
Legal Briefs

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Supervision

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Like anyone else associated with the American Association of Nurse Anesthetists (AANA), in the past few months, I have fielded my share of questions concerning the role of the Association in the Health Care Financing Administration's (HCFA's) decision to eliminate its requirement that nurse anesthetists be supervised by a physician. There has been so much misinformation concerning the Association's motives that I thought it might be useful to summarize some of the legal considerations that led to AANA's actions. I am particularly encouraged to respond because misinformation about the legal aspects of supervision is what drove the Association to seek its elimination. Those opposed to nurse anesthesia, having misused supervision to discourage the use of nurse anesthetists, refuse to acknowledge their role and create yet a new attack — that the Association is seeking independent practice.

The word "supervision" probably never adequately described the relationship between anesthetist and surgeon. In recent years, thanks to misinformation by those who opposed nurse anesthe-

sia, the term was increasingly being used to wrongly restrict CRNA practice. While we knew that concerns about a surgeon's liability were being grossly misrepresented, some surgeons, sometimes including even those who had worked happily with nurse anesthetists for years, believed it and were sometimes becoming reluctant to work with nurse anesthetists. The Association found itself in a position where something had to be done to protect practice settings that had been well accepted in the healthcare community for more than a century. Because CRNAs are the sole anesthesia provider in more than 65% of rural hospitals, the issue had important implications for the nation's healthcare.

The origin of "supervision"

To understand why the Association was forced to act on supervision, it is necessary to review the history of anesthesia. For many years after anesthesia was discovered there were no nurse anesthetists, there were no anesthesiologists, and there was no reimbursement for administering anesthesia. Surgeons would ask people who were present in the operating room to give anesthesia. Often, these persons were medical students who were trying to learn surgical tech-

niques. The students gave anesthesia in exchange for the opportunity to watch the surgeons operate. While the use of students kept costs down, the students were much more interested in the surgery than in keeping track of the pace by which ether or chloroform had to be given. Patient care was affected by a lack of anesthesia vigilance. In the 1880s, leading surgeons began to ask their favorite nurses to give anesthesia.

Thanks largely to the efforts of these early nurse anesthetists, anesthesia began to develop from a chore to a profession. These pioneers of anesthesia were able to show, by the turn of the century, that if the administrator of anesthesia was careful and became committed to mastering anesthesia, outcomes improved. (See, for example, the court's description of Margaret Hatfield and her success in *Frank v South* (175 Ky. 416, 1917) or the professional writings of Alice Magaw, the "Mother of Anesthesia.") With the increasing professionalism of anesthesia created by nurse anesthetists, physicians also became attracted to the field. To speculate on motivation would only further inflame what is already sufficiently inflamed, but the turn of the century also brought with it organized medicine's objections to the administration of anesthesia by nurses. A number of legal challenges were instituted, the most famous of which and the one that got to an appellate court first was *Frank v South* in the state of Kentucky.

Practicing nursing, not medicine

The Jefferson County Medical Society claimed that Margaret Hatfield, a nurse anesthetist, was making independent judgments as she administered anesthesia and, therefore, was illegally practicing medicine. The Jefferson County Medical Society sued Hatfield's surgeon for permitting her to practice illegally. In a landmark decision, the Supreme Court of Kentucky upheld the practice of nurse anesthesia. It ruled that using discretion and making independent judgments in the process of giving anesthesia was no different than using discretion and making independent judgments in any other recognized function of nursing. Hatfield worked very closely with Dr. Lewis Frank, a surgeon. Frank, the holder of a medical degree, made the diagnosis and determined the treatment that were the medical judgments to be made. The court held that Hatfield was not engaged in the illegal practice of medicine because she worked "under his direction and supervision."

Following *Frank v South*, nurse anesthetists

sought legislation to blunt the attack of organized medicine in the courts. A number of states adopted statutes recognizing the practice of nurse anesthetists. Typically, these statutes followed the formulation in *Frank v South* and provided that nurse anesthetists were to work under the "supervision" or "direction" of a physician. It is clear that the legislation was not attempting to create new duties and responsibilities but merely to describe what was already going on in practice. The surgeon provided the medical component, and the nurse anesthetist provided the administration of the anesthetic. The nurse anesthetist was practicing nursing not medicine. The statutes were only intended to explain why nurse anesthetists were not practicing medicine. (See, for example, the Ohio Nurse Anesthesia provision that was adopted as an exception to the Medical Licensing Act (Ohio Revised Code §4731.35)). "Supervision" was not defined in these statutes nor would it be defined in the next 80 years. Healthcare was left to work out appropriate roles for nurse anesthetists and surgeons without interference from the legislature. What was clear was that the nurse anesthetist used discretion and independent judgment and that supervision did not require substantive knowledge. The surgeons at the Mayo Clinic did not have Alice Magaw's expertise when they "supervised" her. Nor was the relationship of supervision intended to affect legal liability. In those days, surgeons were liable for everything that happened in the course of an operation whether or not they knew about it, controlled it, or could have done anything to avoid it.

The competition between organized medicine and nurse anesthesia continued but after the *Dagmar Nelson* case (*Chalmers-Francis v Nelson*, 6 Cal. 2d 402 (1936) decided in 1936 in a manner similar to *Frank v South*), the attacks stayed out of the legal arena. Until approximately 1980, physician supervision of nurse anesthetists went largely unnoticed.

If, when these statutes were adopted, one compared an anesthesiologist's behavior with that of a nurse anesthetist, you would have been hard pressed to figure out which was which. This has continued to the present day, as well. One of the attributes of nurse anesthesia that appears to really bother anesthesiologists is the lack of a distinction in the way the two groups administer anesthetics, achieve results, or function as part of the surgical team (a lack of distinction that some anesthesiologists wanted to solve by requiring nurse anesthetists to wear badges so that people

would have a way to tell the difference between CRNAs and anesthesiologists).

The number of anesthesiologists triple

Two things happened in the 1960s and 1970s that brought supervision into the spotlight. First, Congress decided that the way to control medical costs was to create more physicians. It provided more financial support for physician education. The number of physicians increased dramatically from 1970 until 1995. The number of physicians who claimed to be anesthesiologists tripled from approximately 11,000 in 1970 to more than 34,000 in 2000. During the same period, the number of nurse anesthetists only doubled. The result of the multiplication in anesthesiologists meant that sometime between 1985 and 1990, nurse anesthetists, who had outnumbered anesthesiologists in 1970 by 1.5 to 1, became outnumbered by them.

Anesthesiologists had assumed that with increased numbers, healthcare would flock to them. Much to the surprise of the newly minted anesthesiologists, nurse anesthetists did not fade into oblivion, and the demand for nurse anesthetists kept increasing even in 1995 when the public press reported a surplus of anesthesiologists. Enemies of nurse anesthesia now had to find ways to convince surgeons to avoid nurse anesthetists in favor of anesthesiologists. Attacks on nurse anesthesia practice increased. Nurse anesthetists had ignored previous anti-CRNA behavior in the belief that surgeons knew better and on the theory that even if surgeons believed what their enemies were saying, there were not enough anesthesiologists to cover the nation's operating rooms. With so many anesthesiologists, these attacks had to be taken more seriously.

"Captain of the ship" declines

The second major change that occurred was the gradual disappearance of the legal doctrine of "captain of the ship." Hospitals began to develop in the second half of the 19th century. They were staffed by human beings and mistakes occurred. Injured patients sought redress. The courts were reluctant to allow recoveries against the hospitals, many of which were charitable institutions that depended on public contributions. Instead, courts placed liability on surgeons for damages caused by hospitals and hospital employees. Making surgeons vicariously liable for the negligent activities of those who provided care for their patients became known as "captain of the ship." The surgeon was made responsible for everything that happened in the

operating room in a manner that was similar to the military chain of command where the captain was responsible for everything that occurred on the ship.

"Captain of the ship" was an unsatisfactory legal doctrine from the very beginning. First, it was unfair. It made surgeons liable for negligence they did not know about and could not avoid. Shortly after its introduction, the courts began to introduce subdoctrines to make it less unfair. For example, surgeons were responsible for "medical" actions but not "administrative" actions. Mistakes made during admission procedures or mistakes made by the maintenance staff were "administrative" and could not be blamed on the surgeon. However, efforts to distinguish between things that surgeons should be blamed for and things that surgeons should not be blamed for became silly and illogical. When a hospital employee placed a scalding hot water bottle on a patient's skin, was that an "administrative" or a "medical" activity?

Second, as medical knowledge grew and medical specialization increased, it became increasingly obvious that surgeons were not responsible for everything that occurred in the operating room. Modern operations began to depend on teamwork and the interrelationship of large numbers of people, each contributing expertise and each collaborating with the other members to ensure a good result.

Third, the doctrine became unnecessary. Many hospitals became big businesses, not fragile charities. They were either better able to afford recoveries than surgeons or they purchased insurance. These points were not lost on the courts, and the doctrine of "captain of the ship" began to crumble.

Supervision alleged as a basis for liability

So, at a time when surgeons were beginning to escape liability as "captain of the ship" deteriorated, the very language of statutes designed to protect nurse anesthetists from unfair attack became the springboard for yet new attacks. In June 1985, H. Ketcham Morrell, MD, the then president of the American Society of Anesthesiologists, wrote to JAMA: "...that the providing of anesthesia care is legally defined as the practice of medicine in every state of the Union of which I am aware. For this reason, it should be noted, the operating surgeon or obstetrician who purports to provide medical direction of the nurse, in the absence of an anesthesiologist, carries a high risk of exposure, on a variety of legal theories, for the acts of the nurse."

The threat was clear. Surgeons who “supervised” nurse anesthetists were allegedly assuming significant legal liabilities and risk because a nurse anesthetist had to be supervised while an anesthesiologist did not. The reality was that the same legal principles that governed the liability of a surgeon for the negligence of a nurse anesthetist also governed the liability of a surgeon for the negligence of an anesthesiologist and had nothing to do with supervision. The issue was whether the surgeon *controlled* the procedure that gave rise to the injury. Liability depended on the facts of the case, not a statute requiring supervision. If the surgeon was in control, the surgeon was liable; if the surgeon was not in *control*, the surgeon was not liable, even if the surgeon was “supervising.”

There are any number of cases in which surgeons were not liable when working with nurse anesthetists and while there are cases where surgeons were liable when nurse anesthetists were negligent, there were also cases where surgeons were sued and held liable for the negligence of anesthesiologists. Counsel for the American Society of Anesthesiologists even agreed with this analysis of the law. In 1985, he wrote a letter to the *AANA Journal* responding to an article I had written. In it, he said, “*In that article, Mr. Blumenreich correctly stated that whether a surgeon will be held liable for the actions of a nurse anesthetist depends on the facts of the case.*” Nonetheless, enemies of nurse anesthetists continued to state, despite the authority to the contrary, that surgeons working with nurse anesthetists were automatically exposing themselves to great risk. Tragically, they were believed. Worse, enemies of nurse anesthesia convinced hospitals to adopt bylaws and policies expanding the nature of supervision to unnecessarily increase the exposure of surgeons working with nurse anesthetists. (See *Denton Regional Medical Center v. LaCroix*, 947 S.W. 2d 941, (1997), *Harris v. Miller*, 438 S.E. 2d 731, (1994).)

The only appropriate remedy

Thus, leadership of the American Association of Nurse Anesthetists came to the conclusion that if enemies of nurse anesthetists were going to continue to misuse statutory requirements of supervision to intimidate surgeons from working with nurse anesthetists, then the only appropriate remedy was to get rid of the requirements of supervision on which they were basing the campaign of misinformation. Obviously, nurse anesthetists would continue to collaborate and work closely with the operating physician, just as

they always had and just as anesthesiologists did. But the regulatory distinction that was being abused would be eliminated.

By 1990, Medicare and Medicaid reimbursement had become a very significant force in healthcare policy. While the states were far from uniform on requirements for supervision of nurse anesthetists, HCFA had a requirement for hospitals participating in Medicare that nurse anesthetists be supervised by a physician. Thus, changing state law would have little effect if hospitals that wished to participate in Medicare, and almost all did, would have to continue to require that CRNAs be physician supervised. HCFA became the logical starting point. Its actions carried weight in the healthcare community. Moreover, the adoption of specialty-level healthcare guidelines was out of character for HCFA. Except for anesthesia, HCFA’s practice was to leave substantive regulation of healthcare up to the states. (In opposing the HCFA proposal to eliminate CRNA supervision, the American Medical Association (AMA) is in the position of asking a federal agency to issue more regulations affecting healthcare and to become directly involved in setting guidelines for a specialty medical area. The political anomaly of the AMA asking HCFA to more closely regulate healthcare is an irony worth remembering.) The Association began to talk to HCFA about modifying or eliminating its requirement of supervision. While formulations to modify the language to try to eliminate the liability issue were discussed, it was clear that enemies of nurse anesthesia would attempt to exploit any difference in the regulatory pattern to disadvantage nurse anesthetists.

Having turned “supervision” into the legal equivalent of quicksand, the enemies of nurse anesthesia now ignore their own role in making “supervision” unacceptable. The enemies of nurse anesthesia instead accuse nurse anesthetists, who are merely trying to preserve a practice setting that has been accepted for more than 120 years, with making radical changes to the healthcare stage. One of the arguments constantly made in the face of HCFA’s decision on supervision is that nurse anesthetists are looking for independent practice. There is, of course, a huge difference between asking for the elimination of the requirement of supervision and wanting “independent practice.” Can anyone, physician or nurse, “independently” administer anesthesia? From its inception, anesthesia has been primarily a “means” and not an “end.” In the area in which the HCFA rule is invoked,

patients do not go into hospitals for anesthesia; they go into hospitals for some kind of surgical or medical procedure that *requires* anesthesia. In these cases, there must be, and there always will be, the same close cooperation and collaboration between surgeon and anesthetist with or without a requirement of supervision, not independence.

Members of the surgical team, not independent practitioners

One of the reasons why nurse anesthesia did not fade into oblivion when massive numbers of new anesthesiologists flooded into the field was that surgeons *liked* to work with nurse anesthetists. They valued CRNAs as members of the surgical team. This close relationship, which was the reason that nurses were recruited 120 years ago and why the profession of nurse anesthesia survived under continual attack, continues to this day. It is obvious to anyone who looks at the legal

history of nurse anesthesia, that the continuation of nurse anesthesia as a profession has depended on the very opposite of independent practice.

Thus, the present situation is yet another irony for nurse anesthetists. For years, nurse anesthetists saw “supervision” misinterpreted to restrict their practice. The misinformation continued despite our efforts to publish accurate information. To defend their practice, nurse anesthetists were given no other choice but to attempt to eliminate the wording whose meaning had been distorted. Now, the enemies of nurse anesthesia twist the motives of the Association. They attack the Association for taking the action they forced on it. Let us hope that the number of people who ignore the close relationship with surgeons that has been the key to nurse anesthetists’ success and survival is fewer than the number who mistakenly believed that supervising CRNAs automatically leads to liability.