Legal Briefs

GENE A. BLUMENREICH, **JD**
AANA General Counsel
Nutter, McClennen & Fish
Boston, Massachusetts

The nature of supervision

Key words: Captain of the ship, standard of care, supervision.

In some states, nurse anesthetists must be supervised or directed by a physician. Even in states where there is no statute requiring nurse anesthetists to be supervised, hospitals or other institutions may require it. "Supervision," despite its frequent appearance remains one of the least understood concepts in nurse anesthetist practice. Its genesis is traced to the historical development of nurse anesthetist practice. A few months ago, yet another court rejected arbitrary constraints concerning supervision and followed the reality of practice in upholding a jury determination that a surgeon was not liable for the improper supervision of a nurse anesthetist.

In recent years, enemies of nurse anesthesia have attempted to increase responsibilities associated with supervision. The dispute about the nature of supervision has nothing to do with patient care. No study has ever shown that anesthesia administered by an anesthesiologist or administered by a nurse anesthetist supervised by an anesthesiologist is any safer or otherwise "better" than anesthesia administered by a nurse anesthetist working alone. Nonetheless, both the American Association of Nurse Anesthetists (AANA) and the American Society of Anesthesiologists (ASA) have much different positions on supervision. The AANA has **stated that** ***"Supervision or direction"*** *refers* ***to*** *a* ***variety*** *of different practice* ***settings within*** *a continuum. While all satisfy the legal requirement, practice* ***settings take into*** *account* ***the*** *education, experience and capabilities* ***of the nurse anesthetist, the rules*** *and guidelines of the institution in which anesthesia is* ***to*** *be provided, and the needs and desires of the patient, nurse anesthetist, physician, dentist, podiatrist or other health care professional.*

ASA's position

The ASA's position is set forth in its "Guidelines for the Ethical Practice of Anesthesiology." [2] Anesthesiologists working with nurse anesthetists are expected by ASA, to carry out the following responsibilities:

a. Preanesthetic evaluation of the patient.
b. Prescription of the anesthesia plan.
c. Personal participation in the most demanding procedures in this plan, especially those of induction and emergence.
d. Following the course of anesthesia administration at frequent intervals.
e. Remaining physically available for the immediate diagnosis and treatment of emergencies.
f. Providing indicated postanesthesia care.

The ASA standards look remarkably like the Tax

Equity and Fiscal Responsibility Act (TEFRA) standards which were adopted in 1982 to determine when a CRNA was "medically directed." Although it may appear that TEFRA supports the ASA position, such a conclusion **would be incorrect.** The TEFRA requirements are for reimbursement purposes only and, even then, only if the anesthesiologist is to be reimbursed at the same rate as if the anesthesiologist had personally performed the procedure. The Health Care Financing Administration (HCFA) will reimburse anesthesia services provided by a nurse anesthetist whether or not the nurse anesthetist is medically directed by an anesthesiologist and whether or not the supervising anesthesiologist performs the TEFRA conditions.

While the words may be the same, there is a vast difference between a level of supervision which entitles an anesthesiologist to be paid as if he or she administered the service himself or herself and a level of supervision needed to satisfy certain state licensing requirements that there be physician involvement when anesthesia is administered. Nonetheless, ASA has attempted to maintain that "ethical anesthesia" requires that an anesthesiologist evaluate the patient, be present for induction, and perform the remainder of the steps outlined above.

Standards adopted by JCAHO

The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) has adopted standards for supervising anesthesia care which are quite different from the ASA's requirements. JCAHO standards require that anesthesia care for each patient is provided directly by a licensed independent practitioner or by an individual who is "directed or supervised" by a licensed independent practitioner. A JCAHO publication explains: *"The standards do not require that a supervising, licensed independent practitioner (for example, surgeon or obstetrician) have privileges to administer anesthesia, but the practitioner must be capable of reviewing the results of the preanesthesia evaluation, of determining that the patient is an appropriate candidate to undergo the planned anesthesia* (SA.1.5.2), *and of determining that the patient can be discharged* (SA.1.5.6)." [3]

Some history

Nor does history support the ASA's restrictive position. What was meant by "supervision" when nurse anesthetist statutes were originally enacted? Even in the early days of anesthesia, nurse anesthetists, being bright and capable, rapidly became more adept at anesthesia than the physicians "supervising" them. Consider three nurse anesthetists (these examples are derived from Virginia Thatcher's book, *History of Anesthesia with Emphasis on the Nurse Specialist*, and the historic notion of supervision. Thatcher found the first group of nurse anesthetists to be Catholic sisters and she reported an interview with a Sister Secundina Mindrup, CRNA, who had developed a timing device for administering a mixture of ether and chloroform depending on how much relaxation was required: "a decade of prayers on her rosary and it was time to give a little more." [4] Is it likely that the physician "supervising" Sister Secundina would have told her to give anesthesia by timing it with her prayers?

Alice Magaw, the famous nurse anesthetist at the Mayo Clinic, devised her own method of administering open-drop chloroform and ether anesthesia superior to virtually anything that was being used at the time. Physicians came to Mayo to learn *her* methods. It is obvious that the physicians who admired her work could have added little to her methods or safety through "supervision." Finally, George Crile, MD, wrote that Agatha Hodgins had learned to skillfully adjust dosages based on her experience and experimentation with anesthetic agents.

Thus, historically, those who supervised nurse anesthetists acknowledged that nurse anesthetists were more knowledgeable, got better results, and had better techniques than the "supervisors." It was not necessary that Dr. Crile be able to administer anesthesia to "supervise" Agatha Hodgins, CRNA. Being the bright and dynamic woman that she was, it was obvious that after a relatively short period of time of specialization Agatha Hodgins would clearly know more about anesthesia than Dr. Crile. Yet, under the statutes then being adopted, it was understood that Dr. Crile was "supervising" Agatha Hodgins. ASA's requirements for medical direction were never what licensing laws contemplated by "supervision." Physicians provided some medical input but they were not expected to control the anesthetic process.

In contemporary times, the dispute between AANA and ASA has raged for many years. Since the issue involves the meaning of "supervision" in laws and statutes, it can be assumed that the courts would be involved. However, it has been difficult to find cases in which a court reviews these issues. Licensing and regulatory bodies permit healthcare wide latitude. Since the practice of nurse anesthetists

working directly with surgeons is so well accepted, regulatory procedures involving supervision of nurse anesthetists rarely come to court. Similarly, issues of supervision seldom arise in malpractice cases. Nurse anesthetists are expected to administer anesthesia with the same quality and results as anesthesiologists. Thus, most anesthesia malpractice cases are decided on the basis of the standard of care rather than the level of supervision. A surgeon's liability is usually based on whether the surgeon controlled or had the right to control the procedure which gave rise to the negligence. Cases based on a claim that the surgeon failed to carry out some obligation to supervise are rare. Consequently, it is "news" that the Mississippi Supreme Court recently had an opportunity to discuss supervision in a decision upholding a jury verdict in favor of a surgeon working with a nurse anesthetist.

Starcher v Byrne

In *Starcher v Byrne,* 687 So. 2d 737 (Mississippi, 1997), a patient was admitted to a hospital to correct a ventral hernia. Anesthesia was administered by a CRNA employed by an anesthesiologist. As the CRNA began induction, the surgeon received an emergency page. He went into the hallway outside the operating room, but, in compliance with hospital policy, remained within the operating suite to answer the page while the CRNA induced the patient. The nurse anesthetist had trouble inducing the patient. When the surgeon returned, he and the nurse anesthetist determined that the patient was suffering from a bronchospasm. Based on their diagnosis, the operating team conducted emergency treatment. Due to the patient's condition, her heart rate began to fall rapidly. The surgeon successfully administered cardiopulmonary resuscitation to the patient and she was stabilized. However, as a result of her inability to breathe and the failure of her heart to adequately pump blood to all regions of her body, specifically her brain, for several minutes, the patient suffered brain damage resulting in decreased intellectual and physical capacity. The patient remained comatose for several days following the incident.

The plaintiffs (the patient and her husband) brought suit against the surgeon contending that he was negligent because he was not present in the operating room at the induction of anesthesia by the nurse anesthetist. They contended that the standards of practice for nurse anesthetists required that a CRNA work under the direction of and in the physical presence of a licensed physician. Because the nurse anesthetist's employer, the anesthesiologist, was not in the operating room or even at the hospital, the plaintiffs claimed that the surgeon was in charge of the operating room. Therefore, his failure to be present at the induction of anesthesia constituted a breach of the standard of care. At trial, the jury returned a verdict in favor of the surgeon. The plaintiffs appealed, claiming that the jury's verdict was contrary to the weight of the evidence and that the surgeon's absence from the operating room should mean that he was liable because he failed to properly supervise the nurse anesthetist.

Mississippi does not have a statute on nurse anesthesia practice. The Mississippi Board of Nursing requires that nurse practitioners, which includes nurse anesthetists in Mississippi, practice in a collaborative/consultative relationship with a licensed physician or dentist. Interestingly, the Mississippi Supreme Court never mentioned licensing requirements in its decision. Instead, the case was decided based on practice standards and legal doctrines concerning tort liability. The Supreme Court of Mississippi upheld the jury verdict and dismissed the appeal. Basically, the Supreme Court held that the standard of care did not require the supervising physician to be in the operating room while anesthesia was being induced.

Judge disagrees with decision

The decision in the *Starcher* case was not unanimous. One of the judges did not agree with the majority and wrote his own opinion. His dissent is interesting because it gives us a hint of what the arguments were on the other side. Those arguments are quite familiar to nurse anesthetists. The dissenting judge quoted a well-known legal work: *"In most states, surgeons may be found liable for the failure to supervise a nurse anesthetist or vicariously liable for a nurse anesthetist's negligence.*8 Am.Jur. Proof of Facts 2d, Surgeon's Failure to Exercise Supervision and Control over Anesthetist § 1,6 (1976). *Such liability is usually predicated upon the captain of the ship doctrine... That the surgeon is captain of the ship does not expose him to unfettered liability for the acts of all personnel in the operating room. Rather, at least one court has found that the 'vital test' is whether the surgeon has the right to control the employee. Harris v Miller,* 103 N.C.App. 312, 322, 407 S.E.2d 556, 562 (1991). *In...* [this case]..., *the issue of whether* [the surgeon] *had the right to control* [the nurse anesthetist] *was a proper matter for the jury to consider."*

Unlike the dissenting judge, the majority of the Mississippi Supreme Court was willing to analyze the relationship of the defendants and not rely on labels, as the dissent urged. The statement quoted by the dissent from *Proof of Facts* has caused a number of problems for nurse anesthetists. Someone probably *assumed* that surgeons "may be found liable for the failure to supervise a nurse anesthetist" because of a number of legal doctrines which once prevailed, such as "captain of the ship." These doctrines are now outmoded and seldom followed. **Even** when they **were** followed, **the** statement **gives** an inaccurate picture. It is unclear how it came to be published or who purported to count the cases. There have been any number of decisions in which surgeons were **not** held liable for the negligence of nurse anesthetists. (In fact, in the *Starcher* case, there is no suggestion or evidence in the report of the case that the nurse anesthetist was negligent.)

The majority of justices of the Mississippi Supreme Court analyzed the relationship between surgeon and nurse anesthetist and concluded that there was sufficient evidence to uphold the jury's verdict. At trial, testimony had showed that the surgeon had little, if any, say over and was not expected to inject himself into the anesthesia process. There was testimony which the court said the jury could have believed that the surgeon could not tell the nurse anesthetist what to do. Nor could the surgeon expect the nurse anesthetist to obey the surgeon's commands if the nurse anesthetist thought that the surgeon was wrong. Moreover, the court found that it was common practice for a CRNA to perform the anesthesia for surgical procedures, in the absence of an anesthesiologist, so long as a physician was available in case of an emergency.

The plaintiffs had claimed that the standard of practice required that a nurse anesthetist work under the direction of and in the physical presence of a licensed physician. The Mississippi Supreme Court said there two reasons why the plaintiffs argument must fail. First, the standards of practice apply to CRNAs, not physicians. The plaintiffs failed to present any evidence that the standards apply to physicians. Second, with the exception of the plaintiffs' expert witness, no doctor called by either side stated that a physician must be physically present in the operating room at the induction of anesthesia. Every other doctor called unequivocally stated that the common practice was only that the surgeon be in the operating suite. It was the general consensus of all doctors who testified, except for the plaintiffs' expert, that the operating physician had a tendency to get in the way more than anything else when he or she was in the operating room at the induction of anesthesia. Further, the head of a neighboring hospital testified that it was their hospital policy that the operating physician be within the operating suite, not in the operating room at the induction of anesthesia. The plaintiffs had made a number of claims concerning "captain of the ship" and "borrowed servants" which the court dismissed because the nurse anesthetist was an employee of the anesthesiologist. What made the case of interest was the court's holding on supervision. The court rejected artificial rules and looked to the reality of practice in its holding: *"There was adequate evidence that the CRNA could administer anesthesia where neither a surgeoN nor an anesthesiologist is present in the operating room, that Mississippi CRNAs are licensed to do so, and that this was a fairly common practice."*

REFERENCES

(1) Relationship Between Health Care Professionals. (Adopted by AANA Board of Directors, March 1987; Revised May 1988.) In: *Professional*
Practice Manual for the Certified Registered Nurse Anesthetist. Park Ridge, Illinois: American Association of Nurse Anesthetists. Position Statement No. 1.2.
(2) Guidelines for the Ethical Practice of Anesthesiology. (Approved by House of Delegates on October 3, 1967 and last amended on October 25, 1995.) In: *1996 Directory of Members.* 61st edition. Park Ridge, Illinois: American Society of Anesthesiologists. 1996:401-403.
(3) Surgical and Anesthesia Services. In: *1990 Joint Commission Accreditation*
Manual for Hospitals. Volume II. Scoring Guidelines. Oakbrook Terrace, Illinois: Joint Commission on Accreditation of Healthcare Organizations. 1990:18.
(4) Thatcher VS. *History of Anesthesia with Emphasis on the Nurse Specialist.*
Philadelphia: J.B. Lippincott. 1953.