
Legal Briefs

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An examination of professional relationships between CRNAs and other health care professionals

On March 1, 1987, the AANA Board of Directors unanimously adopted the position statement on relationships between health care professionals which is printed at the conclusion of this article. The purpose of this statement is to provide a context—the reality of practice—to assist those, including lawyers and judges, who are interpreting “supervision” or “direction” or who are otherwise attempting to understand the relationship between nurse anesthetists and physicians, dentists, podiatrists or other health care professionals.

Various licensing laws regulating nurse anesthetists require the nurse anesthetist to work under the supervision or direction of a physician. Licensing laws were designed to establish quality standards within professions and provide legislative recognition of the scope of a profession’s practices. Licensing laws protect the public, not the profession and, in the health care field, generally describe practice rather than define it. Therefore, to understand health care licensing laws, one must first understand the reality of the profession’s practice settings.

Reality of the practice settings

For example, in the major cases which established that nurse anesthetists were not illegally practicing medicine, the courts considered the reality of practice in interpreting Medical Practice Acts. In *Frank v. South*, (175 Ky. 416), the court took note that there was a “usual custom as to the administration of anesthetics by trained

nurses in the country at large” (p. 418). In *Chalmers-Frances v. Nelson*, (6 Cal 2d 402) the Court remarked that:

There was much testimony as to the recognized practice of permitting nurses to administer anesthetics and hypodermics. One of the plaintiff’s witnesses testified to what seems to be the established and uniformly accepted practice and procedure followed by surgeons and nurses, and that is that it is not diagnosing nor prescribing by the nurses within the meaning of the Medical Practice Act. (p. 404)

The AANA’s Position Statement is especially important in view of the American Society of Anesthesiologists’ campaign to convince surgeons that they are automatically responsible for the actions of a nurse anesthetist. Courts have consistently confirmed that mere supervision or direction is *not* sufficient to establish liability. In order for a surgeon to be held liable for the negligence of a nurse anesthetist, there must be a determination that the surgeon was in control of the procedure giving rise to the negligence. Is control required? Clearly not under nurse anesthesia licensing laws, as numerous courts have indicated; and clearly not in practice, as the AANA Position Statement makes clear.

Some states require that nurse anesthetists be supervised by a physician, others provide for *direction* and others provide for *supervision and direction*. In the

reality of practice, the functions performed by nurse anesthetists in working with physicians, dentists, podiatrists or other health care providers are no different in states requiring *supervision* than in states requiring *direction*. In the reality of practice, these words are used interchangeably and do not have distinct meanings. They represent a legislative effort to *describe* a relationship.

What is the relationship being described? There are probably as many types of professional relationships between nurse anesthetists and supervising physicians, dentists, podiatrists or other professionals as there are nurse anesthetists and other health care providers. Which one of these millions of relationships was intended to be described by the statutes? The answer is: All of them.

The California legislature set forth its intent in adopting the California nursing statutes:

"Nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures which have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems which provide for collaboration between physicians and registered nurses. . . ."

What the AANA Position Statement does

The AANA Position Statement recognizes that "supervision" is necessarily a general term designed to include a large variety of practice settings. The "right" relationship must take into account a number of factors and conditions. To believe that one of these potential relationships is legislatively required is to promote stereotypes over reality. All of these practice settings satisfy the legal requirements of "supervision." The AANA Position Statement reaffirms that *supervision does not require control*. In fact, given the education, training and responsibilities of nurse anesthetists, in all but truly unique cases, control of the nurse anesthetist by one providing statutory supervision would be inappropriate.

The AANA Position Statement also suggests that, *in practice*, the relationship between nurse anesthetist and physician, dentist, podiatrist or other health care professional is often one of *consent*.

As they have in the past, one can expect that there will be some who will be critical of the AANA Position Statement. There are those who, for their own purposes, will seek to define supervision so as to restrict the scope of practice of nurse anesthetists.

State licensing laws are not intended to address "turf battles" among competitors. State licensing laws providing for the scope of practice of nurse anesthetists are clearly not designed to protect physicians or physician specialty groups. The AANA Position Statement may be criticized by those who wish it were different, but it clearly describes the *reality* of practice.