CRNAs and their employment situations

This month’s column examines some of the legal issues CRNAs are facing concerning employment. While it would be convenient to point out that every case depends on its specific facts (which is, of course, true) these problems seem to have common or recurring themes. It is important for all members of the AANA to be aware of the situations concerning some of their fellow members and to be aware that some anti-CRNA activity can be dealt with. The intent of this article is not to offer specific legal advice, but merely to make AANA members aware of these problems and how their own lawyers may be able to offer assistance.

Can a CRNA be self-employed?

Most nurse practice statutes (which in some cases are exceptions to medical practice statutes) provide that CRNAs may administer anesthesia only under the supervision of a physician. In some cases, the statutes require the presence of a physician and some statutes require direction and/or supervision of a physician. We have learned that in Indiana, for example, some hospitals have been given a legal opinion that the Indiana statute (which is similar to most others) requires a CRNA to be an employee. The opinion offers the choice that the CRNA can be the employee of a hospital or of a physician but indicates that self-employment is prohibited. This opinion, with which we disagree, is based on the following reasoning:

1. An “independent contractor” is one who may carry out his or her profession without being under the immediate supervision of another.

2. Indiana law requires a CRNA to practice under the direction of a physician.

3. Therefore, a CRNA may never be an independent contractor and thus, may not be self-employed.

Self-employed CRNAs should challenge the assumption that a self-employed CRNA is an independent contractor or that a self-employed CRNA cannot be an independent contractor for some purposes and not for others. Under Indiana law, a CRNA must be under the direction of a physician. If an independent contractor is one who by definition does not practice under the direction of another, then the CRNA cannot be an independent contractor. But, this is not the same thing as saying that a CRNA cannot be self-employed.

Can a hospital restrict CRNA practice to CRNAs employed by physicians?

The lack of a prohibition against self-employed CRNAs is not, on the other hand, the guarantee of the right of a self-employed CRNA to practice. Recently an AANA member asked if a hospital could restrict hospital privileges to only those CRNAs who are employed by physicians with active staff privileges at the hospital. Many readers may be aware of legislation adopted in the District of Columbia requiring hospitals to grant privileges to qualified CRNAs whether or not they are employed by physicians. Similar legislation has also been introduced (but not yet enacted) in other states.

In the absence of such legislation, some CRNAs have legally challenged hospital policies
which make it difficult for CRNAs to work. Under these theories, if a hospital should adopt a provision requiring that CRNAs be employed by a physician, those CRNAs who had worked at the hospital prior to the adoption of the provision might have a claim that a third party interfered with the CRNAs’ advantageous contract (specifically the CRNAs’ employment contract). To maintain the action, the CRNAs would have to show that the third person intentionally interfered with the contract out of malice or an improper motive and had no privilege or excuse for doing so.

Some CRNAs have also sought protection under the Federal Anti-Trust Statutes. They have claimed that the hospital policy constituted a restraint of trade in favor of a group of physicians.

At one time it was difficult, if not impossible, to bring a successful anti-trust suit against a group of physicians, since those engaged in the practice of medicine were said to be exempt from the anti-trust law, under the so-called “learned profession” exception. Since 1943, the Courts have increasingly recognized that certain activities which restrain trade or create or further a monopoly are violative of the anti-trust laws, notwithstanding the fact that physicians, rather than businessmen, engage in the activities. However, “learned professions” are not treated in the same manner as commercial enterprises, and the courts permit activity which would otherwise be restricted by anti-trust laws if the activity “contributes directly to improving service to the public.” Furthermore, if the challenged activity is a direct result of state regulation of the profession, the activity will not be found to violate the anti-trust law.

When CRNAs are employed by anesthesiologists or other physician groups which are affected by anti-CRNA activities, the employer may also have the causes of action discussed above.

**Must a CRNA be supervised or directed by an anesthesiologist?**

The language of most nurse practice statutes requires that the CRNA be supervised or directed by a physician, not by an anesthesiologist. It may be possible for a hospital to justify a determination that CRNAs be supervised only by anesthesiologists. However, if the only purpose of this provision was to secure financial benefit for a particular group of physicians, some CRNAs might argue that it is a restraint of trade.

**Can a hospital restrict anesthetic practice to anesthesiologists?**

This question will probably be easier to answer after the Supreme Court’s decision in *Jefferson Parish Hospital v. Hyde*. This is the case in which the AANA filed an *amicus curiae* brief describing CRNAs but not commenting on the legal issue. The issue in the *Hyde* case was whether or not a hospital could offer an exclusive contract to a group of anesthesiologists. Let us look at this question again once the *Hyde* case has been decided.

**Can a hospital adopt 2:1 or 4:1 CRNA to anesthesiologist ratios as a standard of practice?**

Some hospitals have adopted 2:1 or 4:1 ratios based on the Health Care Financing Administration (HCFA) regulations. As AANA Washington consultant Richard Verville has pointed out on several occasions, HCFA supervision ratios were adopted solely for purposes of reimbursement and were not intended to evidence a level of anesthesia care. However, it has come to our attention that some hospitals have adopted these staffing ratios as standards for practice. These regulations were developed because HCFA was trying to distinguish between the types of service anesthesiologists performed which were of a general supervisory nature (for which the anesthesiologist could not separately bill) and services performed by anesthesiologists which were direct patient care (for which the anesthesiologist could bill directly).

In attempting to resolve whether or not the anesthesiologist was providing general supervisory services or direct patient care, HCFA suggested, as a matter of administrative convenience, that if the anesthesiologist was supervising no more than two concurrent surgeries (later changed to four) this would be accepted as direct patient care and separately billable. (HCFA, in fact, reimburses administration of anesthesia by CRNAs even when the staffing ratio is much larger than 4 to 1.) Again, it may be possible for a hospital to have some legitimate reason for adopting such a provision. If the hospital’s sole justification was that its regulation was based on the HCFA requirement, then some CRNAs may believe that there is cause of action either for interfering with an advantageous contractual relationship or restraint of trade.

Although there may be legal resources available to combat certain abuses by hospitals or physicians, a lawsuit is not the only, nor necessarily the best means of approach. However, if “all else fails,” or you think that a hospital or physicians’ group has acted in a particularly outrageous manner, you may want to seek direction from your personal attorney.
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