Physician Supervision of CRNAs Under Medicare Regulations and Wyoming Law: Uncharted Territory for a Frontier State

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I. Introduction: The governor’s choice, whether to opt Wyoming out of Medicare’s physician supervision requirement for CRNAs, is a difficult one.

Nurses and physicians are both indispensable parts of the modern healthcare setting; each has a crucial role caring for patients. In recent times, however, the lines between those roles have blurred. Wyoming’s Governor Mead has recently considered opting Wyoming out of Medicare’s requirements for physician supervision of CRNAs, and asked the Wyoming Board of Medicine and Wyoming Board of Nursing to advise him on the implications of an opt-out. Wyoming and federal law do not clearly state the limits of that “supervision,” making the Governor’s decision much harder.

II. Medicare requires CRNAs to be supervised by the operating physician or an anesthesiologist unless the state has formally opted out, but Wyoming’s licensing regulations are less clear.

Medicare’s Condition of Participation for anesthesia in acute care hospitals, 42 C.F.R. §482.52(a)(4), permits anesthesia to be provided by “[a] certified registered nurse anesthetist (CRNA)... who, unless [the state has opted-out], is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed.” Medicare’s Condition of Participation for anesthesia in critical access hospitals (42 C.F.R. §485.639(c)(2)) and Condition of Coverage for ambulatory surgery centers (42 C.F.R. §416(b)(2)) are similar.

Unlike the federal regulations, Wyoming’s licensing regulations on physician supervision for CRNAs varies depending on the surgical setting. Wyoming’s acute-care hospital licensing regulations require that “[w]hen anesthetics are not administered by an anesthesiologist, they shall be administered by a registered nurse anesthetist under the supervision of the operating physician.”

Wyoming’s critical access hospital (CAH) regulations, however, are silent with respect to physician supervision of CRNAs. Under the CAH regulations, every patient is required to be under the care of a physician, or a mid-level practitioner supervised by a physician, and “furnished services [must]… comply with all applicable licensure standards.” There is no requirement that a CRNA providing anesthesia specifically be supervised by a physician when doing so, unlike the acute-care hospital regulations. Instead, the care provided by mid-level providers must generally be supervised by a physician.

Wyoming’s ambulatory surgery center (ASC) licensing regulations do not appear to require physician supervision of CRNAs, requiring only that the ASC’s governing body “ensure that all services provided are consistent with accepted standards of practice.” Similar to CAH’s, the ASC regulations require that “[f]urnished services, including the contracted services, shall comply with all applicable licensure standards…[m]edical and nursing staff shall be licensed, certified, or registered according to Wyoming laws and rules; and…[s]taff members shall provide health services only within the scope of his or her license, certification, or registration.” Wyoming’s CAH licensure regulations and ASC regulations therefore seem to defer to the prevailing standard of care and licensing requirements to determine whether a physician must supervise a CRNA.

Wyoming’s Nursing Practice Act clearly does not require a physician to supervise a CRNA’s work. CRNAs are considered “advanced practice registered nurses” (APRNs) under Wyoming’s nursing practice regulations, along with clinical nurse midwives, clinical nurse practitioners, and clinical
nurse specialists. Until 2005, Wyoming’s Nursing Practice Act required an APRN (then called an “advanced practitioner of nursing”) to practice “in collaboration with a licensed or otherwise legally authorized physician or dentist, in such manner to assure quality and appropriateness of services rendered.” The collaboration requirement was removed in 2005, and APRNs’ scope of practice was broadened to include, “responsibility for the direct care and management of patients and clients in relation to their human needs, disease states, and therapeutic and technological interventions.”

Wyoming APRNs (including CRNAs) may therefore practice in Wyoming without any type of physician supervision, unless the state licensing statutes or regulations require physician supervision.

III. Wyoming does not follow the “captain of the ship” doctrine, which would make the operating physician liable for a CRNA’s malpractice.

One common rationale for the opting out of Medicare’s supervision requirement is that the operating surgeon does not have the expertise to supervise the CRNA’s work, but remains liable for the CRNA’s work because he or she is required to supervise the CRNA. Remove the CRNA supervision requirement, the argument goes, and the operating physician’s potential liability will be consequently reduced. The kernel of this argument is the “captain of the ship” theory of liability: the operating physician is responsible for every action of every person in the operating room during an operation. Wyoming has, however, never formally adopted the “captain of the ship” theory of liability, and many states’ courts have abandoned it. Those that still apply the theory do so, for the most part, in a much reduced form.

Traditionally, surgeons have been described as the “captain of the ship” in the operating room: everyone in the operating room, and everything that happens in it, is the surgeon’s responsibility, and the surgeon is liable for all mistakes that happen irrespective of his or her personal responsibility. In a 2010 case applying Wyoming law, the federal Tenth Circuit Court of Appeals in Willis v. Bender noted that Wyoming has never adopted the “captain of the ship” theory, and likely would not, since “more recent courts have rejected the ‘captain of the ship’ doctrine in favor of general agency principles.” The Tenth Circuit specifically quoted from another court’s rejection of the “captain of the ship” theory, stating, “[i]n modern medicine, the surgeon is a member of a team of professionals, and we see no reason why the surgeon should be deemed responsible for the actions of other professionals neither employed nor controlled by him.”

It is much more likely that a Wyoming court would only find a surgeon liable for a CRNA’s malpractice if the surgeon had attempted to exercise some control over the CRNA’s practice, as both the states that have explicitly rejected the “captain of the ship” doctrine, and those that apply a modified form, have done. States that reject the “captain of the ship” doctrine have applied the “borrowed servant” doctrine to determine whether a surgeon should be held liable for CRNAs (or other persons in the operating room), which requires that the surgeon actually controls, or has the right to control, the CRNA’s actions.

Under Wyoming’s version of the “borrowed servant” doctrine, the surgeon becomes liable for the CRNA’s work only when the surgeon actually directs the CRNA’s work. The Wyoming Supreme Court has stated that a property owner retaining the “broad general power of supervision and control” is not liable for an independent contractor’s work. Medicare’s “supervision” requirement is unlikely to be construed by a Wyoming court as sufficient to give the physician the ability to “control” the CRNA’s work to the extent necessary to make the surgeon liable for the CRNA’s work.

IV. Conclusion

As described above, Wyoming does not have to opt out of Medicare’s physician-CRNA supervision requirements to reduce the risk of surgeon liability for a CRNA’s malpractice. Wyoming’s law on the issue is not settled, but it is unlikely that a Wyoming court would find a surgeon liable for a CRNA’s negligence unless the surgeon actually attempts to control or specifically direct the CRNA’s work.

Moreover, Medicare’s physician-CRNA supervision requirement establishes an effective “floor” for all Wyoming hospitals and ASCs with respect to CRNA supervision. Opting out of Medicare’s CRNA supervision requirement would leave hospitals and ASCs in a situation where, at best, patients were potentially subjected to two different standards of safety: in acute-care hospitals, CRNAs would operate only with physician supervision, while in CAHs and ASCs, CRNAs may be able to operate without physician supervision.

If Wyoming opts out, the hospital and ASC licensing regulations should be updated to provide one standard of care for Wyoming patients.

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