Legal Briefs

GENE A. BLUMENREICH, JD
AANA General Counsel
Powers & Hall
Boston, Massachusetts

Anesthesia and JCAHO

Key words: Joint Commission on the Accreditation of Healthcare Organizations, licensed independent practitioner, supervision.

To those who are not healthcare professionals, the anxiety evoked by a visit from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) may be one of the most peculiar aspects of healthcare. Whatever amazement I may initially have felt about the terror generated by these visits has long since been replaced by a somber realization of the very real toll that they cause, especially on nurse anesthetists.

Despite years of complaints, nurse anesthesia remains largely unrepresented on the boards and panels of JCAHO. JCAHO investigators for Anesthesia Departments often do not understand nurse anesthesia or, worse, are anesthesiologists who understand it but have their own purposes to pursue.

JCAHO Standards are written in a unique style sometimes suggesting absurd interpretations. Vulnerable hospitals and medical staffs have, at times, despite JCAHO denials, interpreted JCAHO Standards or Guidelines as requiring measures which restrict the practice of nurse anesthetists or as putting those who work with nurse anesthetists at risk. JCAHO Standards are far from ideal, but JCAHO has adopted a number of interpretations and explanations relating to anesthesia which may be helpful to nurse anesthetists. Unfortunately, these interpretations have a much smaller audience than JCAHO Standards, and misunderstandings persist.

In 1986, the Joint Commission on Accreditation of Hospitals (JCAH), as it was then called, proposed revised standards for surgery and anesthesia for the *JCAH Accreditation Manual for Hospitals.* The Standards defined the licensed independent practitioner (LIP) and stated that the care of patients would be the responsibility of "licensed independent practitioners with appropriate clinical privileges." The AANA held a series of meetings with representatives of JCAH that resulted in a number of documents. These included a letter (dated May 14, 1987) from Harold Bressler, the General Counsel for the Joint Commission, in which Mr. Bressler stated that the Standards' emphasis on "licensed independent practitioners with appropriate clinical privileges" did not require accredited hospitals to utilize the services of anesthesiologists. If under the licensing laws of a state, CRNAs had to be supervised or directed by a physician and were not eligible to become licensed independent practitioners, surgeons and others under whose supervision or direction they may work would meet the requirements of being a "licensed independent practitioner."

This dealt with licensed independent practitioners but what were "appropriate clinical privileges?" Mr. Bressler wrote that the Standards did not require that the responsible licensed independent practitioner have privileges to actually administer anesthesia. Since the Standards required competence in what they were already doing, surgeons who supervised or directed the practice of CRNAs would be expected to have no difficulty meeting the new Standards. Finally, Mr. Bressler wrote that the Standards were not intended to have any impact on the legal liability of surgeons for the malpractice of CRNAs.

Specific reference to CRNAs

In a subsequent letter, Mr. Bressler also discussed AANA's objection to the fact that there was no longer a specific reference to CRNAs in the

Joint Commission on Accreditation on Hospitals

Letter to Gene A. Blumenreich, JD, dated May 14, 1987

As we discussed, I am writing in response to the questions you have raised as counsel for the American Association of Nurse Anesthetists, about the new Surgical and Anesthesia Services standards promulgated by the Joint Commission on Accreditation of Hospitals, effective January, 1988. Essentially, we have discussed three points. First, it should be clear that the promulgated standards do not restrict the freedom of hospitals to permit certified registered nurse anesthetists (CRNAs) to continue the activities in which we understand CRNAs currently lawfully engage.

Second, the standards do not require accredited hospitals to utilize the services of anesthesiologists. You have focused on the references in the standards to the responsibilities of "licensed independent practitioners" with "appropriate clinical privileges." Those references do not mandate that accredited hospitals utilize anesthesiologists. The Joint Commission has defined, for the purpose of its standards, a "licensed independent practitioner" as any individual who is permitted by law and who is also permitted by the hospital to provide patient care services without direction or supervision within the scope of his or her license and in accordance with individually granted clinical privileges. Therefore, the identity of licensed independent practitioners within a hospital is a matter decided by state law and the hospital.

If CRNAs are not eligible to be licensed independent practitioners under various state laws, certainly surgeons and others under whose supervision or direction they may work would be eligible. The standards insist that those surgeons and other individuals be qualified to accept the responsibility of a licensed independent practitioner for overall supervision of the rendering of anesthesia services to a patient. The standards do not require that the responsible licensed independent practitioner have privileges to actually administer anesthesia. Since the standards demand competence in what they are already doing, surgeons who now supervise or direct the practice of CRNAs would be expected to have no difficulty meeting the new standards.

To summarize, the standards do not say that only an anesthesiologist can supervise or direct anesthesia care or perform any other function. The standards do call for hospitals to determine that individuals supervising or directing anesthesia care provided in the hospital are competent to do so.

Finally, you have raised the question whether the standards impact on the respective legal liabilities for malpractice of surgeons and CRNAs. I read your material and studied the issue. The standards are not intended to have that effect and in my view do not. In many places in the *Accreditation Manual for Hospitals* there are expressions of responsibility of physicians and other licensed independent practitioners. Such expressions of responsibility do not purport to necessarily delineate legal exposures, and should not impact on your argument that individual facts determine individual liability.

I am, of course, available to discuss these matters in additional detail.

Sincerely,

Harold J. Bressler
General Counsel

Standards. Mr. Bressler stated that the new Standards mentioned neither CRNAs nor anesthesiologists and that this was consistent with the Commission's overall intent to focus attention on the evaluation of individual competence rather than relying on disciplinary categorization. In fact, he had earlier pointed out, previous JCAH requirements that anesthesia departments be evaluated by an anesthesiologist had been deleted.

In July 1987, Dennis O'Leary, MD, president of JCAH, responded to several congressmen to explain the requirements of JCAH as they applied to CRNAs. He wrote, "*We can state without equivocation that the new Standards permit accredited hospitals full latitude to continue to authorize certified registered nurse anesthetists (CRNAs) to engage in those activities in which they currently and lawfully participate... the revised standards (as adopted for the hospital accreditation program and proposed for ambulatory health care services) make no specific reference to either physician anesthesiologists or nurse anesthetists. Further, neither current standards nor the revised standards require hospitals voluntarily seeking accreditation to use the services of anesthesiologists.*"

What did JCAHO require the "licensed independent practitioner with appropriate clinical privileges" to do? The requirements were that the licensed independent practitioner "*be responsible*

Joint Commission on Accreditation on Hospitals

Sample of letter to members of U.S. House of Representatives, dated July 23, 1987

I am writing in response to your inquiry of June 30, 1987 concerning the Joint Commission on Accreditation of Hospitals and the recent revisions in Joint Commission standards addressing the provision of anesthesia services.

Your letter specifically inquires whether the changes in the revised (1988) Joint Commission anesthesia standards will have any practical effect on the practice of nurse anesthetists who are presently in compliance with the current standards. In response, we can state without equivocation that the new standards permit accredited hospitals full latitude to continue to authorize certified registered nurse anesthetists (CRNAs) to engage in those activities in which they currently and lawfully participate. With regard to the content of the revised standards, whereas the current standards for anesthesia service specifically identify certain responsibilities and duties for physician anesthesiologists and for nurse anesthetists, the revised standards do not. The revised standards (as adopted for the hospital accreditation program and proposed for ambulatory health care services) make no specific reference to either physician anesthesiologists or nurse anesthetists. Further, neither current standards nor the revised standards require hospitals voluntarily seeking accreditation to use the services of anesthesiologists.

The revised standards do require that in an accredited organization, a "licensed independent practitioner with appropriate clinical privileges" be responsible for the anesthesia care of a patient, make a determination that the patient is an appropriate candidate to undergo the planned anesthesia, and be responsible for the decision to discharge the patient after anesthesia. For Joint Commission standards purposes, a "licensed independent practitioner" is defined as any individual who is permitted by law and who is also permitted by the hospital (or other health care organization) to provide patient care services without direction or supervision within the scope of his or her license and in accordance with clinical privileges individually granted by the hospital (or other organization). Therefore, the identity of licensed independent practitioners within an accredited hospital (or other organization) is a matter decided by state law and the hospital (or other organization), not by Joint Commission standards.

Where CRNAs are not eligible to be licensed independent practitioners under various state laws, certain surgeons and others under whose supervision or direction CRNAs may now work would fulfill the Joint Commission's definition of licensed independent practitioners, and such relationships would be acceptable for standards compliance purposes. The revised standards do require that in an organization seeking accreditation, those surgeons and other individuals who accept the responsibility for overall supervision of the rendering of anesthesia services to a patient be qualified to do so. These standards, however, do not require that the responsible licensed independent practitioner have privileges to actually administer anesthesia (i.e., to be a physician anesthesiologist). In this important regard, the standards have not changed. Surgeons and others who now supervise or direct the practice of CRNAs would be expected to have no difficulty continuing to do so under the revised standards.

If you have any interest in a detailed description of the Joint Commission, its purposes and mode of operation (and the standards setting process in particular), we would be pleased to provide this information to you or your staff in writing or in person at your pleasure.

I trust the foregoing information is responsive to the inquiries in your letter. If you feel I have not adequately answered your questions or if you have additional questions or concerns, I would be most willing to provide a further response.

Sincerely yours,

Dennis S. O'Leary, MD
President

for the anesthesia care of a patient, make a determination that the patient is an appropriate candidate to undergo the planned anesthesia, and be responsible for the decision to discharge the patient after anesthesia." The president of JCAH reiterated Harold Bressler's statement that the Standards *"do not require that the responsible licensed independent practitioner have privileges to actually administer anesthesia (i.e., to be a physician anesthesiologist). In this important regard the Standards have not changed. Surgeons and others who now supervise or direct the practice of CRNAs would be expected to have no difficulty continuing to do so under the revised Standards."*

From the very beginning, JCAHO interpre-

Joint Commission on Accreditation of Healthcare Organizations

Letter to a surgeon, dated March 20, 1989

Your letter of February 14 relates to documentation in the medical record, and specifically any requirement for the surgeon countersigning the anesthesia record when the anesthesia is provided by a certified registered nurse anesthetist.

There is no requirement in Joint Commission standards for the surgeon to countersign the anesthesia record nor is there a requirement for a documented postanesthesia visit for evaluation.

When the operating team consists of a surgeon and certified registered nurse anesthetist, the surgeon is considered to be the "licensed independent practitioner with appropriate clinical privileges" who is responsible for determining that the patient is an appropriate candidate to undergo the planned anesthesia in the absence of an anesthesiologist. Preanesthesia evaluation may be done by the certified registered nurse anesthetist, if authorized by the hospital to do so under policies and procedures approved by the medical staff, or the surgeon. If it is done by the certified registered nurse anesthetist, and the surgeon does not separately document in the medical record that the patient is an appropriate candidate to undergo the planned anesthesia, the surgeon is to countersign the certified registered nurse anesthetist's medical record entry to indicate the patient is an appropriate candidate to undergo the planned anesthesia based on the certified registered nurse anesthetist's preanesthesia evaluation.

In summary, the surgeon is responsible for countersigning the planned anesthesia based on the certified registered nurse anesthetist's preanesthesia evaluation or makes a separate entry in the medical record; there is no requirement for the surgeon to countersign the anesthesia record.

We trust we have been of assistance.

Sincerely,

Peter Van Schoonhoven, MD
Associate Director
Department of Standards

ted the Standards to require the licensed independent practitioner to make a determination that the patient was an appropriate candidate to undergo the planned anesthesia. What did the licensed independent practitioner have to do? Peter Van Schoonhoven, MD, the associate director of the Department of Standards of the Joint Commission, clarified JCAHO's position in a letter dated March 20, 1989, to a surgeon. If the CRNA was being supervised by a surgeon, was the surgeon required to engage in activities that would be any different than if the surgeon were working with an anesthesiologist? Dr. Schoonhoven responded, *"Preanesthesia evaluation may be done by the certified registered nurse anesthetist, if authorized by the hospital to do so under policies and procedures approved by the medical staff, or the surgeon. If it is done by the certified registered nurse anesthetist, and the surgeon does not separately document in the medical record that the patient is an appropriate candidate to undergo the planned anesthesia, the surgeon is to countersign the certified registered nurse anesthetist's medical record entry to indicate the patient is an appropriate candidate to undergo the planned anesthesia based on the certified registered nurse anesthetist's preanesthesia evaluation. In summary, the surgeon is responsible for countersigning the planned anesthesia based on the certified registered nurse anesthetist's preanesthesia evaluation or makes a separate entry in the medical records; there is no requirement for the surgeon to countersign the anesthesia record."*

Changes in manual heighten concern

Although these requirements have remained unchanged, the anxiety engendered by JCAHO visits have caused practitioners and hospital administrators to view changes in JCAHO Accreditation manuals with heightened concern. Every change in language, no matter how minor, is assumed to be full of meaning and nuances which can have earth shattering effect. The remarks of Dr. Schoonhoven and Dr. O'Leary soon found their way into the *JCAHO Accrediatation Manual for Hospitals.* The 1992 Accreditation Manual provided *"The Standards do not require that a supervising, licensed independent practitioner (for example, surgeon or obstetrician) have privileges to administer anesthesia, but the practitioner must be capable of reviewing the results of the preanesthesia evaluation, determining that the patient is an appropriate candidate to undergo the planned anesthesia and determining that the patient can be discharged."* By 1995 that requirement had been

Joint Commission on Accreditation of Healthcare Organizations

Letter to Gene A. Blumenreich, JD, dated July 6, 1995

Re: Your Questions Relating to Joint Commission Standards, and the Provisioning of Anesthesia

You have raised with me the question whether certain language found in the Joint Commission's *1995 Comprehensive Accreditation Manual for Hospitals* relating to the role of licensed independent practitioners was intended to change prior interpretations of the relevant standards. You particularly focused on whether the statement in the Examples of Implementation for Standards PE.1.8 through PE.1.8.4, that a licensed independent practitioner "determines that the patient is a candidate for the *planned choice of anesthesia*" (emphasis added), is expressing the position that surgeons, when working with certified registered nurse anesthetists who under a particular state law or a particular hospital decision are not acting as licensed independent practitioners, are to engage in a great deal more detailed analysis of the anesthesia plan than you believe Joint Commission standards previously required in accredited hospitals. I have inquired about that issue and determined that there was no intent to change prior interpretations of the standards. Thus, there continues to be a standards requirement that the licensed independent practitioner determine the patient is an appropriate candidate for the kind of anesthesia contemplated (general, local, etc.), but no requirement that he or she evaluate and approve the precise anesthesia agent to be used. All this, of course, is subject to whatever any particular state law or individual hospital policy may require.

You also raised with me the question whether the Joint Commission, when promulgating its standards in this area, intended to say anything or have any impact on the respective potential liabilities or legal responsibilities of surgeons and nurse anesthetists when they are working together. The answer to that question is no. Joint Commission standards are promulgated solely for the purpose of fulfilling the Joint Commission's mission to help improve quality of care for the public.

I assume this answers your questions. If not, please let me know.

Sincerely,

Harold J. Bressler
Legal Counsel

rewritten: *"After the preanesthesia assessment and before the administration of anesthesia, a licensed independent practitioner with appropriate clinical privileges directly determines that the patient is a candidate for the planned choice of anesthesia."* Some surgeons and hospital administrators chose to view this change (adding "choice" to "planned *choice* of anesthesia") as requiring that a nonanesthesiologist licensed independent practitioner had to approve the anesthesia plan including, in their views, the approval of the anesthetic agents to be used.

Once more, we made inquiry to the Joint Commission and on July 6, 1995, Harold Bressler wrote that *"There is no intent to change prior interpretations of the Standards. Thus, there continues to be a standards requirement that the licensed independent practitioner determine the patient is an appropriate candidate for the kind of anesthesia contemplated (general, local, etc.), but no requirement that he or she evaluate and approve the precise anesthesia agent to be used. All this, of course, is subject to whatever any particular state law or individual hospital policy may require."*

Thus, the heightened apprehension about JCAHO promotes misunderstandings about minor changes in the language of JCAHO Accreditation Standards which, in turn, may result in exaggerated responses. JCAHO does *not* require anesthesiologist supervision of anesthesia, and they have consistently denied trying to force supervising surgeons to become more intimately involved in the anesthesia process. Moreover, JCAHO assures us that it is not subjecting those who supervise nurse anesthetists to any greater liability for anesthesia mishaps. While we still hear of inappropriate comments by JCAHO's surveyors and others, CRNAs should not be afraid to challenge assertions that JCAHO requires anesthesiologists or requires anesthesiologist supervision.