Regional anesthesia, for the purpose of this paper, includes all forms of anesthesia other than general anesthesia. General anesthesia is the influence on the brain or central nervous system by drugs or gases in a manner which produces a totally unconscious state.

The Lawyers' Medical Cyclopedia (S25.3) includes various techniques of regional anesthesia, those being:

1. Topical anesthesia—Where the drug blocking the conduction of pain is applied directly to the operating field.
2. Local anesthesia—Where the drug blocking the conduction of pain is injected into the operating area.
3. Nerve block—Where the drug blocking the conduction of pain is injected around the nerves leading from the operating field.
4. Epidural anesthesia—Where the drug blocking the conduction of pain is placed in proximity to nerves close to where they enter the coverings of the spinal cord.
5. Spinal anesthesia—Where the drug blocking the conduction of pain is injected into the space within the sheath enveloping the spinal cord.
6. Regional analgesia—Defined as brain influence by drugs to ignore pain stimulus where an unconscious state is not achieved.

Most of the literature discussing the legal aspects of regional anesthesia (and there really is not very much) only singles out the last four of these techniques: nerve block, epidural anesthesia, spinal...
anesthesia, and regional analgesia for discussion, perhaps because of the relative safety and simplicity of local and topical anesthesia.

Conduct proscribed

Now that we know what it is that we are discussing, it would be well for us to know what sort of conduct is being proscribed vis-a-vis the use of regional anesthesia. There are three possibilities from the attorney's point of view. They are:

1. Diagnosis of a patient's health status for purposes of eliminating anesthetic agents or techniques from all of those which are available.

2. Prescription of a particular anesthetic agent and/or technique, and

3. Actual administration of the prescribed agent through the application of the prescribed technique.

Most of you will no doubt recognize immediately the qualitatively large step from anesthesia administration on the one hand to diagnosis and/or prescription on the other. This is the traditional differential between the physician and all others, licensed or not, who work with him or her. While I am quick to acknowledge that CRNA's occupy what Dr. Frederick Hehre describes as the "grey area between the surgeon and the anesthesiologist in the diagnosis and prescription process," that is a subject for another day.

Consider, then, these remarks to be concerning only the legal propriety of the actual administration of regional anesthesia by CRNA's, whether they be hospital employees or freelance independent contractors.

Incidentally, the Joint Commission on Accreditation of Hospitals (JCAH) acknowledges in its Hospital Survey Profile p. 2 (1977) that anesthesia can be or is administered by anesthesiologists, other physicians, staff and independent CRNA's, other registered nurses, dentists, anesthesiology residents and student nurse anesthetists and others, such as podiatrists and osteopaths, all of whom may be the dramatis personae in anesthesia crises and in the lawsuits that often follow on a daily basis. While the rationale may be somewhat the same regarding all non-physicians, my comments are intended to relate only to CRNA's and, tangentially, to other nurses.

Why differing standards?

Why, you might be asking yourselves, have I earlier singled out California in my discussion? If patient conditions, anesthesia agents, and techniques are otherwise all the same, why should a CRNA in California have differing legal standards from a CRNA in Illinois or Florida?

In response, I quote: "The necessity of a concurrent jurisdiction . . . results from the division of the sovereign power: and the rule that all the authorities of which the states have not explicitly divested in favor of the union remain with them in full vigour, is not only a theoretical consequence of that division, but is clearly admitted by the whole tenor of the instrument . . ."

[Cooke, Jacob E. (Ed.), The Federalist p. 203 (Wesleyan Univ. Press 1961)]

The author?: An anonymous character known only as "Publius" when he published his comments to the people of New York on January 2, 1788. The work is now known as the Federalist Paper No. 32, and the author is one of our founding fathers, Alexander Hamilton. Before the instrument to which he refers could be adopted, of course, it became necessary to state expressly what Mr. Hamilton saw as being only implicit. Thus, the 10th Amendment to the Constitution of the United States provides that, "The powers not delegated to the United States by the Constitution nor prohibited by it to the states, are reserved to the states respectively, or to the people."

One of these powers reserved to the states is the power to regulate the rendering of health care, particularly as regards licensure of health professionals.
The United States Supreme Court has recognized this state power on several occasions. *Barsky v. Board of Regents*, 347 U.S. 442, 449 (1954); *Linder v. United States*, 268 U.S. 5, 17 (1925).

Acting pursuant to that power, each state has enacted its own, unique medical practice act and nursing practice act, and each state literally has the power to ignore what the universe may consider as good medical practice in setting its own standards. It appears to me that the state of California may have availed itself of this broad power in the case of the administration of regional anesthesia.

The law of California

Perhaps, it would be instructive for us to look closely at the law of California on this subject. The “law” as we call it comes from many sources. The broadest and most powerful sources are constitutional provisions. We have already seen how the 10th Amendment to the U.S. Constitution gives California the freedom to go its own way if it wishes.

After constitutional mandates come statutes, which are simply the expression of the elected representatives of the people. The statutes both articulate law and authorize others to do so, such as state officials who issue regulations and formal rulings on what the statutes mean.

Finally, there are the courts, which construe the Constitution, the statutes, the regulations and the rulings to see if the uses to which they are put are legally defensible. In addition, courts are generally authorized by the Constitution to make the law up to meet new fact situations, and, this is what we call the common law. Often, these varying sources build on each other for precedent.

On December 29, 1972, the attorney general of California issued a formal opinion, authorized by law, to construe the then existing case law and statutory law of California. The opinion, labeled No. CV 72/106, was written in response to an inquiry by a California assemblyman, who asked, among other things, the following questions:

1. “May nurse anesthetists administer spinal, epidural, and regional anesthesia and analgesia?”

2. “Who may or must supervise a nurse anesthetist, i.e. physician, dentist, osteopath, podiatrist, other nurse, etcetera?”

3. “What may licensed registered nurses enrolled in an approved school for anesthesiology do?”

For controlling authorities, the attorney general looked to the California statutes and cases. First, he found a 1936 California Supreme Court case which very squarely held that a nurse anesthetist may administer general anesthesia when under the immediate direction and supervision of the operating surgeon. *Chalmers-Francis v. Nelson*, 6 Cal. 2d 402, 57 p. 2d 1312 (1936). That case expressly found that the nurse anesthetist was neither diagnosing nor prescribing by acting under the supervision of a physician.

Next, the attorney general found a 1961 California Supreme Court case involving an anesthesiologist who had three totally unlicensed persons assist him in administering both general and regional anesthesia. The Board of Medical Examiners had revoked the license of the anesthesiologist for aiding in the unlicensed practice of medicine. On appeal, the court in *Magit v. Board of Medical Examiners*, 17 Cal. reprtr. 488, 366 p. 2d 816 (1961) upheld the Board’s finding of a violation of the medical practice act, even though it also ruled that revocation of Dr. Magit’s license was too strong a penalty.

The language of the *Magit* opinion, which would have greater meaning later for CRNA’s, stated that the terminology of the California Nursing Act, adopted after the 1936 Chalmers-Francis case, “... is so broad that the administration of certain forms of anesthetics by a registered nurse, acting under the immediate direction and supervision of a licensed physician, may come within its scope. To what extent and under what conditions it authorizes nurses to per-
form such acts is not before us, and we need note only that any authority they may have in this field is derived from their special statutory position and does not affect the authority of others. Obviously, the Chalmers-Francis decision related only to the then existing practice and to the particular general anesthetics in use at that time, and it is not controlling with respect to any other anesthetic or any other method of producing anesthesia.” (Emphasis supplied.)

The 1972 California attorney general’s opinion agreed that a CRNA’s authority must be derived from the statutory language of the nursing act and noted that the statute which sets forth nursing educational requirements “... does not contain any requirement for course study or training in anesthesia.”

In conclusion, the opinion said, considering “(1) The limiting language of the Magit case, (2) the fact that no anesthesia training requirements are set forth in the statute, and (3) the statutory definition of nursing, ... it is the considered opinion of this office that registered nurses may not administer spinal, epidural, and regional anesthesia or analgesia.”

What are the results of this opinion? I recently spoke with a CRNA from Sacramento, California, who tells me he performed regional anesthesia for years before this opinion, but has not since the opinion was issued because his hospital is afraid of malpractice suits.

Other states

While California has been exercising its right to regulate its own medical affairs differently, what have other states been doing? I cannot tell you that I know the law in every state, but I can say that I am not aware of any state other than California which has formally taken the position that it is unlawful for a CRNA to administer regional anesthesia. I am informed that several state societies of anesthesiologists have declared that regional anesthesia may only be administered by anesthesiologists, but I do not know the final results of such declarations.

Both the general counsel of the Illinois Hospital Association and I, as counsel for the Illinois Association of Nurse Anesthetists, have rendered written opinions that CRNA’s may administer regional anesthesia in Illinois when under the supervision of a physician.

In addition, the Ohio Association of Nurse Anesthetists has obtained a legal opinion that Ohio law does not preclude regional anesthesia administration by a CRNA. Opinions of knowledgeable anesthesiologists to the same effect have been obtained in Missouri and Massachusetts, although they do not purport to state the law in those states.

The big question

The question which every CRNA should ask himself or herself is whether anyone might successfully assert against him or her or perhaps against his or her hospital a claim for malpractice based upon the theory that the CRNA should not be administering regional anesthesia. My answer to that (except for California) is no, that is if the AANA, the state associations, the hospital, and the CRNA’s do their job.

In the first place, some of the experts in the field of anesthesiology, such as Dr. Jack Collins of St. Louis, Dr. Frederick W. Hehre of Boston, and Dr. Richard A. Rink of Columbia, Missouri, have gone on record in articles and speeches advocating both regional anesthesia and CRNA administration. These comments should be published and circulated.

The Joint Commission on Accreditation of Hospitals says that qualified nurse anesthetists must be able to provide general anesthesia and that the responsibilities of both anesthetists and supervising physicians must be defined in a written policy (Joint Commission on Accreditation of Hospitals) Hospital Accreditation Manual 61 (1976). This policy should specify expressly regional anesthesia and the degree of supervision.
to be exercised in all such cases. The only JCAH reference to regional anesthesia is the requirement that its administration be noted in the chart by the responsible physician, which goes without saying.

AANA continuing education programs should include regional anesthesia, and the accredited schools of anesthesia should include it in their curriculums. Hospitals should consider institutional credentialing as a means of documenting the extent to which they are training their CRNA’s to perform regional anesthesia professionally. When its administration by CRNA’s is more universally accepted in practice and in academia, then the chances are slight that anyone could successfully assert that allowing a CRNA to administer regional anesthesia is negligence.

AUTHOR

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