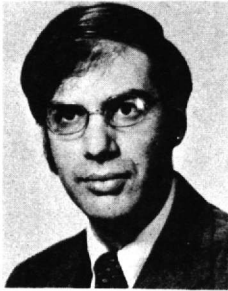


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## Legal Briefs

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### Legal requirements of physician supervision

In many states, the practice of nurse anesthesia is authorized by statutes which require "supervision" or "direction" by a physician. Some have claimed that these statutory requirements establish specific standards which reduce the role of nurse anesthetists to "technicians." There are very few decided cases in which the issue has been discussed, but in those few cases, the Courts have shown that the health care community will be given considerable latitude to determine what is appropriate supervision. In these cases, the Courts have clearly accepted the need for judgment in the role of the nurse anesthetist and have rejected the role of technician.

### Major cases recognizing the legal basis for nurse anesthesia practice

There are statements in the two major cases that recognized the legal basis for the practice of nurse anesthesia, *Frank v. South* and *Nelson v. Chalmers-Frances* (the "Dagmar Nelson Case") on the subject of supervision which, considered out of context, may be confusing without careful analysis.

In the Dagmar Nelson case, the California Supreme Court held that Dagmar Nelson, a CRNA, was not engaged in the illegal practice of medicine. The Court based its reasoning on two lines. First, the Court stated that there had been adequate testimony that what Dagmar Nelson had done was in accordance with the uniform practice in operating rooms. This is consistent with the practice of the Courts to defer to the health care community in determining what are appropriate

practices. The Court's second basis for its decision is more often reflected in statutes: that the nurse anesthetists were "carrying out the orders of the physician to whose authority they are subject. The surgeon has the power, and therefore the duty, to direct the nurse and her actions during the operation."

The Court issued a very short opinion in the Dagmar Nelson case and did not set forth at any length what the relationship between nurse and physician was nor what the Court expected in terms of supervision. But, it is important to remember that what the Court was deciding was whether Dagmar Nelson was engaged in the illegal practice of medicine. The question was: Who was prescribing, the physician or the nurse?

The Court's answer was a description of a model that satisfied the Medical Practice Act: the physician was prescribing and the nurse was carrying out the physician's orders. The Court was not, however, establishing the rules and procedures by which a nurse anesthetist would function with a surgeon. In fact, as long as the surgeon had the power to direct the nurse, it should not have made any difference whether or not the surgeon said anything during the course of the operation at all.

Nineteen years earlier, the Kentucky Supreme Court had issued a lengthy, 11-page decision in the case of *Frank v. South*. In *Frank v. South*, the court again determined simply that what a nurse anesthetist was doing was not the illegal practice of medicine. An argument had been raised "that the trained nurse, who administers an anesthetic, must at some time, exercise her own judgment and thus bring her within the definition of 'to practice medicine,' . . . ." Specifically, it was argued that it might be necessary to apply another anesthetic when the surgeon was so involved in the case that the surgeon would not be able to specifically direct the nurse anesthetist. The Court held that this did not constitute the practice of medicine and gave, as an analogy, that a physician could make a diagnosis and leave standing orders that "when the medicine already given shall effect the patient in a certain way" certain other medications should be given.

*Frank v. South* is a recognition that nurse anesthetists are more than mere technicians since they properly exercise judgment in the administration of anesthetics. The analogy which the court gave in *Frank v. South* was not intended as a limit on the powers of the nurse. The analogy was given by the Court to refute the argument that anytime a nurse exercised judgment, the nurse was practicing medicine.

While there has not been very much litigation questioning the extent of the supervision which is required, there have been at least three cases in which the issue was discussed.

In *Brown v. Allen Sanitarium, Inc., et al.* (Court of Appeal of Louisiana, 1978) an intermediate Court relied on expert testimony as to custom in the health care community. The plaintiff had argued that the physician was negligent in failing to properly supervise the anesthesia administered by a nurse anesthetist and in permitting the anesthetist to select the drug to be used. There was expert testimony "that after the supervising physician decides the patient is suited for a general anesthetic, it is customary to rely on the anesthetist to decide which drugs are most suited for the particular situation. There is no evidence of any improper selection or administration of drugs . . . [by the nurse anesthetist]."

The court held that even though the physician did not specifically direct the nurse anesthetist in the selection and method of application of the drugs used, the physician was, nonetheless, providing the required statutory supervision. "We do not interpret the statute to require the degree of supervision over a person possessing the skill and training of a registered nurse anesthetist as that contended by appellants."

*Gore v. United States*, was a case brought under the Federal Tort Claims Act based on the alleged malpractice of a nurse anesthetist in an Air Force hospital. The plaintiff's claim was based, in part, on the fact that the surgeon was not at the operating table when an anesthetic was administered by a nurse anesthetist. The Court determined that under Michigan law, (applicable in this case) physicians, surgeons or nurse anesthetists were responsible in damages for unfortunate results when, and only when, it was shown that they departed from the standard in the community of treatment and care by skilled doctors and nurses. Again, we see the deference by the courts to the opinion of the health care community.

The court indicated that there was testimony that it was common practice that a surgeon need not be in the operating room. In this case, the surgeon was in an adjoining room which was separated from the operating room by a swinging door containing a window. The Court noted that the Michigan statute had changed from a requirement that the execution of treatments and medications be "under the supervision and direction" of a licensed physician to one of "as prescribed" by a licensed physician.

In the case of *Carlsen v. Javurek et al*, the

United States Court of Appeals for the Eighth Circuit was interpreting South Dakota law. In the process of sending the case back to the district court for further proceedings because of confusion in the trial record as to the facts, the court described the relationship between surgeon and nurse anesthetist as follows: "Moreover, it likewise appears fundamental that a nurse, including a nurse anesthetist, is obligated to follow a surgeon's order, or at a minimum, advise the surgeon of her disagreement."

Implicit in that statement was approval of expert testimony that "without agreement [between surgeon and nurse anesthetist] the operation should be cancelled." The relationship which the court is describing is clearly not a relationship between surgeon and technician, but a relationship between two professionals each exercising judgment for the benefit of the patient.

On the other hand, the April, 1984 opinion of the California Attorney General, determining that registered nurses may lawfully administer regional anesthetics, came to the conclusion that anesthetics had to be ordered by a physician and could not be administered pursuant to a standardized procedure. Opinions of the Attorney General do not have the effect of decisions of a Court, although they are given a great deal of respect. Whether the decision of the California Attorney General with regard to standardized procedures will be accepted, is yet to be seen.

The language of the California Nursing Statute permitting the administration of medications and therapeutic agents "ordered by a physician" would not appear significantly different than the Michigan statute interpreted by the United States District Court in *Gore v. United States*.

## Conclusions

The Courts appear to be much more willing to accept standard practice in the health care community than appears from the California Attorney General. While some plaintiffs have argued that the obligation of the supervising physician is direct one-on-one supervision and control, the Courts have not required this type of strict control.

In both licensing and malpractice cases, Courts have recognized that the role of the nurse anesthetist calls for the exercise of judgment. In fact, in other cases which did not involve anesthesia, the failure of a nurse to exercise this judgment has been held to be malpractice. Certainly, nothing in the applicable statutes has been held to require physicians to tell nurse anesthetists what to do or when to do it.