

Analysis of Ohio HB52

September 2026

Introduction

Ohio House Bill 52 (HB52) revises Ohio's regulatory framework governing certified registered nurse anesthetists (CRNAs). HB52 is not an authorization of CRNA autonomy but represents an expansion of physician delegation authority. All CRNA actions authorized under HB52 require a physician, podiatrist or dentist to request the CRNA to perform them, and must be in accordance with policies adopted by the healthcare facility. Thus, CRNA practice may be limited by both the collaborating physician, podiatrist or dentist and the facility.

HB52 was signed by Governor DeWine on March 10, 2026, and took effect June 9, 2026. It replaces the longstanding supervision model for CRNAs with a collaboration framework; updates statutory provisions regarding CRNA scope of anesthesia practice; introduces patient-notification requirements; clarifies the roles of physicians, podiatrists or dentists who work with CRNAs and introduces protective measures designed to ensure close monitoring of a CRNA's scope of anesthesia practice while ensuring patient safety. HB52's key provisions include, among other things:

1. Shifts the relationship between the CRNA and the physician, podiatrist or dentist from "supervision" to "collaboration," while retaining the requirement that the CRNA's anesthesia related service activities be subject to the request of the collaborating physician, podiatrist or dentist.
2. Emphasizes the responsibility of a healthcare facility to define and limit, within the statutorily defined CRNA scope of practice parameters, the permissible anesthesia related activities a CRNA may perform at the facility through privileging and other policies.
3. Empowers facilities and collaborating physicians, podiatrists and dentists to exercise proper judgment and further limit CRNA anesthesia related service activities in specific cases when such limitations are deemed to be in the patient's best interest.
4. Revises statutory presence requirements for anesthesia administration and related activities, while preserving facility and collaborating physician, podiatrist and dentist authority to apply stricter presence requirements.

5. Revises and clarifies CRNA authority to provide limited anesthesia-related services, if requested, and is subject to limitations imposed by the facility and collaborating physician, podiatrist or dentist.
6. Requires healthcare facilities to provide patients advance notice in writing and verbally regarding the practitioners who will administer anesthesia services.
7. Establishes additional provisions governing collaboration with dentists and podiatrists.
8. Expressly prohibits CRNAs from prescribing drugs for use outside of the healthcare facility.

Purposes and goals of HB52

The legislature's goals in adopting HB52 appear to be to modernize Ohio's nursing statutes to reflect contemporary CRNA practice while maintaining and extending institutional and professional safeguards over CRNA practice. Per HB52's primary sponsor, State Representative Kellie Deeter, HB52 is **not** intended to expand CRNA practice, but instead explicitly clarifies it by (i) modernizing and streamlining Ohio's CRNA statutes, (ii) providing a clear and consistent regulatory framework and (iii) **maintaining physician-led care**.¹ In replacing Ohio's prior supervision model with a collaboration framework, HB52 does **not** establish independent practice for CRNAs. Instead, it eliminates certain statutorily imposed procedural restrictions on CRNA practice, while also shifting responsibility and authority toward healthcare facilities and collaborating physicians, podiatrists and dentists (and the Board of Nursing) to define and limit, within the statutorily defined practice parameters, the anesthesia related service activities a CRNA practicing at the facility may perform. These procedural safeguards effectively empower those with more first-hand knowledge and clinical experience overseeing CRNA practice, rather than the state legislature, to define and limit CRNA practice within specific facilities and in individual circumstances. Altogether, HB52's final enactment preserves and introduces mechanisms intended to protect patient safety, including Board of Nursing oversight, collaboration requirements, physician discretion to restrict autonomy, facility-based restrictions, credentialing controls and mandatory patient disclosures.

¹ [Letter from State Representative Deeter to Ohio House Health Committee](#) (Deeter Testimony).

HB52's principal provisions

Transition from supervision to collaboration

Prior law required a CRNA to practice under the “supervision” of a physician, podiatrist or dentist, requiring that a CRNA perform requested anesthesia related service activities in the supervising physician’s, podiatrist’s or dentist’s immediate presence. HB52 replaces the “supervision” requirement with a collaboration model². Under this model, collaboration is established when a physician, podiatrist or dentist **requests** that a CRNA perform certain authorized patient care activities. Unlike Ohio’s statutes governing collaboration with other advanced practice registered nurses, HB52 does not require that collaborating physicians, podiatrists or dentists enter into a standard care agreement with CRNAs.

Under this new collaboration model, a CRNA’s authority to provide anesthesia in a specific case is established and limited by the collaborating physician’s, podiatrist’s or dentist’s request. Collaboration for a CRNA is defined as a relationship in which a physician, dentist or podiatrist “requests, either verbally or in writing, the nurse to perform certain patient care activities authorized by division (D) of Section 4723.43 of the Revised Code and the request is made in accordance with policies established by the healthcare facility³ where the nurse and the dentist, physician, or podiatrist practice.”⁴ Accordingly, the statute replaces a supervision-based practice model with an authorization-and-collaboration framework under which the collaborating physician, podiatrist or dentist both initiates and defines the CRNA’s involvement in patient care, while the CRNA performs the requested anesthesia related services within the scope of the CRNA’s licensure, and facility privileges and policies. Notably, HB52 provides little in the way of specifics regarding requirements for how or when a collaborating physician, podiatrist or dentist may request CRNA involvement, other than that the request be made “verbally or in writing.” However, the request for, and performance of, CRNA anesthesia related services must be made in accordance with the policies of the healthcare facility where the collaborating physician, podiatrist or dentist and CRNA practice, which empowers the healthcare facility to define and further limit how and when requests for CRNA anesthesia related services may be made. Thus, HB52 transfers responsibility to facilities to define for themselves the process and circumstances in which collaborating physicians, podiatrists and dentists may request CRNA services, which may be more restrictive than is permitted under statute.

Immediate presence no longer required

HB52 repeals the statutory requirement that a collaborating physician, podiatrist or dentist be in the immediate presence of the CRNA while anesthesia is administered or during induction, maintenance and emergence. Instead, HB52 requires that the collaborating physician, podiatrist or dentist be **present** at the healthcare facility when the CRNA is performing induction, maintenance and emergence of general anesthesia.⁵ However, nothing in HB52 prevents a facility from implementing its own, stricter, presence requirements through its policies, particularly for patient safety.

CRNA scope of practice revisions

HB52 maintains CRNA authority to engage in numerous clinical activities associated with anesthesia care, including the selection, ordering and administration of intravenous fluids and medications. HB52 also clarifies CRNA authority to perform certain other anesthesia related tasks and other services. CRNA scope of practice clarifications and revisions under HB52 include:

- Consolidating several statutes containing CRNA scope of anesthesia practice provisions under a single statute section, Ohio Rev. Code § 4723.43(D)
- Specifically permitting CRNAs to perform epidural or spinal anesthetic procedures⁶
- Permitting a CRNA to perform and document evaluations and assessments, which may include ordering and evaluating one or more diagnostic tests, in connection with the performance of clinical support functions in addition to conditions related to the administration of anesthesia⁷
- Clarifying a CRNA’s authority to select, order and administer drugs, IV fluids and treatments for conditions related to the performance of clinical support functions⁸
- Extending the CRNA’s authority to direct a registered nurses (RN), licensed practical nurse (LPN) or respiratory therapist in performing certain supportive care services and administration of drugs, IV fluids and treatments to include performance of clinical support functions⁹
- Expressly prohibiting a CRNA from prescribing a drug for use outside of the location where the CRNA practices¹⁰

2 Medicare conditions of participation for hospitals still impose certain supervision requirements for CRNAs performing anesthesia services if the state where the hospital is located has not opted out of these requirements. See 42 C.F.R. § 482.52. Ohio opted out of these requirements in July 2026, consistent with the legislation, but the opt-out does not reflect any deviation from, or expansion of HB52; it is a natural by-product of it. Facilities and physicians should remain aware of individual private payor supervision requirements and ensure there is no variation in the standard of care based on patient payment source. These issues are outside the scope of this analysis, but nevertheless important factors in setting policies and procedures.

3 For purposes of the CRNA statutes, “healthcare facility” is defined as an ambulatory surgical facility, cardiovascular or vascular center, freestanding birthing center, hospital or office of a dentist, physician or podiatrist. Ohio Rev. Code § 4723.01(L)(3).

4 Ohio Rev. Code § 4723.01(L)(3).

5 Ohio Rev. Code § 4723.43(D).

6 Ohio Rev. Code § 4723.43(D)(3).

7 Ohio Rev. Code § 4723.43(D)(7).

8 Ohio Rev. Code § 4723.43(D)(6).

9 Ohio Rev. Code § 4723.43(D)(8).

10 Ohio Rev. Code § 4723.43(D).

- Eliminating statutory temporal restrictions on performance of certain CRNA anesthesia related service activities, which required that such services be performed in a period beginning with the patient's admission for surgery or procedure, and ending with the patient's discharge from recovery

Importantly, the statutory CRNA scope of anesthesia practice provisions represent the "outer limit" of what services CRNAs may be authorized to perform. The services a CRNA may provide in a particular case are defined, and thus limited by, the scope of request from the CRNA's collaborating physician, podiatrist or dentist. Furthermore, and as discussed in Section IV, HB52 empowers healthcare facilities to limit CRNA scope of anesthesia practice at their respective facilities through credentialing, privileging and other facility policies. Finally, facilities and collaborating physicians, podiatrists and dentists have the authority to limit a CRNA's anesthesia related service activities if the facility or collaborating physician, podiatrist or dentist deems such limitations to be in the patient's best interest. Thus, a facility is not required to permit its CRNAs to perform the full scope of services defined under 4723.43(D).

In evaluating policies and the privileging process regarding CRNA anesthesia related practice, healthcare facilities should carefully consider the degree to which its CRNAs should be permitted to perform the services identified in 4723.43(D), and in what circumstances. For example, HB52's changes expressly recognize CRNA scope of anesthesia practice to include certain services performed in connection with "clinical support functions." However, HB52 leaves "clinical support functions" undefined. It is now up to healthcare facilities and collaborating physicians, podiatrists and dentists to consider how much authority they are willing to provide CRNAs to perform these services in a clinical support context. Since HB52 gives healthcare facilities this authority, great care should be exercised, as the statute cannot be relied upon to provide an excuse for failing to carefully exercise such authority.

Patient disclosure requirements

A new patient-notification requirement mandates that healthcare facilities inform patients, before anesthesia administration or the performance of an epidural or spinal anesthetic procedure, whether the anesthesia service will be provided by a CRNA, physician, podiatrist or dentist.¹¹ Facilities should review admission, informed-consent and pre-procedure documentation processes to ensure compliance with these disclosure requirements.



Collaboration with podiatrists and dentists

Podiatrists

HB52 makes significant changes to CRNA relationships with podiatrists. As discussed above, HB52 replaces the former supervision model with a collaboration framework under which a podiatrist may request that a CRNA perform certain patient-care activities. Most notably, the legislation prohibits the State Medical Board from preventing podiatrists practicing outside hospitals or podiatry colleges from collaborating with CRNAs.¹² This change appears intended to facilitate anesthesia-service arrangements in ambulatory and office-based podiatric practice settings. HB52 also removes the restriction that a CRNA's scope of practice be limited to the anesthesia procedures that the collaborating (formerly supervising) podiatrist has authority to perform.¹³ Nevertheless, CRNA collaboration with podiatrists remains subject to facility policies, credentialing standards and delineated privileges, preserving substantial institutional oversight notwithstanding the statutory expansion of podiatrist collaboration authority. A collaborating podiatrist should exercise great care to ensure ultimate patient safety and the qualification of the CRNA, given that a CRNA may be practicing outside the scope of the podiatrist's own authority.

Dentists

Under HB52, a dentist may collaborate with a CRNA only if the dentist holds a conscious sedation permit or general anesthesia permit issued by the State Dental Board.¹⁴ The legislation thereby conditions CRNA participation on the collaborating dentist's existing regulatory authority to provide sedation or anesthesia services. HB52 appears intended to facilitate collaborative anesthesia care while preventing dentists from utilizing CRNAs to expand the scope of services otherwise authorized under their permits. Unlike with podiatrists, when collaborating with a dentist, the CRNA's scope of practice is limited to the anesthesia procedures that the dentist has the authority to perform under the dentist's conscious sedation or general anesthesia permit. As with physician and podiatrist collaborations, CRNA anesthesia related services activities remain subject to applicable facility policies, credentialing standards and delineated clinical privileges, preserving substantial institutional oversight notwithstanding the statutory shift from supervision to collaboration.

¹¹ Ohio Rev. Code § 4723.434(A).

¹² Ohio Rev. Code § 4731.513.

¹³ See Ohio Rev. Code § 4723.43.

¹⁴ Ohio Rev. Code § 4723.43.

Facilities and physicians should exercise power to limit CRNA authority when appropriate

As discussed above, HB52 does not merely replace supervision with collaboration. It also expressly vests both healthcare facilities and collaborating physicians, podiatrists and dentists with significant authority to limit what a CRNA may do. HB52 shifts the burden for defining a CRNA's scope of practice from legislation and regulation to the facilities and physicians, podiatrists and dentists who work with CRNAs on a daily basis. As a result, HB52 should not be read as creating unrestricted CRNA autonomy. Rather, CRNA anesthesia related activities at a facility are subject to institutional governance and clinical privileging. During the legislature's consideration of HB52, maintaining healthcare facility safeguards and collaborating physician, podiatrist and dentist oversight of CRNA delivered anesthesia related services was cited by key stakeholders as an important component of the bill. For example, in support of HB52, Representative Kellie Deeter noted that HB52 "makes clear that both the healthcare facility and the collaborating provider determine CRNA scope of practice activities consistent with their training, education and delineation of privileges, without altering any model of care,"¹⁵ while a representative from the Ohio State Association of Nurse Anesthetists recognized that HB52 "supports clear, consistent oversight by healthcare organizations and collaborating providers."¹⁶ In light of this, it is very important that healthcare facilities and collaborating physicians, podiatrists and dentists give thorough consideration to the scope of CRNA anesthesia related service activities to be provided in a facility or a particular case, including the circumstances in which anesthesiologist involvement should be required. Facilities and collaborating physicians, podiatrists and dentists should make responsible decisions in the best interests of patient care.

Facility policies become a principal source of authority

HB52 requires a CRNA who performs requested patient-care activities must do so "in accordance with policies established and privileges delineated by the healthcare facility" where the CRNA and collaborating physician, podiatrist or dentist practice.¹⁷ This means that even if Ohio law defines a particular services to be within the CRNA scope of practice, the facility may choose to impose narrower restrictions through its policies, including:

- Medical staff bylaws
- Anesthesia department policies
- Credentialing criteria
- Delineated privileges
- Quality-assurance requirements
- Practice protocols.

For example, a hospital could:

- Require anesthesiologist involvement for specified procedures
- Limit newly credentialed CRNAs to certain cases
- Restrict pediatric, cardiac, trauma or obstetrical anesthesia privileges
- Require consultation with an anesthesiologist before particular anesthetic techniques are used
- Establish documentation or quality-review requirements exceeding statutory minimums

Nothing in HB52 appears to prohibit these types of institutional limitations. Facilities should carefully consider and implement safeguards focused on patient care.

Collaborating physicians, podiatrists and dentists retain case-specific authority

HB52 defines collaboration as occurring when a physician, dentist or podiatrist requests the CRNA to perform certain patient-care activities.¹⁸ Because the collaboration relationship is based upon a request from the collaborating physician, podiatrist or dentist, the collaborating professional necessarily retains authority to define what anesthesia related service activities are being requested in a particular case.

Practically speaking, a collaborating physician could request a CRNA:

- Provide a complete anesthetic
- Perform only certain anesthesia-related service activities functions
- Refrain from particular techniques
- Involve an anesthesiologist in all aspects of care

HB52 does not require a collaborating physician, podiatrist or dentist to delegate every activity within the CRNA's statutorily defined scope of practice. Rather, CRNA authority flows from the requested activity itself.

Authority to restrict activities based on a patient's best interest

HB52 provides the collaborating physician, dentist, podiatrist or facility where the CRNA and collaborating physician, podiatrist or dentist practice, **express statutory authority to restrict CRNA anesthesia related service activities** that are not, in the view of the collaborating physician, podiatrist or dentist or relevant healthcare facility, in the patient's best interest. In this case, even if a CRNA is authorized by statute and his or her delineated privileges to perform a particular service, the facility or collaborating physician, podiatrist or dentist should restrict the CRNA's authority to perform certain services if either believes that such limitation would be in the patient's best interest.

¹⁵ Deeter Testimony.

¹⁶ [Letter from Angela Milosh](#), representative for Ohio State Association of Nurse Anesthetists to Ohio Senate Health Committee, Oct. 22, 2025.

¹⁷ Ohio Rev. Code § 4723.43(D).

¹⁸ Ohio Rev. Code § 4723.01(L).

Examples of such restrictions could include:

- Restricting a CRNA from a difficult airway case
- Limiting management of medically complex patients
- Requiring physician participation in the management of certain complex patients and/or procedures
- Restricting certain sedation techniques
- HB52 imposes no standard other than the patient's best interest on when a facility or collaborating physician, podiatrist or dentist may exercise this authority to limit a CRNA's activities, empowering facilities and collaborating physicians, podiatrists and dentists to further limit CRNA provided anesthesia services in their best judgment for a particular case. Entrusted with this patient safety authority, facilities and collaborating physicians, podiatrists and dentists should exercise their powers carefully, considering the CRNAs ability to handle adverse events, CRNA experience, patient risk factors and other relevant issues.

Liability considerations

HB52's replacement of Ohio's CRNA supervision requirement with a collaboration framework does not eliminate potential liability for physicians and healthcare facilities arising from CRNA provided anesthesia service activities. In Ohio and elsewhere, liability historically has not been based on the distinction between a supervising and collaborating physician. The standard is the same for either role. For example, Ohio courts have consistently looked beyond regulatory labels and instead focused on traditional common law principles of agency, control and assumed duties. Thus, the question after HB52 is not simply whether a physician is designated a "collaborator" rather than a "supervisor," but whether the physician exercised sufficient control over the conduct at issue or otherwise assumed responsibilities whose breach contributed to the patient's injury.

Ohio law recognizes that physicians can be held liable for the conduct of others and their own conduct. In *Baird v. Sickler*, the Ohio Supreme Court held that a surgeon "may, under the doctrine of respondeat superior, indeed be liable for the alleged negligence of the nurse-anesthetist who assisted him [or her] during the operation."¹⁹ There, the plaintiff was rendered permanently paraplegic following a procedure in which a nurse anesthetist administered anesthesia.²⁰ The surgeon testified that he instructed the anesthetist during intubation, observed the procedure and had both the right and duty to stop the procedure if performed improperly.

Thus, the surgeon had exercised enough control of the nurse for the surgeon to be liable for the nurse's actions.²¹ Although the court rejected a broad captain-of-the-ship doctrine that "would hold a surgeon responsible for all that transpires in the operating room," it emphasized that "where, in the operating room, a surgeon does control or realistically possesses the right to control events and procedures, he does so with a high degree of care."²² Accordingly, *Baird* confirms that physician liability remains available whenever the facts support a master-servant relationship, even when a CRNA is not directly employed by the physician. Notably, the later case *Ferguson v. Dyer* did not overrule *Baird*, and instead distinguished by explaining that a surgeon who instructed, supervised and participated in the challenged conduct could still be liable under *Baird*, while a physician who merely issued standing orders would not automatically be liable under *Ferguson*.²³ The inquiry remains fact specific based on the physician's involvement, industry standards and the reasonableness of the physician's decisions.

Physicians may also face direct liability based on duties they independently undertake. In *Lownsbury v. VanBuren*, the Ohio Supreme Court held that "a physician-patient relationship can be established between a physician who contracts, agrees, undertakes or otherwise assumes the obligation to provide resident supervision," and a patient the physician never personally treated.²⁴ The court reasoned that a physician who undertakes supervisory responsibilities may owe patients a corresponding duty of care, and liability may arise from the physician's own failure to discharge those responsibilities.²⁵ Likewise, although *Ferguson v. Dyer* rejected liability based merely on a physician's theoretical authority over a nurse, the court emphasized that "the inquiry focuses on the question of control," specifically whether control over the employee passed to the physician "with reference not only to the result reached but to the method of reaching it."²⁶ The court held only that "mere potential or possible control, of itself, is an insufficient basis to find liability pursuant to the loaned-servant doctrine."²⁷ Thus, *Ferguson* limits automatic liability, but it does not foreclose claims based on actual direction, supervision, or assumed responsibilities.

Healthcare facilities likewise remain exposed to liability under similar theories. Ohio law recognizes that a hospital may be held liable for the conduct of its negligent nurses where it has "a right of control over and responsibility for the actions of the nurse" and the nurse was "engaged in performing the work of the physician or hospital."²⁸ HB52 gives the hospital a right of control over the CRNAs and facilities should exercise this right with care. More recently, *Orac v. Montefiore Foundation* reaffirmed that "hospitals can be vicariously liable for the negligence of its nurses even if the nurse or other hospital employee is not named in a plaintiff's complaint."²⁹ Orac also recognized that negligence claims against a healthcare facility require proof of a duty, breach, causation, and damages.³⁰

¹⁹ *Baird v. Sickler*, 69 Ohio St.2d 652, 654.

²⁰ *Id.* at 652.

²¹ *Id.* at 654–55 (explaining that the surgeon "not only controlled but also participated in the administering of the anesthetic" and "had the right to control it").

²² *Id.* at 655.

²³ *Ferguson v. Dyer*, 149 Ohio App.3d 380, 388.

²⁴ *Lownsbury v. VanBuren*, 94 Ohio St.3d 231, 241

²⁵ *Id.* at 241–43.

²⁶ *Ferguson v. Dyer*, 149 Ohio App.3d 380, 384 (quotation marks and citation omitted).

²⁷ *Id.* at 388.

²⁸ *Morris v. Children's Hosp. Med. Ctr.*, 73 Ohio App. 3d 437, 442 (1991).

²⁹ *Orac v. Montefiore Foundation*, 255 N.E.3d 189, 201 (Ohio Ct. App. 2024).

³⁰ *Id.* at 195, 202–03.

It then allowed claims against a nursing home to proceed in part based on a duty to provide adequate care.³¹ Thus, even where a facility is not liable for a particular employee's conduct, a healthcare facility may also be directly liable **for its own negligent policies**, staffing, supervision, credentialing or other institutional failures. Liability is not based on labels such as "supervision" or "collaboration". Liability is fact-specific and can be based on a failure to exercise reasonable care or reasonable restraint powers.

Accordingly, HB52 does not alter existing common law liability. Neither the statute nor existing Ohio case law supports the conclusion that due to the shift from "supervision" to "collaboration" physicians and facilities face little to no risk from CRNA conduct. The truer reading of Ohio law is that liability will continue to depend on traditional fact-intensive inquiries concerning control, delegation, assumed duties, supervision, credentialing and institutional oversight, rather than the statute's use of the term "supervision" or "collaboration." In light of this, facilities and collaborating physicians, podiatrists and dentists should carefully consider the scope of anesthesia related service activities in which CRNA's should be engaged, and whether it may be preferable to maintain the involvement of anesthesiologists in particular circumstances and through a care team model.

Practical patient safety considerations

In the end, regardless of ultimate legal liability, which may not be determined until after years of lengthy and costly litigation, patient care should be paramount. Facilities and collaborating physicians, podiatrists and dentists should consider safeguards to protect from bad outcomes.

When determining whether anesthesia related services should be provided by a CRNA, a physician anesthesiologist or an anesthesia care team model, healthcare facilities and collaborating physicians, podiatrists and dentists should recognize that the most significant exposure generally arises not from routine, uncomplicated procedures, but from rare and catastrophic events. Cases involving airway emergencies, unrecognized hypoxia, hemodynamic collapse, aspiration, anaphylaxis, malignant hyperthermia, cardiac arrest or other anesthesia-related crises frequently result in substantial litigation and retrospective scrutiny of staffing, supervision, credentialing and coverage decisions.

Importantly, when a serious anesthesia complication occurs, liability exposure is rarely limited to the individual anesthesia provider. Plaintiffs commonly pursue claims against the surgeon, ambulatory surgery center, hospital, anesthesia group and other entities involved in the design and implementation of the anesthesia care model. Allegations often focus on negligent supervision, negligent delegation, inadequate credentialing or privileging, failure to provide appropriate physician backup or institutional decisions that allegedly failed to account for foreseeable emergency situations.

Recent litigation illustrates the magnitude of this risk. In a Texas case arising from routine orthopedic surgery, a patient suffered catastrophic brain injury following alleged anesthesia-related complications and was left in a permanent vegetative state. A jury awarded more than US\$21 million in damages. The litigation focused not only on the actions of the anesthesia providers, but also on the adequacy of supervision, staffing arrangements, monitoring and the level of physician involvement available when complications developed. The case demonstrates how a catastrophic outcome can lead to scrutiny of the entire anesthesia delivery model adopted by the providers and facility.

For surgeons, a particular concern arises when they assume supervisory or collaborative responsibilities over CRNA-provided anesthesia service activities. In the aftermath of a serious adverse event, plaintiffs may argue that the physician, podiatrist or dentist failed to ensure adequate anesthesia coverage, selected an inappropriate anesthesia model for the patient or procedure or participated in staffing decisions that left the patient without immediate access to necessary expertise during an emergency. Even where the collaborating physician, podiatrist or dentist played no role in administering anesthesia, the surgeon's involvement in the care model or oversight structure may become a central issue in litigation.

Facilities face similar risks. Hospitals and ambulatory surgery centers may be accused of negligent credentialing, negligent privileging, inadequate staffing or adoption of policies that placed economic considerations ahead of patient safety. Plaintiffs' counsel often examine whether the facility adequately assessed patient acuity, procedural complexity, available emergency resources and the need for physician-level anesthesia expertise when establishing anesthesia coverage policies. Allegations that a staffing model was chosen primarily for financial efficiency can be particularly damaging when presented to a jury following a catastrophic patient outcome.

A recurring issue in anesthesia litigation is the distinction between routine anesthesia management and crisis management. While anesthesia care is delivered safely in the overwhelming majority of cases, the legal focus often shifts to whether the providers and facility were prepared for the uncommon but foreseeable emergency. When plaintiffs allege delayed recognition of physiologic deterioration, failed airway rescue, ineffective emergency response or inadequate management of a rapidly evolving crisis, they frequently contend that greater anesthesia expertise or more direct physician involvement could have improved the outcome. Whether such claims ultimately prevail, they still create significant risk for all parties involved.

Accordingly, facilities and collaborating physicians, podiatrists and dentists should carefully evaluate the appropriateness of the anesthesia model for each patient population and practice setting. Relevant considerations include patient comorbidities, procedural complexity, anticipated airway challenges, availability of immediate emergency support, provider experience, supervision requirements, credentialing standards and applicable regulatory obligations. Decisions regarding anesthesia coverage should be documented as patient-safety decisions grounded in clinical judgment and risk assessment rather than solely on operational efficiency or cost considerations.

Although no staffing model can eliminate the inherent risks associated with anesthesia care, recent malpractice litigation demonstrates that courts and juries may closely examine the decisions made by facilities and collaborating physicians, podiatrists and dentists regarding anesthesia coverage when catastrophic outcomes occur. Careful consideration of provider qualifications, supervision structures, emergency-response capabilities, and patient-specific risk factors can reduce both patient-safety risks and potential liability exposure.

Takeaways

Although HB52 is often described as simply replacing “supervision” with “collaboration,” healthcare facilities and collaborating physicians, podiatrists and dentists should view the legislation as a broader restructuring of their role in anesthesia governance. In large part, HB52 shifts responsibility from statutory supervision requirements toward facility-driven credentialing, privileging, policies and professional accountability.

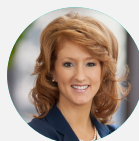
Collaboration does not mean independence – HB52 does not establish independent practice for CRNAs. Rather, CRNAs may provide anesthesia related services activities when requested by a collaborating physician, dentist or podiatrist, and in accordance with the relevant facility’s policies and privileges, as well as any limits deemed suitable by the requesting physician. Facilities should consider whether existing policies should be revised to accurately reflect the facility’s own intended CRNA collaborative practice model.

Facility policies are critically important – With HB52’s enactment, the onus on defining CRNA scope of practice at a particular facility now lies with the facilities themselves. Under the prior regulatory framework, compliance and liability questions frequently focused on whether supervision requirements were met. With HB52’s enactment, such inquiries are likely to now focus on facility policies, the CRNA’s granted anesthesia-related privileges, whether policies were followed and whether other restrictions were or should have been imposed on the CRNA. If the facility believes certain categories of patients, procedures or anesthetic techniques warrant additional oversight, it has a responsibility to address these matters through facility policies, including the credentialing and privileging processes. Facilities should conduct a careful and comprehensive review of anesthesia privileging, credentialing and informed-consent policies to ensure they are consistent with HB52’s framework and the facility’s intended operation of its anesthesia program.

Collaboration should be operationally defined – HB52 defines collaboration broadly as a written or verbal request to a CRNA from a collaborating physician, podiatrist or dentist to perform patient-care anesthesia related activities, but it does not provide detailed guidance concerning elements such as consultation expectations or escalation protocols. Accordingly, facilities may benefit from developing internal standards to address these open issues, such as when consultation with an anesthesiologist is expected and structured processes that should be followed for the management of high-risk cases. A facility’s anesthesiologists should have a role in helping a facility develop operational parameters for requests for CRNA provided anesthesia services.

Liability theories are likely to shift – HB52 does not eliminate malpractice or negligence exposure for either collaborating physicians, podiatrists, dentists or healthcare facilities. However, post-HB52, these cases may focus on claims of negligent credentialing and privileging, adequacy of facility policies, consultation processes, institutional negligence, individual professional negligence and other theories. Because of this, facilities should carefully consider their privileging and other policies, the processes for implementing them and the degree to which the facility will rely upon CRNA provided anesthesia services in light of HB52’s changes. Physicians, podiatrists and dentists should carefully consider the degree to which they request and/or limit CRNA provided anesthesia services.

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