional conduct and may be held liable for those professional acts.' (§ 2828.)"[11]

The BRN has also repeatedly stated that "performing surgery and performing anesthesia, although collaborative, are separate functions. The surgeon is responsible for performing the surgery and evaluating the patient's response to the surgical procedure, while the CRNA is responsible for selecting and administering the anesthetic agent and monitoring the patient's response thereto."[12]

The BRN's opinion on supervision and other CRNA scope of practice issues is entitled to great weight for several reasons.[13] First, the Legislature has made clear that the BRN is the sole agency responsible for defining or interpreting the scope of nursing practice.[14] Moreover, the amount of deference to be accorded the BRN's interpretation has to be considered in light of the BRN's expertise and technical knowledge, its thorough analysis of the issues, and its consistency over time.[15] Applying that standard, the Court of Appeal recently found that the BRN's interpretation of Section 2725(b)(2), "which is a statute at the core of their technical expertise and knowledge," should be "accorded "great weight and respect."[16]

The separate, but collaborative, roles of the surgeon and CRNA repeatedly described by the BRN were also referenced in the recent Court of Appeal opinion:

> Typically, a surgeon (who is responsible for directing the patient's care) orders the anesthesia. On receiving that order, the anesthesia provider, whether CRNA or anesthesiologist, performs the pre-anesthesia evaluation,

[10] *See* BRN Letter to Department of Health and Human Services dated February 8, 2005, attached as Exhibit C.
[11] CSA Case, 204 Cal.App.4th at 405.
[12] *See, e.g.*, BRN Letter re *Practice of the CRNA* dated October 11, 1988, attached as Exhibit D.
[13] We understand that questions have been raised as to whether BRN opinions are valid if they are not accessible on the BRN website. No California law requires the BRN to post opinion letters on its website, nor does any law provide that less credence be given to opinions not accessible on the website.
[14] B&P Code § 2725(e).
[15] *Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 7.
[16] CSA Case, 204 Cal.App.4th at 405.

> administers the anesthetic to the patient, monitors the patient's reaction during surgery, and conducts the post-anesthesia evaluation after the patient recovers….[17]

Of course, that does not mean that individual facilities are required to eliminate physician supervision of CRNAs. Rather, the recent case merely clarified that supervision is not legally required in California. Facilities remain free to organize their departments and deliver anesthesia services in the manner that best serves their patients and communities, including requiring physician supervision of CRNAs if desired.

It also does not mean that there is no physician involvement in facilities that allow CRNAs to administer anesthesia without physician supervision. To the contrary, a CRNA can administer anesthesia in California only to implement a treatment regimen ordered by a physician, dentist, podiatrist or clinical psychologist. But after that treatment regimen is ordered, CRNAs are authorized to implement the order by providing anesthesia services without physician supervision. It is our understanding, based on the industry materials and BRN opinions cited below, that it is common practice for those services to include the following:

1. Performing a pre-anesthetic evaluation of the patient, which includes reviewing the patient's medical records, requesting laboratory and diagnostic tests (e.g., pregnancy or blood tests), selecting, obtaining, ordering and administering pre-anesthetic medications and fluids and obtaining informed consent from the patient.[18]

2. Selecting, ordering, obtaining and administering the anesthetics, adjuvant and accessory drugs and fluids necessary to manage the anesthetic.[19]

3. Monitoring the patient's condition during the procedure, including managing the patient's airway and pulmonary status and responding to emergency situations as necessary.[20]

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[17] CSA Case, 204 Cal.App.4th at 396.
[18] *See CRNA Scope of Practice*, American Association of Nurse Anesthetists, May 2010, attached as Exhibit E; BRN letter dated April 14, 1986, attached as Exhibit F. For further background on a CRNA's authority to obtain informed consent, *see Corwin v. State Farm Fire & Casualty* (Cal. App. 2003) 2003 Cal. App. Unpub. Lexis 875 (case brought against CRNA for failure to obtain informed consent); and Cal. Code of Regulations, title 22, § 70223(d) (person responsible for administering anesthesia must confirm that patient has given informed consent).
[19] C*RNA Scope of Practice*, American Association of Nurse Anesthetists, May 2010 (Exhibit E).
[20] C*RNA Scope of Practice*, American Association of Nurse Anesthetists, May 2010 (Exhibit E).

4. Performing post-anesthesia evaluation of the patient, including selecting, obtaining, ordering and administering post-anesthesia medications, fluids and ventilatory support.[21]

5. Initiating orders to other RNs or appropriate staff as required to provide preoperative and postoperative care relating to the anesthesia experience.[22]

6. Discharging the patient from a post-anesthesia care area and providing post-anesthesia follow-up evaluation and care.[23]

7. Implementing acute and chronic pain management modalities.[24]

We note that the above list appears to be consistent with the educational requirements that the California Legislature mandated for CRNAs. In the Nurse Anesthetists Act, the Legislature mandated that CRNAs graduate from a program accredited by the Council on Accreditation of Nurse Anesthesia Education Programs (COA).[25] The COA curriculum, in turn, requires the following:

> Courses in anesthesia practice provide content such as induction, maintenance and emergence from anesthesia; airway management; anesthesia pharmacology; and anesthesia for special epatient populations such as obstetrics, geriatrics, and pediatrics. Students are instructed in the use of anesthesia machines and other related biomedical monitoring equipment….

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[21] C*RNA Scope of Practice*, American Association of Nurse Anesthetists, May 2010 (Exhibit E); BRN letter dated April 14, 1986 (Exhibit F); BRN Statement re: *Practice of the Certified Registered Nurse Anesthetist (CRNA)* dated July 1990, attached as Exhibit I.

[22] BRN letter dated October 11, 1988 (Exhibit D).

[23] For further background on a CRNA's authority to discharge patients from outpatient and acute care facilities, *see* BRN letter re: *Practice of the CRNA* dated October 11, 1988 (Exhibit D) and BRN letter dated April 14, 1986 (Exhibit F) ("When it is determined by the nurse anesthetist that the patient does not exhibit abnormal characteristics the nurse anesthetist may authorize the patient's release from the recovery area. A release of this type does not require a Standardized Procedure or the countersignature of the physician.").

[24] For further background on a CRNA's authority to provide pain management services, *see* BRN letter dated January 15, 1992, attached as Exhibit G ("It is within the scope of practice of the CRNA to provide pain management services…both inside and outside the operating room suite. These services would include…injection of anesthetic or narcotic substances into the epidural, subdural, or subarachnoid spaces, injection of somatic nerves with anesthetic agents, and injection of sympathetic nerves with anesthetic agents.").

[25] B&P Code § 2826.

> Nurse anesthetists are prepared to administer all types of anesthesia, including general, regional, selected local and conscious sedation, to patients of all ages for all types of surgeries. They are taught to use all currently available anesthesia drugs, to manage fluid and blood replacement therapy, and to interpret data from sophisticated monitoring devices. Other clinical responsibilities include the insertion of invasive catheters, the recognition and correction of complications that occur during the course of an anesthetic, the provision of airway and ventilatory support during resuscitation, and pain management.[26]

CRNA Practice Is Not Limited to Surgical Procedures

Although anesthesia is most often associated with surgical procedures, it is important to understand that nothing in Section 2725(b)(2) limits CRNAs to that setting. To the contrary, the plain language of Section 2725(b)(2) authorizes CRNAs to administer anesthesia necessary to implement a "treatment regimen" ordered by a physician. In some cases, the regimen will involve surgery. In others, it may be associated with other regimens, such as child birth or pain management. As long as the treatment regimen necessitating anesthesia has been ordered by a physician, the statute authorizes CRNAs to administer anesthesia without physician supervision, be it in a surgical suite, an emergency room or a doctor's or dentist's office.[27]

Selecting, Ordering and Obtaining Medications

While CRNAs do not have the authority to write prescriptions in California, the BRN has made clear that CRNAs can select and administer anesthetics and transmit orders for preoperative and postoperative drugs compatible with the anesthesia. Specifically, the BRN has stated:

> The physician is responsible for performing the surgery and evaluating the patient's response to the surgical procedure while *the CRNA is responsible*

[26] *See* McCarthy, E. Jane, *Education of Nurse Anesthetists in the United States*, AANA Journal, Vol. 68, No. 2 (April 2000), pg. 112, attached as Exhibit H. For an up-to-date list of COA curriculum requirements, *see* COA Standards for Accreditation of Nurse Anesthesia Education Programs accessible at http://home.coa.us.com/accreditation/Documents/Standards%20for%20Accreditation%20of%20Nurse%20Anesthesia%20Education%20Programs_January%202013.pdf.

[27] *See* BRN letter dated January 15, 1992 (Exhibit G) ("It is within the scope of practice of the CRNA to provide pain management services and emergency procedures both inside and outside the operating room suite….").

> *for selecting and administering the anesthetic agent*, monitoring the patient's response thereto, and *selecting and administering drugs required to maintain the patient's stability* during the operative period. In accord with the policies of the employer, the CRNA may transmit orders to be implemented by RNs and other appropriate staff for preoperative and postoperative drugs compatible with the anesthesia.[28]

The BRN's opinion on this issue has been consistent.[29] And again, on scope of practice matters like this, the BRN's opinion is to be given "great weight and respect."[30]

We also note that the plain language of Section 2725(b)(2) does not limit CRNAs to the administration of anesthesia, but rather allows the administration of any "medications" necessary to implement a treatment regimen ordered by a physician. So, for example, if a physician orders a CRNA to perform an emergency intubation, a properly trained CRNA can implement that order by selecting, ordering and administering medications necessary to perform the intubation, just as the CRNA may implement a surgical order by selecting, ordering and administering anesthetics.[31]

Some have asserted that this practice is inconsistent with California Business & Professions Code § 4019, which allows medications to be dispensed in a hospital after a physician enters an order on a patient's chart. To our knowledge, this assertion has not been directly addressed by any regulatory agency or court. Nevertheless, we understand that it is common practice in California for hospitals to comply with Section 4019 by requiring the physician to enter an anesthesia order on the patient's chart, which then allows the CRNA to implement that order by selecting, ordering and obtaining the anesthetic and other medications from a hospital dispensary. We also understand that in some hospitals, the scheduling of a procedure requiring anesthesia itself serves as an order for anesthesia. Assuming these understandings are accurate, Section 2725(a) of the Nursing Practice Act provides authority for practices that have common acceptance and usage. We further note that prior BRN opinions appear to be consistent with these

[28] BRN Statement re: *Practice of the Certified Registered Nurse Anesthetist (CRNA)* dated July 1990 (emphasis added) (Exhibit I).
[29] *See, e.g.*, BRN letter dated September 12, 1988, attached as Exhibit J; Exhibits D, I.
[30] CSA Case, 204 Cal.App.4th at 405; B&P Code § 2725(e).
[31] *See* BRN letter dated January 15, 1992 (Exhibit G) ("It is within the scope of practice of the CRNA to provide…emergency services both inside and outside the operating room suite. These services would include endotracheal intubation….").

practices[32] and, tellingly, we are not aware of any enforcement action ever initiated under Section 4019 against a CRNA, physician or hospital with respect to these practices.

Some have also asserted that Section 2725(b)(2) cannot be read to authorize the selection and administration of anesthesia by CRNAs because the statute also applies to nurses who have no specialized training in anesthesia. Section 2725(b)(2) does apply to general registered nurses. But that does not mean that any nurse can select, order and administer anesthetics or related medications. As the BRN has advised, the Nursing Practice Act also requires that the nurse be competent to safely administer a medication:

> Specifically, the registered nurse must be competent to perform the function, and the function must be performed in a manner consistent with the standard of practice. [Business and Professions Code 2761(a)(1); California Code of Regulations 1442, 1443, 1443.5.]
>
> In administering medications to induce conscious sedation, the RN is required to have the same knowledge and skills as for any other medication the nurse administers. This knowledge base includes but is not limited to: effects of medication; potential side effects of the medication; contraindications for the administration of the medication; the amount of the medication to be administered. The requisite skills include the ability to: competently and safely administer the medication by the specified route; anticipate and recognize potential complications of the medication; recognize emergency situations and institute emergency procedures. Thus the RN would be held accountable for knowledge of the medication and for ensuring that the proper safety measures are followed.[33]

Physicians Are Not Automatically Liable for the Actions of a CRNA

Given that California law allows a CRNA to administer anesthesia without physician supervision, a related question is physicians can be subjected to automatic vicarious liability for utilizing the services of a CRNA. The answer is no. There is no captain-of-the-ship or other automatic liability for physicians or anesthesiologists who utilize or supervise CRNAs in California.[34] Rather, liability is determined on a case-by-

[32] *See, e.g.*, BRN Statement re: *Practice of the Certified Registered Nurse Anesthetist (CRNA)* dated July 1990 (Exhibit I).

[33] BRN statement re: *Conscious Sedation* dated July 1997, attached as Exhibit K.

[34] *See California Society of Anesthesiologists v. Schwarzenegger* (2010) Case No. CPF-10-510191 (Superior Ct. of San Francisco), pgs. 6-7 (Exhibit B); *Cavero v. Franklin General Benevolent*

(cont'd)

case basis depending on whether the physician or anesthesiologist in fact exercised direction and control over the CRNA.[35] The Nurse Anesthetists Act similarly makes clear that CRNAs are responsible for their professional conduct and potentially liable for their professional acts.[36] This fact was repeated by the Court of Appeal in the recent CSA Case,[37] and is again consistent with the repeated position of the BRN:

> There is no additional malpractice insurance required for the surgeons since a CRNA is responsible for his or her own professional conduct and is held liable for those professional acts. The CRNA practices under his or her own license not that of a physician.[38]

Patient Access, Cost and Safety

In closing, we would like to briefly highlight some of the policy benefits associated with CRNA practice in California. CRNAs are the sole anesthesia providers in seven California counties.[39] They are also the primary providers of anesthesia care in rural America.[40] In these communities, if CRNAs could not practice independently, there would be no or, at best, extremely limited access to obstetrical or surgical services.

Moreover, CRNAs give hospitals the flexibility to utilize more cost-efficient anesthesia models. A 2010 article by The Lewin Group, a subsidiary of UnitedHealth Group, concluded that CRNAs acting independently "provide anesthesia services at the lowest economic cost."[41] That article also concluded that while a physician supervision model could be efficient in facilities where demand is high and relatively stable, it is inefficient in areas of low demand such as rural communities. In those communities, CRNAs acting independently is the only model likely to result in positive net revenue and thus be economically sustainable.

(… cont'd)

Society(1950) 36 Cal.2d 301, 302-303, 306-308 (operating surgeons were not responsible for a nurse anesthetist's negligent administration of anesthesia).

[35] *See Kennedy v. Gaskell* (1969) 274 Cal.App.2d 244, 249.

[36] B&P Code § 2828.

[37] CSA Case, 204 Cal.App.4th at 402.

[38] *See* BRN letter to Santa Teresita Hospital dated February 18, 1993, attached as Exhibit L.

[39] S*ee*[*www.canainc.org/news/2012archive/CANA%20Supreme%20Court%20Press%20Release%206-12%20_3_.pdf*](www.canainc.org/news/2012archive/CANA%20Supreme%20Court%20Press%20Release%206-12%20_3_.pdf).

[40] *See* www.canainc.org/organization/nurses-at-glance.htm.

[41] Hogan, Paul F. *et al.*, *Cost Effectiveness Analysis of Anesthesia Providers*, Journal of Nursing Economics, Vol. 28, No. 3 (May-June 2010 ("Lewin Study"), pg. 168, attached as Exhibit M.

Recent studies also conclude that the use of CRNAs does not put patients at any increased risk. Indeed, in a 2010 study published in Health Affairs, researchers who analyzed about 500,000 hospitalizations concluded that CRNA administration of anesthesia without physician supervision does not put patients at any increased risk of anesthesia-related deaths or complications.[42] The Lewin study likewise noted that CRNAs can perform the same set of anesthesia services as anesthesiologists, and that there were "no significant differences in rates of anesthesia complications or mortality between CRNAs and anesthesiologists or among delivery models for anesthesia that involve CRNAs, anesthesiologists, or both after controlling for other pertinent factors."[43]

These studies reflect both the high quality of care provided by CRNAs and the relative safety of anesthesia in general. As the Lewin study remarked, "[g]iven the low incidence of adverse anesthesia-related complications and anesthesia-related mortality rates in general, it is not surprising that there are no studies that show a significant difference between CRNAs and anesthesiologists in patient outcomes."[44]

[42] Dulisse, Brian, *et al*, *No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians*, Health Affairs, August 2010, pgs. 1474-1475, attached as Exhibit N.
[43] Lewin Study (Exhibit M), pg. 160.
[44] Lewin Study (Exhibit M), pg. 161.