Anesthesia: A practice of nursing

Anesthesiology is a recognized specialty within both the nursing and medical professions. The practice of anesthesia by a nurse constitutes the practice of nursing. The American Medical Association’s Committee on Nursing in 1970 published a statement recognizing that medicine and nursing share many overlapping functions. The statement pointed out that when a particular function was performed by the nurse it was the practice of nursing, and when performed by a physician, the practice of medicine. State laws, rules and regulations, and court opinions confirm this fact. Many areas of practice, therefore, are not the sole prerogative of either nursing or medicine, just as cure and care, the principal functions which give unique identity to medicine and nursing, are not mutually exclusive.

To be sure, a surgeon or other physician determines the need for a patient to have an anesthetic. A nurse anesthetist, however, may provide the anesthesia service. The nurse anesthetist may perform preanesthesia evaluation, assuring that the patient is ready and in appropriate condition for the anesthetic; administer anesthetic, adjunctive, and accessory drugs necessary to achieve the anesthesia care goals and assure the patient’s well-being; monitor and maintain the patient’s responses within acceptable limits; and perform a post-anesthesia evaluation. Historically, quality anesthesia care has required a competent, knowledgeable provider experienced in the anesthesia process. This process of care far more mirrors the nursing process than it does medical practice.

The practice of anesthesia does not fit the definition of a primary medical procedure or service. Anesthesia is rarely administered as a diagnostic or therapeutic regimen, i.e., for cure purposes. Rather, anesthesia facilitates cure just as nursing and dietetics facilitate cure.

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Anesthesiology has presented anesthesiologists with difficulty in establishing a bona fide identity within medicine comparable to other medical specialties. There are a variety of reasons for this, two of which are:

1. In the United States, the anesthesia nursing specialty was established and evolved prior to the medical specialty. The performance of anesthesia by nurses originated as early as the American Civil War and the Franco-Prussian War, and emerged as a nursing specialty within the first decade of the twentieth century. Some physicians administered anesthesia during this period, and a few even limited their practice to providing anesthesia. Anesthesiology did not gain momentum as a
medical specialty, however, until following World War II.

2. Prior to World War II, many physicians viewed anesthesia more as a nursing specialty than as a medical specialty, and as such, physicians were slow to be attracted to it. In fact, even as late as the 1960's and early 1970's foreign medical graduates filled about 65 percent of medical anesthesia residencies. However, the large increase in medical school graduates in the late 1970's and 1980's, increased awareness of the relatively high income of anesthesiologists, and advances in knowledge and technology making it possible for more complex operative procedures to be performed under anesthesia, have made anesthesiology more attractive to American-trained physicians.

The practice of nurse anesthesia is not delegated medicine. Anesthesiologists often claim that the practice of anesthesia is a practice of medicine and that permitting nurses to provide anesthesia constitutes delegated medicine. This contention, however, is not supported by legal opinion or precedents.

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1. State laws and regulations have implicitly recognized that medicine does not have a monopoly on certain types of functions or responsibilities. Because a function or responsibility is identified within a state's medical practice act or its rules or regulations, does not preclude its presence or authorization in practice acts or regulations governing dentistry, pharmacy, or nursing. A variety of court rulings attest to this, e.g., Frank v. South, State of Arizona v. Borah, Chalmers-Frances v. Nelson.2345

2. In an October 12, 1984 letter to the American Association of Nurse Anesthetists, the Louisiana Board of Nursing confirmed that medicine does not have a monopoly on selected functions of procedures by stating:

"The Board of Nursing recognizes that the Board of Medical Examiners, by statute, can state what it believes to be the practice of medicine. However, the Board of Nursing, by statute, can state what it believes to be within the realm of the practice of nursing."

In this instance the Board of Medical Examiners had issued a regulation which, in effect, precluded nurses from administering regional anesthesia. The Board of Nursing issued an opinion that the administration of regional anesthesia fell within the scope of practice of Certified Registered Nurse Anesthetists (CRNAs) within the state of Louisiana. After the Board of Nurs-

ing threatened to take the Board of Medical Examiners to an administrative court for attempting to regulate nurses, the Board of Medical Examiners issued a statement that physicians could delegate the administration of regional anesthesia under certain conditions. Notwithstanding the Board of Medical Examiners' opinion, the administration of regional anesthesia remains an appropriate nursing function for CRNAs in the state of Louisiana under the nursing rules and regulations.

3. Explicit language in the California Nurse Practice Act and the Missouri Supreme Court's decision in Sermchief v. Gonzales further confirms that nursing and medical functions may overlap. The following legislative intent was included along with amendments in the California Nurse Practice Act in 1974:

"In amending this section [Sections 2725 and 2726] at the 1973-74 session, the legislature recognizes that 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 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. . . ."

In Sermchief v. Gonzales, the Missouri Supreme Court stated that the parties had asked the court to "define and draw that thin and elusive line which separates the practice of medicine from the practice of nursing." The court refused, holding that the nurses, who had been charged with the practice of medicine, were doing exactly the kind of things that the legislators had intended in previous amendments to the Nurse Practice Act.34

"In the vast majority of anesthetics performed, anesthesia is not an end unto itself."

4. Physicians prescribe many things such as diet, nursing care, and physical therapy that do not constitute delegated medicine. In fact, the New York state laws and regulations governing medical practice provide no authority to physicians regarding the delegation of medical services to professional nurses, yet New York recognizes the CRNA as a legal provider of anesthesia care within its Hospital Code and the rules and regula-
tions governing Free-Standing Ambulatory Surgery Services. Indeed, in other situations, the New York legislature has authorized physicians to delegate or assign medical services and when it intends to do so, it has expressed its intent clearly. The New York laws and regulations concerning physician or specialist assistants specifically authorize physicians to assign medical services under defined circumstances. If New York considers the administration of anesthesia solely a medical service, it does not say so in any of its laws, regulations, or codes (Hospital, Free-Standing Ambulatory Surgery Services, and Nursing Practice) which address CRNAs and their practice.

Further, within the New York laws governing nursing practice, the practice of professional nursing by a registered nurse is defined as:

"diagnosing and treating human responses to actual or potential health problems through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed or otherwise legally authorized physician or dentist. . . ." In New York, therefore, an anesthetic is prescribed by a physician and the CRNA may administer it and provide other care supportive of the patient's life and well-being. In so doing, the CRNA practice is entirely consistent with the state's definition of nursing.

Nurse anesthetists were first identified in the Ohio Medical Practice Act in 1919. This was the first such legal recognition of a nursing specialist within a state practice act. The Ohio provision is an exclusionary clause stating that the Medical Practice Act shall not exclude qualified nurses from performing anesthesia.

"It should be remembered that nurse anesthetists, as independently licensed professionals, are under a legal obligation to exercise independent judgment regarding the care they provide to patients."

The history behind the adoption of the exclusionary clause in the Ohio Medical Practice Act is interesting. Dr. George Crile, Sr. chose this route to stop those physicians who persisted in challenging the legal authority of nurses to provide anesthesia services under prescribed conditions in Ohio.

5. State laws and regulations stating that nurse anesthetists provide anesthesia under the direction, supervision, in collaboration with, or with the consent of a physician, do not confer "delegated medicine" status to the nursing practice. Courts have interpreted those phrases to mean that physicians or other health professionals permitted by law to prescribe or direct anesthetics are the persons who determine that a patient requires an anesthetic, and order or prescribe the anesthetic. In addition, the physician or other health care professional is required to be available for general supervision of patient care and for participation in life support activities in case of complications necessitating the prescriber's expertise.

"It is legal for nurses to compete with physicians in providing services in which there is role overlap or when there is reasonable interchangeability between providers."

In the vast majority of anesthetics performed, anesthesia is not an end unto itself. Because the purpose of the anesthetic is to facilitate the goal of the concurrent medical intervention, it is not unreasonable for a physician to be present and involved in orchestrating those concurrent activities needed to accomplish the primary goal of the medical intervention. Indeed, this interpretation is supported in that the legal duty to supervise, direct, collaborate or consent does not impute liability to the surgeon for anesthesia mishaps regardless of whether the provider is a nurse anesthetist or anesthesiologist unless the surgeon actually exerts control over the anesthesia or intervenes in some specific way.

Anesthesiologists are perhaps not required to function under the direction and supervision of the physician who prescribes an anesthetic because medical practice acts have not addressed medical specialty practice and the relationship of the anesthesiologist to other physicians. Historically, the Captain-of-the-Ship legal doctrine imputed liability to the surgeon for acts of the anesthetist, be it physician or nurse. In recent years, most jurisdictions have abolished or refused to apply this doctrine.

It should be remembered that nurse anesthetists, as independently licensed professionals, are under a legal obligation to exercise independent judgment regarding the care they provide to patients. The physician's prescription for anesthesia may place selected constraints upon what type of services might be included within the anesthesia management. The nurse anesthetist, however, must make an independent judgment concerning the possible effect the prescription, including its constraints, will have on the patient's safety and well-
being, and accept, negotiate, or refuse to provide the service based on that decision.5

It is common and accepted practice for a nurse anesthetist to select the anesthetic agents for the administration of anesthesia, as the 1978 Louisiana appellate decision of Brown v. Allen Sanitarium, Inc., et al. confirms.5

It is legal for nurses to compete with physicians in providing services in which there is role overlap or when there is reasonable interchangeability between providers. In the federal court decision, Bhan v. NME Hospitals, Inc., the defendants argued at the District Court level that the nurse anesthetist had no standing under antitrust law to sue anesthesiologists for alleged anticompetitive practices because of the different licensure of physicians and nurses. The judge accepted this argument and dismissed the complaint. On appeal, the Federal Court of Appeals reversed the District Court’s ruling and reinstated the complaint. The Appellate Court held that the issue was not whether the individuals had to perform identical services, but rather whether “there is reasonable interchangeability of use or . . . cross-elasticity of demand between the services provided by nurse anesthetists and by MD anesthesiologists.” 10

“As practiced by legally licensed professional nurses, anesthesia clearly falls within the scope of nursing practice and does not constitute delegated medicine.”

This standing of CRNAs to seek relief under federal antitrust legislation was confirmed in a recent landmark Montana federal court decision in favor of a CRNA, Oltz v. St. Peter’s Hospital. This case has been appealed by the hospital. Several anesthesiologists who had allegedly conspired with the hospital to revoke Oltz’s clinical practice privileges for anticompetitive reasons settled their portion of the case prior to trial.11,12 (For other information pertaining to antitrust implications for nurse anesthesia practice, refer to the additional bibliography cited.)

In conclusion, it is our position that the practice of anesthesia may legally fall within the scope of nursing and medical practice. As practiced by legally licensed professional nurses, anesthesia clearly falls within the scope of nursing practice and does not constitute delegated medicine.

REFERENCES

(6) California Board of Registered Nursing: Laws relating to nursing education, licensure, practice, rules and regulations. Article 2, Scope of Practice. p. 23.

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