Anesthesia—It’s finally the practice of medicine

Key words: Licensing laws, practice of medicine.

In December 1998, the House of Delegates of the American Medical Association (AMA), presumably weary from their efforts in trying not to appear to be taking sides as to what constituted “having sex” for purposes of President Clinton’s impeachment, journeyed to Hawaii. While there, in the midst of adopting important policies and standards to improve the nation’s healthcare, they also found time to adopt a resolution: “Resolved that Anesthesiology is the Practice of Medicine.”

Well, Boston, where I live and practice, was cold and wintry in December 1998, and I thought of those many doctors so concerned about the nation’s healthcare that they would journey all the way to Hawaii. I began to wonder, “What were they thinking? What did anesthesiologists think they had been practicing for all of these years?” As this column has pointed out on many occasions, professions do not have monopolies. The practice of a profession is what that profession is allowed to do under its governing licensing laws. (See In re Carpenter, 196 Mich. 561 (1917), and Sermchief v Gonzales, 600 SW2d 683 (Mo. 1983.) When we say that something is the practice of a profession, we mean that the profession is legally allowed to practice that function. Thus, anesthesia, when practiced by CRNAs, is the practice of nursing. More than 100 years of history and practice in 50 states, the District of Columbia, and Puerto Rico establish, beyond any question, that anesthesia is an appropriate nursing practice.

Why did the AMA feel it necessary to declare anesthesiology to be the practice of medicine? And isn’t this even more peculiar because it is not “anesthesia” that they declare to be the practice of medicine, but “anesthesiology,” a term that refers to the study of anesthesia. I had never seriously questioned whether physicians could legally practice anesthesia. While physicians have not been specializing in anesthesia as long as nurses have, physicians, nonetheless, have a pretty substantial history of practicing anesthesia. Moreover, although there are areas of the country that physician anesthesiologists tend to avoid, such as inner city areas and rural communities, anesthesiologist practice is nonetheless sufficiently widespread that, until the AMA vote, I would have thought that there could hardly be many physicians who would have disputed that anesthesia was a practice of medicine.

I scratched my head at such a difficult puzzle. Why, oh why, was the AMA passing this resolution? Who had questioned the physician’s right to practice anesthesia? In my consternation I called, as I often do in these situations, my muse, the guru of anesthesia. “Ira,” I said, “What in the world were they thinking?”

“Well . . .,” said Ira (the muse speaks with a Texas drawl), “Maybe they have reason to question
whether it is the practice of medicine. Did you ever look at the old cases that are cited in *Thatcher* or the *Dagmar Nelson* case? Some of them do question whether anesthesia is really the practice of medicine. You ought to take a look."

**The origins of the debate**

After looking at these cases, I now realize what the AMA was worried about. If you have to accept the traditional definition of the practice of medicine—diagnosis and prescription—then whether anesthesia is the practice of medicine is open to debate.

In *Spain v Burch* (154 S.W. 172, 169 Mo. App. 94, 1913), the plaintiff sued a physician for malpractice in administering an anesthetic. The plaintiff's wife had hemorrhoids (even 85 years ago, it was still the simplest operation in which anesthesia incidents occurred). To examine the patient, the doctor used laughing gas or, nitrous oxide, "one of the safest, if not the safest, anesthetic known" (154 S.W. at 173). The doctor also used state-of-the-art methods to administer the anesthetic: the "Teters apparatus," a mechanical device for mixing oxygen with nitrous oxide. "This is accomplished by having jars of each of the gases, under pressure, connected with a mixing chamber, from whence the mixed gases are administered to the patient by means of a tube and hood fitting over the face. The flow of each gas is regulated by stopcocks which are manipulated by the person administering the anesthetic... The Teters apparatus is one of the comparatively late improvements for this purpose, and is used quite extensively in hospitals and by physicians everywhere, and its use is becoming more extensive." (154 S.W. 173).

The case revolved around 2 issues, whether the physician had properly determined that the patient could withstand the anesthetic and whether there was any evidence of negligence in administering the anesthetic. The physician had examined the patient the day before the operation, but on the morning of the operation, although he claimed that he had examined the plaintiff, the plaintiff's daughter testified that no such examination had been conducted. Expert testimony explained that it was common for physicians to examine patients on the morning of the operation in case they had made a mistake in their prior examination.

The court questioned whether there was sufficient evidence to send the case to the jury and ordered that the case be sent back to the trial court for further proceedings. Since it was going back to the trial court, the appellate court wanted to give the trial court a little guidance. The appellate court said that "where, as in this case, physicians and dentists are... used as experts on the question of the proper use of this anaesthetic, and it is shown that dentists use it more often than physicians, and are often more proficient and skilled in its use than an ordinary practitioner of medicine, that the usual and customary methods of using it by dentists, skilled in that respect, is a legitimate source of inquiry, and such evidence should not be excluded. The skill and proficiency by which a physician administering an anaesthetic is to be judged is not to be measured by the usual and ordinary skill possessed by other physicians only, but extends to that possessed by other persons, whose occupation and study give them an equal or better knowledge of the right methods of its use than is possessed by a general practitioner of medicine." (154 S.W. at 176).

Well, no wonder physicians have been upset! Not only is the court saying that anesthesia is not the exclusive practice of medicine, but they are saying that physicians may not even be as good at administering anesthesia as are "other persons." Physicians held to the standards of a dentist? How insulting! It certainly seems that anesthesia was not the practice of medicine in 1913 when the Missouri Court of Appeals told its trial court to make sure physicians at least follow the careful practices of dentists, who are "often more proficient and skilled in its use than an ordinary practitioner of medicine."

But a greater insult occurred in *Yates v International Travelers Association* (16 S.W. 2d 301, Court of Civil Appeals of Texas, 1929). In *Yates*, the Texas Court of Civil Appeals basically ruled that anesthesia was not a medical or surgical treatment for disease! Mr. Yates suffered from "quinsy." Although "quinsy" is no longer found in many medical dictionaries, it referred to a peritonsular abscess which was treated by lancing. Of course, it is hard to lance an abscess on the tonsils of a healthy patient without some form of anesthetic. The physician's testimony was that Mr. Yates was, in fact, "a healthy fellow physically, but rather a little too fat." Once more, nitrous oxide was the anesthetic of choice but unfortunately, Mr. Yates took the gas "badly." After some effort they finally got him under, but during the operation he grew rigid and had a hard convulsion. His physician was convinced that his death resulted from nitrous oxide poisoning—asphyxia.

Mr. Yates had a life insurance policy that contained an exception for "any injury, fatal or otherwise, sustained... being in any degree under the influence of a narcotic or intoxicating liquor... from disease or medical or surgical treatment therefor." Well, said the Texas Court, Mr. Yates'
death was not within the exception to the policy as to medical or surgical treatment for disease. That is, his death came from anesthesia, and anesthesia is not equivalent to a medical treatment for disease. No wonder physicians have been so worried! No wonder they found it necessary to keep repeating that “anesthesia is the practice of medicine!”

Defining the practice of medicine

The ancient case of Underwood v Scott, (23 P. 942, 43 Kan. 714 (1890)), has served as the traditional basis for the definition of the practice of medicine. Kansas passed a statute in 1870 that prohibited anyone from practicing medicine who had not attended a course of instruction, graduated from a school of medicine, and received a certificate of qualification from a state or county medical society. The plaintiff, an unlicensed physician, had made a house call and left medication for the defendant, who refused to pay. (A “house call” was a rather quaint but now outmoded procedure in which a physician actually left his office to “call” on an ill patient at the patient’s home or “house.” Evidence of this ancient custom still exists. In urban areas, physicians were permitted to park their vehicles in unorthodox locations requiring that physicians receive specially marked license plates so they would not be towed or given traffic citations.) The court had ruled that if the plaintiff was “practicing medicine,” his practice was illegal and he could not collect. The court defined medicine as consisting of 3 things: “First, in judging the nature, character, and symptoms of the disease; second, in determining the proper remedy for the disease; and third, in giving or prescribing the application of the remedy to the disease.”

But how well does the “classic” definition of medicine fit anesthesia? In the Yates case, the court ruled that a death from anesthesia was not a death from the medical treatment of a disease. In an earlier case, Beile v Travelers Protective Association of America, (135 S.W. 497, 155 Mo. App. 629, 1911) the court also distinguished between anesthesia and medicine or surgery. In Beile, another insured died when chloroform was administered to him by a physician preparatory to performing a surgical operation. Although the court does not call anyone an anesthesiologist, there appear to be 2 physicians present, 1 of whom was there to conduct the operation and the other to administer the chloroform. The plaintiff was insured by a policy that contained exceptions for death or disability when caused “wholly or in part by any bodily or mental infirmity or disease . . . or to cases of . . . injury fatal or otherwise, resulting from any poison or infection, or from anything accidentally or other-

wise taken, administered, absorbed or inhaled, disease, death or disability resulting from surgical treatment.” It has to be remembered that these cases arise in the very early days of anesthesia and surgery when the public and insurance companies felt a lot differently about the safety of surgical treatment. When the physician began to administer chloroform by the “drop method,” 20-30 drops had fallen on Beile’s mask when Beile collapsed and instantly died without the surgical treatment having begun.

Expert testimony was introduced by both the insured and the defendant insurance company. The policy had an exception for “anything accidentally or otherwise taken, administered, absorbed or inhaled.” One of the questions was whether the chloroform had caused Beile’s death. There was expert testimony that 20-30 drops of chloroform should not be fatal to an otherwise healthy individual. Because Beile died when the anesthetic was administered, the insured’s experts concluded that Beile had a disease, and it was the disease that killed him when the chloroform was administered. But what makes the case stand out was the court’s analysis of whether Beile had died as a result of “surgical treatment.”

The policy had a clause that allowed the insurance company to refuse payment if death resulted from surgical treatment. Beile died as a result of the anesthetic. The court concludes that anesthesia is not surgery. The court quotes a standard dictionary as defining “surgery” as “the branch of the healing art that relates to external injuries, deformities, and other morbid conditions to be remedied directly by manual operations or instrumental appliances. . . . ‘Treatment’ means the act or manner of treating. ‘To treat means to apply remedies to, as to treat a disease or patient.’ These definitions are consistent with the classic definition of medicine in Underwood. But what of anesthesia? Administering chloroform did not, in the view of the court, come within the view of any of these definitions or meaning. It was administered preparatory to the surgical operation. According to the court, anesthesia could be compared to giving the plaintiff a bath. “If he [the plaintiff] had died in his bath, it would not be seriously contended that he died as a result of a surgical treatment.” Anesthesia was not a surgical treatment, and Beile’s death from anesthesia did not prevent his estate from collecting on his insurance policy.

Conclusion

Do we really believe that there is an issue as to whether physicians are legally authorized to practice anesthesia? While it is fun to speculate about
the nature of these old cases, no one should seriously question whether physicians or CRNAs may legally practice anesthesia. The classic definition of medicine in *Underwood v Scott* clearly does not fit anesthesia. The cases that interpret various insurance contracts only show that this ancient analysis is inadequate. If *Underwood v Scott* was the only legal authority as to what constituted the practice of medicine, then even AMA's resolution could not make anesthesia the practice of medicine. However, it is silly for physicians and nurses to quibble about whether or not the practice of medicine is something other than merely what physicians are legally entitled to do. The practice of medicine is

what physicians are legally entitled to do and the practice of nursing is what nurses are legally entitled to do. Lots of people give anesthesia—nurses, physicians, dentists.

The real issue is not whether something is the practice of medicine, but how and by whom it is to be practiced. Nurse anesthetists have made anesthesia a practice of nursing by more than 100 years of the highest quality anesthesia, and by practice in all jurisdictions and in all practice settings. The AMA resolution shows only that nurse anesthesia is so safe and cost-effective that anesthesiologists can compete only by resorting to slogans.

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