

CALIFORNIA ASSOCIATION OF NURSE ANESTHETISTS CRNA SCOPE OF PRACTICE GUIDELINES

The following offers guidance on the scope of practice for Certified Registered Nurse Anesthetists (CRNAs) in California. CRNAs are highly-trained advanced practice nurse specialists that are required to complete six to seven years of education, hundreds of hours of clinical work, and a minimum of 450 anesthetics before they qualify to sit for their national certification examination. Each day, CRNAs work in collaboration with other qualified health care providers in hospitals, surgical centers and office settings around the state. Typically, they administer anesthesia to facilitate diagnostic, therapeutic and surgical procedures. They also are called upon to administer anesthesia for pain management associated with obstetrical labor and delivery, acute and chronic pain, for the management or monitoring of ventilatory problems, and for other conditions.

Because they are highly-trained specialists, California, like many other states, allows CRNAs to administer anesthesia without physician supervision. That practice is supported by the fact that CRNAs are independent practitioners who are legally responsible for their own actions.

CRNA Scope of Practice

As recognized by the California Legislature, the practice of nurse anesthesiology is a dynamic field that is continually evolving to include more sophisticated patient care activities and functions, including those also performed by physicians. Today, CRNA scope of practice includes, without limitation, the following:

1. Performing and documenting a pre-anesthesia assessment and evaluation of the patient, including requesting consultations and diagnostic studies; selecting, obtaining, ordering and administering pre-anesthetic medications and fluids; and obtaining informed consent for anesthesia.
2. Developing and implementing an anesthetic plan.
3. Initiating the anesthetic technique that may include general, regional or local anesthesia with or without sedation.
4. Performing and managing regional anesthetic techniques including, but not limited to, subarachnoid, epidural and caudal blocks; plexus, major and peripheral nerve blocks; intravenous regional anesthesia; transtracheal, topical and local infiltration blocks; intracapsular, intercostal and ocular blocks; and use of nerve stimulator devices and ultrasound that aid in the placement of the block.

5. Selecting, ordering, applying and inserting appropriate non-invasive and invasive monitoring modalities for continuous evaluation of the patient's physical status.
6. Selecting, obtaining and administering anesthetics, adjuvant and accessory drugs and fluids necessary to manage the anesthetics.
7. Selecting and ordering adjuvant and accessory medications, fluids, laboratory testing and other modes of analysis to evaluate patient status and promote well-being.
8. Managing a patient's airway and pulmonary status using current practice modalities including fiberoptic intubation and mechanical support.
9. Facilitating emergence and recovery from anesthesia by selecting, obtaining, ordering and administering medications, fluids and ventilator support.
10. Discharging the patient from a post-anesthesia care area, outpatient surgery section of a facility or from an ambulatory surgery center and providing post-anesthesia follow-up evaluation and care.
11. Implementing acute and chronic pain management modalities.
12. Responding to emergency situations by providing airway management, administration of emergency fluids and drugs, and using basic or advanced cardiac life support techniques.

Legal Foundation for CRNA Scope of Practice

Determining CRNA scope of practice requires a two-part analysis. First, each function must fit within one of the categories of nursing functions set out in the Nursing Practice Act, California Business & Professions Code (Cal. B&P Code) § 2725(b). Second, each must be a common and accepted function for CRNAs to perform. *See* Cal. B&P Code § 2725(a) ("It is the intent of the Legislature...to provide clear authority for functions and procedures which have common acceptance and usage."). All of the functions listed in the above CRNA scope of practice meet this two-part test.

CRNAs are authorized to administer anesthesia without physician supervision

Both the Nursing Practice Act and common and accepted practice support the conclusion that CRNAs can administer anesthesia without physician supervision. As for the Nursing Practice Act, § 2725(b) generally provides as follows:

The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill.

Subsection 2725(b)(2) authorizes nurses to administer “medication 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.” This statutory authorization is universally understood to include the administration of all forms of anesthesia. In fact, the California Attorney General has specifically concluded that this language “provides express authority for a registered nurse to administer an anesthetic.” 67 Ops. Att’y. Gen.’1 122, 139 (1984). Historically, it has been a common and accepted practice for CRNAs to administer anesthesia without physician supervision, be it in hospital, surgical center, or office settings. Thus, under the two-part analysis for determining CRNA scope of practice, CRNAs may administer anesthesia without physician supervision in California.

Over the years, some have questioned whether the language of the Nursing Practice Act—specifically, §2725(b)(2)—requires CRNAs to administer anesthesia under physician supervision. It does not. On its face, § 2725(b) simply requires that anesthesia be “ordered” by a physician, dentist, podiatrist, or clinical psychologist acting within the scope of his or her license. So, for example, in the typical surgical setting where an individual is the patient of the surgeon, the law requires that the surgeon “order” the anesthesia for the patient. It does not, however, require the surgeon to subsequently supervise a CRNA (or an anesthesiologist for that matter) when he or she administers the anesthetic to the patient.

Some have countered that even though the term “supervise” does not appear in § 2725(b)(2), the phrase “ordered by...a physician” is synonymous with supervision and, therefore, the Legislature intended to require physician supervision of CRNAs. Again, that is not the case. Other provisions of the Nursing Practice Act make clear that the Legislature knows full well that “order” and “supervise” are two different things. For example, Cal. B&P Code § 2746.51(a)(4) states:

The furnishing or *ordering* of drugs or devices by a certified nurse-midwife occurs under physician and surgeon *supervision*...Physician and surgeon

supervision shall not be construed to require the physical presence of the physician.... (Emphasis added.)

Similarly, Cal. B&P Code § 2836.1(d) states:

The furnishing or **ordering** of drugs or devices by a nurse practitioner occurs under physician and surgeon **supervision**. Physician and surgeon supervision shall not be construed to require the physical presence of the physician.... (Emphasis added.)

In these two examples, the Legislature gave nurse-midwives and nurse practitioners the authority to **order** drugs, i.e., direct that medications be dispensed to the patient, as long as there was physician **supervision**. Clearly, the Legislature did not intend for “order” and “supervise” to be synonymous terms in the Nursing Practice Act. Put differently, if the Legislature wanted to require physician supervision of CRNAs, it could have used the term “supervision” in § 2725(b)(2) or in some other statute, just as it did in §§ 2746.51(a)(4) and 2846.1(d).¹

Over the past 25 years, various California agencies have consistently reached the same conclusion. For example, since 1986 the Board of Registered Nursing (BRN) has concluded on at least eight separate occasions that physician supervision of CRNAs is not required.² As the state agency responsible for

¹ This conclusion is consistent with federal regulations, which equally do not seek to impose a supervision requirement by using the term “order.” Rather, when federal regulations want to require supervision of CRNAs, they utilize the term “supervision.” See 42 C.F.R. §§ 416.42; 482.52 and 485.639.

² See BRN opinion letter to Timothy Wolf, April 14, 1986; BRN opinion letter to Carol Tarnowsky, September 12, 1988; BRN Memorandum to Interested Persons, October 11, 1988; BRN Memorandum to Interested Persons, July 1990; BRN opinion to Robert Deliman, M.D., February 18, 1993; Correspondence from Ruth Ann Terry, Executive Officer of the Board of Registered Nursing, to Roberto Martinez, Chief, Medical Policy Division, Department of Health Services, July 11, 2002; Correspondence from Ms. Ruth Ann Terry, Executive Director of the Board of Registered Nursing, to Ms. Brenda Klutz, Deputy Director of Licensing and Certification, Department of Health Services, November 23, 2004; and Correspondence from Ms. Ruth Ann Terry, Executive Officer of the Board of Registered Nursing, to Mr. Harold Bressler, General Counsel, Joint Commission on Accreditation of Healthcare Organizations, January 20, 2005.

interpreting the Nursing Practice Act, the BRN’s conclusion must be accorded great weight and deemed authoritative unless clearly erroneous. Sara M. v. Superior Court, 36 Cal.4th 998, 1011-12 (2005).

The Governor of California similarly determined that California law does not impose a supervision requirement as part of his decision to opt out of the federal Medicare supervision requirement. That federal requirement, contained in regulations maintained by the Center for Medicare and Medicaid Services (CMS), provides that CRNAs must be supervised by a physician for hospitals and certain other facilities to receive facility reimbursement payments for anesthesia services under Medicare Part A and Medicaid (Medi-Cal in California). However, individual states may opt out of (i.e., exempt themselves from) the physician supervision requirement if the governor of the state sends a letter to CMS attesting that, after consulting with the state’s medical and nursing boards, the governor has determined that opting out is *consistent with state law* (i.e., that state law does not impose a supervision requirement) and is in the best interests of the people of the state. On July 17, 2009, Governor Schwarzenegger sent a letter to CMS containing the required determinations and, in turn, making California the 15th state to opt out of the federal supervision requirement.

The Department of Health Services (DHS) also concluded that a supervision requirement is inconsistent with the Nursing Practice Act. In 1987, DHS amended a Medi-Cal Program regulation to eliminate the then existing requirement that nurse anesthetists be supervised by a physician as a condition of coverage under the Medi-Cal program. At the time, the regulation stated:

“(a) Nurse anesthetists services are covered subject to all of the following conditions:

“(1) **Anesthesia shall be administered only under the immediate direction, supervision and in the presence of a licensed physician, podiatrist, or dentist who is attending the patient, or a physician, who is authorized by the attending practitioner to administer, or supervise the administration of, such anesthesia or analgesia;**

“(2) Nurse anesthetists shall administer only general anesthesia by inhalation or intravenous methods.” 22 Cal. Code of Regs. § 51326 (emphasis added).

DHS replaced that language with the following:

Nurse anesthetist services are covered when provided by a nurse anesthetist within the scope of his or her licensure.

In its statement of reasons for making the change, DHS made clear that supervision of CRNAs is not required by California law. Specifically, DHS stated:

This regulation, as now written, does not permit nurse anesthetists to administer regional anesthetics, nor does it permit the administration of anesthesia except under direct supervision, and is therefore inconsistent with the Business and Professions Code.

The suggested change in wording is needed to clarify that the Department of Health Services does not impose additional qualifications on, nor does it limit the practice of nurse anesthetists beyond that specified in the Business and Professions Code. Notice of Proposed Changes in Regulation of the Department of Health Services Regarding Nurse Anesthetists (R-34-85) at 4. (emphasis added)

DHS took a similar action in 1991, amending a regulation that allowed only physicians to conduct pre- and post-anesthesia evaluations and discharge functions in acute care hospitals. *See* 22 Cal. Code of Regs. §§ 70233 and 70527. Specifically, DHS made clear that, consistent with the Nursing Practice Act, CRNAs also could perform those functions. Significantly, DHS again did not impose any supervision requirement.

The Attorney General also refused to find a supervision requirement for CRNAs. In its seminal opinion on CRNA scope of practice issued in 1984, the Attorney General determined that CRNAs may administer all forms of anesthesia on the sole condition that anesthesia be “ordered” by a physician, dentist or podiatrist acting within the scope of his or her license. 67 Ops. Att’y. Gen’l. 122, 139 (1984). In reaching this conclusion, the Attorney General overruled a 1972 opinion of its office—56 Ops. Att’y. Gen’l. 1—that held that CRNAs could only administer general anesthesia when supervised by a licensed physician or dentist. The 1984 AG opinion also included an exhaustive review of early case law that suggested physician supervision was required. *See Chalmers-Francis v. Nelson*, 6 Cal.2d 402 (1936); *Magit v. Board of Medical Examiners*, 57 Cal.2d 74 (1961); 56 Ops. Att’y. Gen’l. 1 (1972). Yet, despite this early case law (and the 1972 AG opinion), the Attorney General still refrained from expressing or implying any supervision requirement, presumably because he concluded that the Legislature intended to supersede this outdated authority when it enacted extensive

amendments to the Nursing Practice Act in 1974 and 1978, without including any express physician supervision requirement.

Indeed, the Legislature has implicitly supported this conclusion on several other occasions. For example, as noted above, the 1974 amendments to the Nursing Practice Act also recognized “the existence of overlapping functions between physicians and registered nurses,” permitted “additional sharing of functions within organized healthcare systems,” and sought “to provide clear authority [for CRNAs to perform] functions and procedures which have common acceptance and usage” (such as the administration of anesthesia without physician supervision). Cal. B&P Code § 2725(a).

In 1989, the Legislature also removed an obsolete reference to a supervision requirement pertaining to procedures in dental outpatient settings.³ Clearly, the Legislature did not do this so that it could replace an express supervision requirement with an implicit one that uses the term “order.” Rather, the Legislature made this change so that Cal. B&P Code § 1646.1 would be consistent with § 2725(b), which does not require physician supervision

And in 1994, the Legislature enacted an outpatient surgery center law that specifically permits anesthesia services to be performed by a CRNA, and prevents such centers from arbitrarily restricting a CRNA’s privileges. Cal. Health & Safety Code §§ 1258.15(3) and (10)(d). Again, the Legislature enacted this law without including any express supervision requirement.

Moreover, over the last 20 years, the Legislature has consistently refused to write a supervision requirement into the Nursing Practice Act in the face of repeated BRN interpretations that supervision is not required. In fact, although the Legislature has amended § 2725 three times since 1989, it has never sought to impose a supervision requirement or otherwise contradict the BRN. Instead, in 2003, the Legislature specifically reaffirmed that BRN has the *exclusive* authority to interpret the Nursing Practice Act. See Cal B&P Code § 2725(e) (“No state

³ Previously, Cal. B&P Code § 1646.1 stated that a dentist could not “administer or supervise the administration of general anesthesia” unless the dentist held a valid general anesthesia permit. In 1989, the Legislature replaced the word “supervise” with “order.” Section 1646.1 now states that a dentist cannot “administer or order the administration of general anesthesia” without the required permit.

agency other than the board may define or interpret the practice of nursing for those licensed pursuant to the provisions of this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless so authorized by this chapter, or specifically required under state or federal statute.”).

Finally, California liability law is consistent with the conclusion that CRNAs can administer anesthesia without supervision. There is no captain-of-the-ship or other automatic liability for surgeons who utilize CRNAs under California common law. Rather, surgeon liability is determined on a case-by-case basis depending on whether the surgeon in fact exercised direction and control. *See Kennedy v. Gaskell*, 274 Cal.App.2d 244, 249 (1969). Consistent with the fact that CRNAs are independent practitioners, the Legislature in 1983 passed the Nurse Anesthetists Act which made nurse anesthetists independently responsible for their professional conduct and potentially liable for their professional acts. Cal. B&P Code § 2828.

In sum, the Nursing Practice Act, both by its language and its authorization of common and accepted practice, allows CRNAs to administer anesthesia in California without physician supervision. Over the course of the past 25 years, this conclusion has been reached on numerous occasions by the BRN, the agency with expertise in CRNA scope of practice matters, and is consistent with numerous actions and determinations of other relevant state agencies and officials.

CRNAs are authorized to perform all of the direct and indirect patient care services associated with the administration of anesthesia

Sections 2725(b)(1)-(4) also authorize CRNAs to perform all of the direct and indirect patient care services associated with administering anesthetics and ensuring the safety, comfort, and protection of patients, including observing and treating reactions to anesthesia and initiating emergency procedures. This necessarily includes all of the functions listed in the above CRNA scope of practice, such as conducting pre- and post-anesthesia assessments, obtaining informed consent from a patient⁴, selecting the anesthetic and any pre- and post-

⁴ For further authority on a CRNA’s ability to obtain informed consent, *see Corwin v. State Farm Fire & Casualty*, 2003 Cal.App.Unpub. Lexis 875 (Cal. App. 2003) (case brought against nurse anesthetist for failure to obtain informed consent); and Cal. Code of Regulations § 70223(d) (person responsible for administering anesthesia must confirm that patient has given informed consent).

anesthetic medications⁵, managing a patient's airway, cardiovascular and pulmonary status while under anesthesia, providing post-anesthesia follow-up evaluation and care, treating acute and chronic pain, and responding to emergency situations.

In practice, it is also common for CRNAs to perform these functions. In fact, the California Legislature mandated that CRNAs receive instruction on these functions. In the Nurse Anesthetist Act, the Legislature mandated that CRNAs graduate from a program accredited by the Council on Accreditation of Nurse Anesthesia Education Programs (COA). Cal. B&P Code § 2826. The COA curriculum includes the following requirements:

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

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. To meet COA standards..., a student must have performed a minimum of 450 anesthetics, which must include specialties such as pediatric, obstetric, cardiothoracic, and neurosurgical anesthesia....

Clearly, if the Legislature requires CRNAs to learn all of these functions, it expects CRNAs to actually perform them.

⁵ To be clear, CRNAs do not have the authority to write prescriptions. However, after anesthesia has been ordered, CRNAs do have the authority to select the anesthetic and any pre- and post-anesthetic medications that ensure the safety and comfort of the patient.

Finally, the above CRNA scope of practice is consistent with the American Association of Nurse Anesthetists' (AANA'S) "Guidelines for Core Clinical Privileges" and "Scope and Standards for Nurse Anesthesia Practice." Like these California guidelines, the AANA's national guidelines authorize a nurse anesthetist to evaluate and prepare a patient for anesthesia, administer all types of anesthesia, utilize invasive and non-invasive monitoring, and manage the recovery process.

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