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The Law and the Nurse Anesthetist

Beverly Ann Krause

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Beverly Ann Krause, CRNA, BA

A Digest Presented to the Faculty of the Graduate School of the Lindenwood Colleges in Partial Fulfillment of the Requirements for the Degree of Master of Science

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DIGEST

Should the surgeon, as "captain of the ship", be liable for the negligent acts of the Certified Registered Nurse Anesthetist? The Certified Registered Nurse Anesthetist is a highly skilled and educated nurse and is far more informed about anesthesia than the surgeon. The surgeons resent this needless liability, and because of this, the use of Certified Registered Nurse Anesthetists to administer anesthetics might decrease.

To prove that the hypothesis was correct, several methods of research were done. A content analysis showed that the courts are divided on their decisions. There have been many decisions absolving the surgeon and just as many holding him liable.

Existing data was also analyzed. The premium rates for malpractice insurance have risen dramatically in the last ten years. This proves that the malpractice crisis does exist and that the problem must be dealt with. This analysis also supported the fact that the laws in the United States differ from state to state, which adds confusion to the liability status of Certified Registered Nurse Anesthetists and surgeons.

The third method used was a questionnaire. By random sampling, 10 percent of the membership of the

Missouri chapter of the American Society of Anesthesiologists, of the Missouri Association of Nurse Anesthetists, and of the Missouri College of Surgeons were surveyed. These groups were asked eight questions relating to the legal responsibility for nurse anesthetists.

The results did not completely prove my hypothesis. It was proven that confusion reigns in the area of liability. Because the administration of anesthesia is both a nursing and medical function, the Certified Registered Nurse Anesthetist must have legal authority to perform this task. To do this, the Nurse Practice Acts must be revised to include a definition of this scope of practice. This would relieve the surgeon of liability. Secondly, there must be uniformity of laws and court decisions in the United States, so that those involved will know their responsibilities.

THE LAW AND THE NURSE ANESTHETIST

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This project is dedicated to Diane,
John, Matt, and David, whom I love
very much and to YOU, who
never really understood.

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CHAPTER 1

INTRODUCTION

Should the surgeon be liable for the negligent acts of the Certified Registered Nurse Anesthetist? According to most court decisions, the surgeon, as "captain of the ship" is, indeed, liable for everything that happens in the operating room (Kucera, April 1980, p. 164). This "captain of the ship" concept began years ago, when anesthesia was in its infancy. At this time, since anesthesia was only a means to the end of surgery, the anesthetist was forced to take a subservient role. Many times the surgeon administered the drugs himself, or asked some lay person to do it. Because of many other problems of surgery, like a high mortality rate due to infection, poor medical education, and inexperienced surgeons, the science of anesthesia did not advance quickly. Few people were attracted to the field, and those who were, were not the uppercrust of the medical profession (Bakutis, 1953, pp. 8-9). The following statement, made in 1883, illustrates the general sentiment towards an anesthetist:

> He arrives late with everyone waiting and produces cumbersome equipment. He starts the anesthetic, pushing ether until it is necessary to use artificial respiration. And then the patient vomits. Finally, all is going well again and the operation begins. The anesthetist becomes so engrossed in the operation that the patient shows signs of asphyxiation requiring resuscitation again, and finally the anesthetist finds he has no battery on hand, or having one on hand, it is not in order, so no faradic stimulation can be given (Bakutis, 1953, p. 10).

As surgeons improved and surgical techniques grew, the need for competent anesthetists became apparent. Many surgeons taught their nurses to do the anesthesia under their supervision. These nurses, in turn, taught others, and although schools of anesthesia appeared in the United States during the early 1900's, the surgeon remained the person who instructed the nurse on how to do the anesthesia (Bakutis, 1953, p. 10).

As could be expected, as the field expanded, the actions of these anesthetists were questioned. Injuries occurred and law suits insued. The courts recognized that there existed certain circumstances where liability imposed upon one person should also be imposed upon another because of a special relationship which existed between the two. This doctrine evolved because of the inability of one party to respond in payment for damages (Kucera, 1980, p. 162). The earliest application was imposed liability upon a master for

the negligent acts of his servant, because of the master's ability to control the acts of the servant and the servant's inability to pay damages (Kucera, 1980, p. 162).

Today, the situation still exists. The surgeon, as "captain of the ship", is liable for the nurse anesthetist by application of the "borrowed servant" doctrine of respondeat superior (Strieff, 1975, p. 65). But today the situation is much different from the early 1900's. The Certified Registered Nurse Anesthetist is a registered nurse who has had additional education in the art and science of anesthesia, has passed a national qualifying examination, and every two years is required to be recertified through continuing education. Because of the complexity of surgery and anesthesia, surgeons are no longer able to stay abreast of the effects of the different anesthetic agents and techniques on the physiology of the patient.

The question arises, then, how the courts can continue to enforce the "captain of the ship" concept. Since the surgeon has no choice in who administers the anesthesia, but, rather, is assigned a nurse anesthetist by the hospital, and since the surgeon has no knowledge of the skills of this anesthetist, it may

be argued that the surgeon must not be held liable. If the nurse anesthetist is certified and has passed the standards of employment at the hospital, that nurse anesthetist, alone, should be liable for his/her own actions.

In this paper, I will attempt to prove that the nurse anesthetist should be liable by reviewing the literature to show the history of the nurse anesthetist, including present educational requirements, the right to practice, and legal liability; the insurance system; and the trends of court decisions. Through my research I will try to establish that there is a need for change in the judicial decisions concerning this liability, and I will try to project the consequences to the nurse anesthetist, the patient, and the surgeon if these changes are not made.

Nurse anesthetists are educated and professionally accountable. They have been taught to function independently. They function, not as physicians, but as nurse practitioners. The laws must be changed to accommodate them, while removing the burden of liability from the surgeon.

CHAPTER 2

LITERATURE REVIEW

History of Nurse Anesthesia

The role of the nurse anesthetist developed because of a need for someone to administer the anesthesia for the surgery. In the 1800's, some strides were being made in the field of anesthesia. Nitrous oxide and ether were first found to have anesthetic properties in the 1840's, and these agents began to be used (Bakutis, 1953, p. 4). Few, if any, physicians were interested in the field of anesthesia since it was not a glamorous position. What was needed was one who: would be satisfied with the subordinate role that the work required; would make anesthesia his one interest; would not look on the situation as one that put him in a position to watch and learn from the surgeons' technique; would accept a comparatively low salary; and would have a natural aptitude and intelligence to develop a high level of skill in providing the smooth anesthesia and relaxation the surgeon demanded (Bakutis, 1953, p. 10). With these needs, it was no wonder that the surgeon turned to the nurse for his anesthetic needs.

In the United States, the first nurse anesthetists were people accepted by the Sisters of the Catholic Hospitals. In 1883, Mother Superior approached William Mayo to instruct one of her nurses in anesthesia. He accepted, and Edith Graham became the first nurse anesthetist in the United States. Her successor, Alice McGraw, brought fame to the profession by reporting 1,092 cases in 1900 and 14,000 cases in 1906 (Bakutis, 1953, pp. 10-12).

About the same time the first school of anesthesia was founded in Cleveland in 1926, legal problems began to arise. The question was where does nursing end and medicine begin (Bakutis, 1953, p. 15)? Two states ruled against nurses: New York considered it a violation of the law, and California ruled that only a physician could administer anesthesia. Many surgeons and nurses wanted to fight these new rulings. In 1917, the rule was tested in Kentucky. The decision was favorable to the nurse anesthetist, and nurse anesthesia became legal in several states (Bakutis, 1953, p. 22). The only court trial to test the legality of the nurse anesthetist was in California in 1934. The defendant was a nurse anesthetist from Los Angeles. A group of physicians brought suit to prevent nurses from giving anesthesia by proving that the administration of anesthesia was the practice of

medicine because it incorporated the diagnosis and treatment of a physical and mental condition. The suit was filed by the Anesthesia Section of the Los Angeles County Medical Association. They tried to establish these facts:

1. The surgeon could in no way supervise the nurse anesthetist;
2. Anesthetics were drugs and in the administration of the drug, the nurse anesthetist used her own judgement as to the amount, which was treating the patient;
3. In observing the signs of anesthesia and acting on these signs, she was practicing medicine (Bakutis, 1953, pp. 26-28).

The defendant showed that the giving of drugs under direct or understood instructions of a physician was recognized as a function of nursing and that the reporting of changes in a patient's condition and acting accordingly, under the direct or understood supervision of a physician, were also within the province of nursing. It was also shown that anesthetic drugs were in this classification, and therefore, their administration was within the law for Registered Nurses. The court found in favor of the defendant (Bakutis, 1953, pp. 28-29).

By 1933 the nurse anesthetists organized and the American Association of Nurse Anesthetists was formed. Antinurse anesthetist campaigns continued, in spite

of the fact that in 1950 one half of all anesthetics were being given by nurses. The American Association of Nurse Anesthetists set up standards for schools and established a national qualifying examination. The length of the educational program changed from six months in 1935 to one year in 1948, to eighteen months in 1961, and to two years in 1975 (Bakutis, 1953, pp. 30-41).

The organization had the development of educational standards as one of its major objectives and immediately established minimum standards for schools. By 1955 the American Association of Nurse Anesthetists was listed on the United States Commission of Education list of national recognized accrediting agencies, and remained there until 1975 when accreditation was transferred to the Council on Accreditation of Nurse Anesthesia Educational Programs/ Schools (Council on Accreditation, 1980, p. 1). Three councils were developed: Council on Certification; Council on Accreditation; and Council of Nurse Anesthesia Practice (Council on Accreditation, 1980, p. 2).

According to the American Association of Nurse Anesthetists Standards, a Certified Registered Nurse Anesthetist is a "health care professional who renders nursing and anesthesia services to patients requiring

a combination of these services". The statement goes on to say that "those services which are medically delegated are provided under the direction of the licensed physician delegating those services". The Certified Registered Nurse Anesthetist demonstrates sound professional, moral, and ethical standards in his/her practice and is responsible and accountable for the quality of service he or she provides. This Certified Registered Nurse Anesthetist must be competent to give care while under the direction of a surgeon, internist, cardiologist, or any licensed physician since many times there is no anesthesiologist available (Council on Accreditation, 1980, p. 3).

To qualify as a Certified Registered Nurse Anesthetist the person must first be a graduate nurse of an accredited nursing school, licensed to practice in the state. He/She must then be a graduate of an accredited anesthesia school, and must have passed the national qualifying examination. Once certified, this nurse anesthetist must be recertified every two years by obtaining continuing education, which must be approved by the American Association of Nurse Anesthetists (Council on Accreditation, 1980, p. 3).

To be admitted to an accredited school of anesthesia, the student's requirements shall include

graduation from an approved baccalaureate or higher degree program in nursing or an approved associate degree or diploma program in nursing with a minimum of thirty hours, or its equivalent, of college credits which include: Biophysical Sciences, five courses; Communication Skills, two courses; Humanities and Behavioral Sciences, three courses. He/She must have a current license as a Registered Nurse and a minimum of one year of nursing experience in an acute care setting. At this time, the American Association of Nurse Anesthetists is considering requiring, within the next five years, an appropriate baccalaureate degree as a prerequisite for admission (Council on Accreditation, 1980, p. 8).

The educational programs are 24 months in length and require a minimum of 450 anesthetic cases and 800 hours of clinical experience. The didactic requirements are at least 450 contact hours. This includes 45 hours of Professional Aspects; 135 hours of Anatomy and Physiology in relation to anesthesia, including cell physiology, nervous system, respiratory system, cardiovascular system, endocrine system, and excretory system; 60 hours of Chemistry; 75 hours of Pharmacology; 75 hours of principles of anesthesia; and 35 hours of journal clubs and conferences (Council on Accreditation, 1980, pp. 14-17).

The American Association of Nurse Anesthetists defines anesthesia service as:

1. Management of procedures for rendering a patient insensible to pain within the confines of operative, diagnostic and/or therapeutic situations, and physiological and pathological conditions of the patient;
2. Support of life functions under the stress of anesthesia and surgical manipulation;
3. Clinical management of life support of the patient, unconscious from any cause;
4. Management of pain relief;
5. Management of problems in cardiac and respiratory resuscitation;
6. Application of selected methods and procedures of respiratory care;
7. Clinical management of various fluids, electrolytes, and metabolic disturbances (Council on Accreditation, 1980, p. 4).

The scope of practice, according to this same organization is within the scope of professional nursing practice to include those nursing functions for which the nurse anesthetist bears independent responsibility and those functions which have been medically delegated by a licensed physician. Each of these functions can have both a nursing and a delegated medical component and the Certified Registered Nurse Anesthetist should be prepared to perform both types of functions and should be able to recognize when the needed care is beyond his/her

competence. At this time, consultation should be sought (Council on Accreditation, 1980, p. 4).

Right To Practice

Today's nurse anesthetists practice under the nurse practice acts of their own states. Before discussing the current situation of nurse practice acts, one must first look back on the evolution of nursing. The nurse has gone from being indispensable to a subordinate role and then back to the expanded role that exists now. These roles have led to changing positions professionally and medicolegally (Weisgerber, 1980, p. 83). These periods of nursing started with the registration era in the late 1800's. During this time, both the National League for Nursing and the American Nurses Association were formed. The American Medical Association brought suit against the states for the licensing laws, but the courts upheld the states' licensing rights based on an 1888 case in West Virginia in which the legality of licensure was tested and upheld by the United States Supreme Court (Dent v West Virginia, U.S.R. 129 114-128). Thus, in 1903, North Carolina became the first state to pass a Nurse Registration Act. By 1923, every state had one (Weisgerber, 1980, pp. 84-85).

The second era began in 1938 when New York enacted the first Nurse Practice Act. This act required mandatory licensure and defined the scope of nursing (Weisgerber, 1980, p. 86). Licensure, which was the first major step in nursing organization, is the process by which some competent authority grants permission to a qualified individual to perform certain specified activities that would be illegal without a licensure. In the health care field, this process is accomplished by a licensing board or a department of the state. This board grants to any individual who meets certain predetermined standards, the legal right to practice a health profession and to use the specified health professional title. The licensing board determines eligibility for initial licensing and for relicensing; enforces licensing statutes, including suspension, revocation, and restoration of the license; and supervises training institutions (Streiff, 1975, pp. 51-52). The objective of these licensing boards is to limit and control admission into the various health occupations and to protect the public from unqualified practitioners by enforcing the standard of practice within the profession (Cazalas, 1978, p. 77).

The current phase started ten years ago with the appearance of the nurse practitioner. A nurse practitioner is an additionally trained Registered Nurse, operating in an expanded role (Weisgerber, 1980, p. 83). The nurse practitioner operates beyond a nursing spectrum, and is closer to the role of physician than a nurse. He/She is the initial patient provider and performs diagnoses by drawing on education and extensive clinical experience. He/She is not designed to function on his/her own, but rather as a time saver for the physician (Weisgerber, 1980, p. 92).

Each state has their own method of defining their scope of practice in the Nurse Practice Act. Because of this, confusion reigns. There has been an effort, since 1971 when Idaho passed their "expanded role" act, to have medical and nursing associations clearly define the practice of professional nursing in the Nurse Practice Act in order to grant legal authority for nurses to perform the functions which are now being delegated to them. These include both medical and nursing duties (Cazalas, 1978, pp. 84-86).

The American Nurses Association, in the middle 1970's, attempted to clarify the confusion, Their

statement of nursing practice defined the practice of professional nursing to mean:

> ...the performance, for compensation, of any acts in the observation, care and counsel of the ill, injured, or infirm; or in the maintenance of health or prevention of illness of others; or in the supervision and teaching of other personnel; or the administration of medication and treatment as prescribed by a licensed physician or dentist, requiring specialized judgement and skill based on knowledge of the principles of biological, physical, and social sciences. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures (Streiff, 1979, p. 59).

This definition seemed to suffice for general nursing; but as more and more nurse practitioners surfaced, it became difficult to determine if the tasks these nurses were performing were nursing practice or medical practice since they were performing duties formerly performed by physicians in the emergency room, operating room, and intensive care units. Since there is no clear distinction between nursing diagnosis and medical diagnosis, many states began amending their statutes to permit nurses to perform "medical" or "additional acts" (Cazalas, 1978, pp. 84-87).

To gain recognition under the law, the nurse practitioner, including the nurse anesthetist, can take one of three basic directions. He/She can

work for the inclusion of additional acts in the Nurse Practice Act, for the "expanded role", or for the mention of the nurse practitioner by specific name (Kaspar Communication, 1981).

The additional acts method defines expanded responsibilities and duties that are allowable under the practice of professional nursing. Iowa is one of the states which follows this method (Kaspar Communication, 1981). This Nurse Practice Act allows for the "...formulation of a nursing diagnosis and treatment" and "...for performance of additional acts or nursing specialities which require educational training"...."which are recognized by the medical and nursing professions and are approved as being proper to be performed by an R.N." (Iowa Statutes Annotated, 1980, p. 49).

The expanded role model includes the phrasing of Advanced Registered Nurse Practitioner and allows for the definition of this expanded role in the Nurse Practice Act (Kaspar Communication, 1981). Kentucky's Nurse Practice Act states that the Advanced Registered Nurse Practitioner is one who is certified to engage in advanced Registered Nurse practice, including, but not limited to, the nurse anesthetist, nurse midwife, and nurse practitioner. It defines Advanced Registered

Nurse Practice as the performance of additional acts by a Registered Nurse who has gained added knowledge and skills through an organized post basic program of study and clinical experience approved by the organization or agency which has the authority to certify the Advanced Registered Nurse Practitioner. In the performance of those procedures which are normally considered as the practice of medicine, the nurse will conform to the standards of the Medical Practice Act and established medical protocal (Kentucky Revised Statutes, 1980, pp. 33-34).

The third direction, which is the mention by name of the nurse practitioner, is used in Arkansas. The Nurse Practice Act states, "In order to safeguard life and health, any person practicing or offering to practice as a Registered Professional Nurse, Professional Nurse, Nurse Anesthetist, ...shall hereafter be required to submit evidence that he or she is qualified to do so." Qualifications for a Certified Registered Nurse Anesthetist are as follows: any R.N. registered in Arkansas who shows proof of satisfactory completion, beyond generic nursing preparation, of a formal educational program which meets the standards of the Council on Educational Programs of the nurse anesthetists or other nationally

recognized accrediting body which has as its objective preparation of nurses to perform as nurse anesthetists, and current certification from the Council on Certification of the nurse anesthetists, Council on Recertification, or other recognized certifying body (Arkansas Statutes, 1979, p. 8).

Many nurses still function under the basic definition of the Nurse Practice Act (Kaspar Communication, 1981). These acts make no mention of the expanded roles and therefore, nurse practitioners, including Certified Registered Nurse Anesthetists, have no legal protection for their actions. The crucial provision bearing on the legal scope of professional nursing practice is the definition of that practice (Hall, 1975, p. 7). Steps must be taken to change the Nurse Practice Acts of all states to include nurse practitioners and expanded definitions, so that those nurse practitioners are legally protected to practice their profession (Bullough, 1980, p. 55).

Figures 1 and 2, pages 19-24, show a summary of the various Nurse Practice Acts.

Legal Responsibility

The legal responsibility of the medical professional is under the civil law of each state.

Figure 1

If Additional Acts Amendment, Criteria and Conditions Stated

State	Type of Definition	Definition Includes Prohibition Against Acts of Diagnosis and Prescription	Rules and Regulations	Professional Opinion	Education and Training	If New Definition, Incorporated some or all of New York's	Prohibitions of Practice of Medicine in Nurse Practice Act	Exception for Nursing in Medical Practice Act	Physician Supervision of Nurse Practioners	Degree of Supervision
Alabama	New & Additional Acts Amendment	No	Yes	–	–	Yes	No	No	Required for Nurse Anesthetist	Direct for 30 days, then protocol for midwife
Alaska	Traditional & Additional Acts Amendment	Yes (Applies to "medical" acts only and additional acts not subject to prohibition.)	Yes*	–	–	–	No	No	Collaborative relationship for Nurse-Midwife	
Arizona	Traditional & Additional Acts Amendment[1]	No	Yes*	Yes*	Yes	–	No	Yes (Under physician supervision)	Under direction of and in collaboration with	Presence required for Nurse Anesthetist
Arkansas	Traditional	Yes (Applies to "medical" acts only)	–	–	–	–	No	Yes (Also separate exemption for nurse acting under physician supervision)	Required for Nurse Anesthetist	Presence required
California	New	No		–	–	No	No	Yes (For persons lawfully practicing another profession)		As defined by policies and protocols developed for specific setting
Colorado	New & Additional Acts Amendment	No	Yes**	No	Yes	Yes	No	Yes (Also separate exemption for persons acting under physician supervision)	Required	Defined in protocols
Connecticut	New	No	–	–	–	Yes	Yes	Yes (Under physician supervision)	Not stated	
Delaware	Traditional	Yes	–	–	–	–	No	No	Not stated	
District of Columbia	No Definition	–	–	–	–	–	No	Yes	Not stated	
Florida	Traditional & Additional Acts Amendment	No	Yes	–	–	–	Yes	Yes (Under physician supervision)	Not stated	
Georgia	Traditional	No	–	–	–	–	No	Yes (Also separate exemption for persons acting under physician supervision)	Nurse Anesthetists function under direction of physician	
Hawaii	Traditional	Yes (Applies to "medical" acts only)	–	–	–	–	No	No (?)[2]	No specific legislation	
Idaho	Traditional & Additional Acts Amendment	Yes	Yes (Applies to "medical" acts only and additional acts not subject to prohibition)	No	No	–	No	No	None referred to but "practice policies" for individuals may so indicate	
Illinois	Traditional	Yes (Applies to "medical" acts only)	–	–	–	–	No	Yes (For persons lawfully practicing another profession)	No specific legislation	
Indiana	New & Additional Acts Amendment	No	Yes***	No	No	Yes	No	Yes	Required for Nurse Anesthetist	
Iowa	New & Additional Acts Amendment	No	–	–	–	Yes	Yes	Yes	No specific regulations	
Kansas	Traditional	Yes	–	–	–	–	No	Yes (Also separate exemption for persons acting under physician supervision)	No legislation	
Kentucky	Traditional	Yes (Applies to "medical" acts only)	–	–	–	–	No	Yes	No legislation	
Louisiana	New & Additional Amendment Act	Yes	Yes	–	–	Yes	No	Yes	Required	

(continued)

Figure 1 continued

State	Type of Definition	If Additional Acts Amendment, Criteria and Conditions Stated: Definition Includes Prohibition Against Acts of Diagnosis and Prescription	Rules and Regulations	Professional Opinion	Education and Training	If New Definition, Incorporated some or all of New York's	Prohibitions of Practice of Medicine in Nurse Practice Act	Exception for Nursing in Medical Practice Act	Physician Supervision of Nurse Practioners	Degree of Supervision
Maine	Traditional & Additional Acts Amendment	No	No	No	Yes	–	No	No	Physician can delegate certain services	
Maryland	New & Additional Acts Amendment	No	Yes**	Yes*	Yes	Yes	No	Yes (For persons lawfully practicing another profession)	Not stated	
Massachusetts	Traditional & Additional Acts Amendment	No	Yes*	Yes**	Yes	Yes	No	Yes (Applies only to nurses performing "Additional acts")	No regulations	
Michigan	Traditional	Yes (Applies to "medical" acts only)	–	–	–	–	No	Yes (For persons lawfully practicing another profession and separate exemption for persons acting under physician supervision)	No specific legislation	
Minnesota	New	No	–	–	–	Yes	No	Yes (For persons lawfully practicing another profession)	No specific legislation	
Mississippi	Traditional & Additional Acts Amendment	Yes (Applies to "medical" acts only and additional acts not subjected to prohibition)	Yes*	No	No	–	No	No	Not stated	
Missouri	New	No	–	–	–	Yes	No	Yes	No specific legislation	
Montana	Traditional	Yes	–	–	–	–	No	Yes	No specific legislation	
Nebraska	New & Additional Amendment Act	Yes, Medicine	Yes	–	–	Yes	No	Yes (For persons lawfully practicing another profession—not applicable to prescription or administration of drugs)	Required	Specific to each approved expanded role
Nevada	Traditional & Additional Acts Amendment	Yes (Applies to "medical" acts only and additional acts not subject to prohibition)	Yes**	Yes*	Yes	–	No	Yes	Collaboration	As agreed in writing
New Hampshire	New & Additional Acts Amendment	Yes (Additional acts not subject to prohibition)	Yes*	Yes**	Yes	Yes	No	Yes	Collaboration	Nurse anesthetists function within physical presence of physician
New Jersey	New	No	–	–	–	Yes	No	Yes (Under physician supervision)	No specific legislation	
New Mexico	Traditional	Yes (Applies to "medical" acts only)	–	–	–	–	No	Yes (Plus separate exemption for nurse practitioners in certain settings)	Required	
New York	New	No	–	–	–	Yes	Yes	Yes (For persons lawfully practicing another profession)	No regulations	
North Carolina	Traditional & Additional Acts Amendment	Yes (Applies to "medical" acts only and excepts acts under supervision of physician)	Yes*	No	No	–	No	Yes (For nursing and those acts "otherwise constituting medical practice" which are permitted by regulations of medical and nursing boards)	Required	Telecommunications, predetermined plan for emergencies, review of practice
North Dakota	Traditional	No	–	–	–	–	No	No	No regulations	

(continued)

Figure 1 continued

If Additional Acts Amendment, Criteria and Conditions Stated

State	Type of Definition	Definition Includes Prohibition Against Acts of Diagnosis and Prescription	Rules and Regulations	Professional Opinion	Education and Training	If New Definition, Incorporated some or all of New York's	Prohibitions of Practice of Medicine in Nurse Practice Act	Exception for Nursing in Medical Practice Act	Physician Supervision of Nurse Practioners	Degree of Supervision
Ohio	Traditional	Yes (Applies to "medical" acts only)	–	–	–	–	Yes	Yes (For nurse anesthetists only, under physician supervision)	Required for nurse-midwife and nurse anesthetist	Nurse anesthetist must work in presence of physician
Oklahoma	Traditional	Yes	–	–	–	–	No	Yes (Under physician supervision)	No regulations	
Oregon	New & Additional Acts Amendment	No	Yes**	Yes*	Yes	Yes	No	Yes	Collaboration	
Pennsylvania	New & Additional Acts Amendment	Yes (Applies to "medical" acts only and additional acts not subject to prohibition)	Yes*	No	No	Yes	Yes	No	Required	Telecommunications, predetermined plan for emergency
Rhode Island	Traditional	No	–	–	–	–	No	No	No specific legislation	
South Carolina	Traditional	Yes (Applies to "medical" acts only)	Yes	–	–	–	No	Yes	Required	Near proximity, available for consultation
South Dakota	New & Additional Acts Amendment	No	Yes	No	Yes	Yes	Yes	Yes	Not stated	
Tennessee	Traditional	Yes (Applies to "medical" acts only)	–	–	–	–	No	Yes (Plus separate exemption for nurses under physician supervision)	Required	As indicated in written protocols for specific situations
Texas	Traditional	Yes (Applies to "medical" acts only)	Yes	–	–	–	Yes	Yes	Required (for medical treatment)	
Utah	New & Additional Acts Amendment	No	–	–	–	Yes	No	Yes	Required	
Vermont	New & Additional Acts Amendment	Yes	No	Yes	Yes	Yes	Yes	Yes (Under physician supervision)	No regulations	
Virginia	Traditional (Additional Amendments to Medical Practice Act)	No	Yes	–	–	–	No	Yes (Includes specific reference to certain procedures, which must be performed under orders of physician, plus separate exemption for nurses acting under physician supervision pursuant to rules and regulations of Boards of Nursing and Medicine)	Must be available for consultation	
Washington	New & Additional Acts Amendment	No	Yes**	Yes*	Yes	Yes	No	No	Uses "scope of practice" as in statements by national associations	

(continued)

Figure 1 continued

If Additional Acts Amendment, Criteria and Conditions Stated

State	Type of Definition	Definition Includes Prohibition Against Acts of Diagnosis and Prescription	Rules and Regulations	Professional Opinion	Education and Training	If New Definition, Incorporated some or all of New York's Prohibitions of Practice of Medicine in Nurse Practice Act	Exception for Nursing in Medical Practice Act	Physician Supervision of Nurse Practioners	Degree of Supervision
West Virginia	Traditional	No	–	–	–	–	No	Yes	Required	Nurse anesthetists in presence of physician, nurse-midwives according to ACNM standards
Wisconsin	Traditional	No	–	–	–	–	No	Yes (Under physician supervision)[4]	No specific legislation	
Wyoming	New	No	–	–	–	–	No	Yes (Under physician supervision)	Required	Telecommunications, referral and consultation, regular chart review, predetermined plan for emergencies, protocols for medication

[1] Arizona's additional acts amendment, unlike any other, describes substantively one such act: the dispensing of prepackaged, labelled drugs under certain limited, specific circumstances.
[2] Hawaii has a delegation provision which applies to "any physician-support personnel" and which could be construed as including nurses.
[3] Although Maryland's additional acts amendment does not mention physician supervision, the amendment could be interpreted as subordinate to the definition's general description of nursing as consisting of "independent" nursing functions and "delegated" medical functions, in which case any medical acts within the additional acts amendment would have to be delegated acts.
[4] North Carolina's additional acts amendment does not mention physician supervision, but it appears in a separate section from the definition and would appear to be subordinate to that provision of the definition which prohibits acts of medical diagnosis and prescription except under physician supervision.
[5] Oregon alone among the states with additional acts amendments which refer to professional opinion speaks only of nursing opinion, as opposed to medical and nursing opinion.
[6] Wisconsin's law in this regard is somewhat oblique, but it would appear that not only nurses but any persons are authorized to "assist" physicians.

*By Boards of Nursing and Medicine.
**By Board of Nursing.
***By Board of Nursing or "in collaboration with" Board of Medicine.
*Cumulative with rules and regulations.
**Independent of rules and regulations.

Source—Cazalas, M.W. Nursing and the Law. Maryland: Aspens, 1978, 222-228.

Figure 2

State Nurse Practice Act Support for Role Expansion

State	Diagnosis Allowed*	Treatment Allowed*	First R.N. Act	Expanded Role Recognized
		Northeastern States and the Four Other Jurisdictions		
Connecticut	Yes—all R.N.	Yes—all R.N.	1905	1975
Delaware	No	No	1909	1978*
Maine	Yes	Yes—N.P.	1915	1974
Massachusetts	Yes—N.P.	Yes—N.P.	1910	1975
New Hampshire	Yes—N.P.	Yes—N.P.	1907	1974
New Jersey	Yes—all R.N.	Yes—all R.N.	1903	1974
New York	Yes—all R.N.	Yes—all R.N.	1903	1972
Pennsylvania	Yes—all R.N.	Yes—N.P. Protocols	1909	1973
Rhode Island	Not prohibited	No	1912	Not yet
Vermont	Yes—all R.N.	Yes—N.P.	1911	1974
District of Columbia	Not prohibited	No	1907	Not yet
Guam	No—if medical	No	1952	Not yet
Puerto Rico	No	No	1963	Not yet
Virgin Islands	No	No	1945	Not yet
		Midwestern States		
Illinois	Yes—if not medical	Yes—if not medical	1907	1975 (Board for Opinions on Prof. Nursing)
Indiana	Yes—all R.N.	Yes—N.P.	1905	1974
Iowa	Yes—all R.N.	Yes—N.P.	1907	1976
Kansas	Yes—N.P.	Yes—N.P.	1913	1978
Michigan	Yes—N.P.	Yes—N.P.	1909	1978
Minnesota	Yes—all R.N.	No	1907	1974
Missouri	Yes—all R.N.	No	1909	1976
Nebraska	Yes	Yes—N.P.	1909	1974 (But problems with
North Dakota	Yes	Yes—N.P.	1915	1977
Ohio	No—if medical	No	1915	Not yet
Oklahoma*	No	No	1909	Not yet
South Dakota	Yes	Yes—N.P.	1917	1972 & 1976
Wisconsin	Not prohibited	No	1911	(in process)
		Southern States		
Alabama	Yes	Yes—N.P.	1915	1975
Arkansas	No—if medical	No	1913	Not yet
Florida	Yes—N.P.	Yes	1913	1975
Georgia	Not prohibited	No	1907	Not yet
Kentucky	Yes—all R.N.		1914	1978
Louisiana	Yes—N.P.	Yes—N.P.	1912	1976
Maryland	Yes—N.P.	Yes—N.P.	1904	1974
Mississippi	Yes—N.P.	Yes—N.P. Protocol	1914	1976
North Carolina	Yes—M.D. supervision	Yes—M.D. supervision	1903	1973
South Carolina	Yes—all R.N.	Yes—N.P. Protocol	1910	1975
Tennessee	Yes in regs. No in law	Yes in regs. Protocol	1911	1972
Virginia	Yes—N.P. Medical pract act	Yes—N.P.	1903	1975—regs.
West Virginia	Not prohibited	No	1907	Not yet
		Western States		
Alaska	Yes—N.P.	Yes—N.P.	1941	1974
Arizona	Yes—all R.N.	Yes—N.P.	1921	1973
California	Yes—all R.N.	Yes—Protocol	1905	1974
Colorado	Yes—all R.N.	Yes—Nursing	1905	1974
Hawaii*	No—if Medical	No—if Medical	1917	Not yet
Idaho	Yes—N.P.	Yes—N.P. Practice Policies	1911	1971 1977—regs.

(continued)

Figure 2 continued

State	Diagnosis Allowed?	Treatment Allowed?	First R.N. Act	Expanded Role Recognized
Montana‡	Not prohibited	No	1913	1976
Nevada	Yes—all R.N.	Yes—N.P.	1923	1973
New Mexico	Yes—N.P.	Yes—N.P. Protocol	1923	1975
Oregon	Yes—N.P.	Yes—N.P.	1911	1973
Texas	No	No	1909	Not yet
Utah	Yes—all R.N.	Yes—all R.N.	1917	1975
Washington	Yes—all R.N.	Yes—A.R.N. S.R.N.	1909	1973
Wyoming	Yes—all R.N.	Yes—N.P.	1909	1975

*Although the Delaware law forbids diagnosis by nurses, the Board of Nursing has issued a 1978 statement recognizing Advanced Nurse Practitioners who hold certification from the American College of Nurse Midwives, the ANA, or the NAPNAP.
†Oklahoma board indicates law allows N.P. but statute sounds negative.
‡Board states that N.P. can practice.
Dates of the original nurse registration acts are from American Nursing Association, Facts about Nursing, 69-71 (1977); other data is from the statutes.

Source—Bullough, B. The Law and the Expanding Nursing Role. New York: Appleton-Century-Crafts, 1980, 52-54.

This civil law defines and determines the rights of individuals in protecting their person or property (Ross, 1981, p. 2). The legal process is the procedure through which a person with a claim can institute an action in a court of law (Ross, 1981, p. 10). These actions can be decided by statutory law, a body of legislative enactments, or through common law, an accumulated and organized body of previous court decisions, divided into categories according to subject matter and used as precedent for decisions (Ross, 1981, p. 5; Mannio, 1981, p. 2).

The driving force in American jurisprudence is this common law, under which equity must be obtained. This means that while it is the function of the governors of a society to suggest and pass laws that will provide justice for the people, it is for the courts to interpret these laws and apply them with equity (Guenther, 1978, p. 25). The actions of common law include the recovering of money damages for breach of contract or for a tort or recovery of possessions of real or personal property (Hyatt, 1972, p. 6).

A tort is a civil wrong, an invasion of any private and personal right which each of us have by virtue of the federal and state laws and the

constitution. The person responsible for a tort is any person who violates these rights of another. The only exception to this responsibility is if a peace official or public official who in their official capacity and in performance of their duty violates a personal right of a private citizen. This person may be absolved of liability if it was an act necessary for the public safety or welfare (Ross, 1981, pp. 200-202).

One type of tort is negligence. This is based on an existing duty to use proper care and diligence in a certain situation (Ross, 1981, p. 215). There are four elements of negligence: there must be a standard of due care under the circumstances; there must be a failure to meet the standard of due care; there must be the foreseeability of harm from failure to meet the standard; and there must be evidence that the breach of this standard proximately caused the injury (Streiff, 1975, p. 4). This negligence can be an act of omission or commission, but there is no liability if no injury occurs or if there was no deviation from the standard of care (Cazalas, 1978, pp. 18-19).

Malpractice is negligence in the performance of a professional act (Quimby, 1979, p. 13). It is associated with any professional misconduct,

unreasonable lack of skill or fidelity in professional or fiduciary duties, or illegal or immoral conduct (Morris, W., 1981, p. 110). A malpractice claim can be filed against any person who holds himself out to the public as a member of a profession, qualified to render services as required in a skillful and competent manner. The plaintiff must prove that he retained the defendant to perform the professional services, and that this employment was accepted, and that he suffered damages or injury through these acts either because the professional did not use reasonable care in exercising his skill and learning or because he did not possess the necessary experience or learning (Ross, 1981, p. 222).

A medical injury is the result of an untoward event arising during the course of medical care. This includes losses resulting from negligence as well as unavoidable complications (Beyond Malpractice, 1978, p. 2).

Accountability

Who then is accountable for this negligence? The fundamental principle of American jurisprudence is that the individual who performs an act in a negligent manner or who negligently fails to perform

an act must compensate the injured victim by payment of damages. The perpetrator of the negligent act is personally liable, and no other doctrine affects this personal liability of the practitioner. In spite of this, it is an established practice for the liability of one person to be imposed on another if a certain relationship exists between the two. This doctrine, called respondeat superior, has been used in courts of law for many years (Kucera, April 1980, p. 162). This doctrine imputes the negligence of an employee onto the employer if the negligent act was within the scope of his employment (Ross, 1981, p. 217). This is an example of vicarious liability, which imposes the liability onto a person who has not performed the negligent act. Employers, with very few exceptions, are always liable for the injuries caused by the negligent acts of employees (Holder, 1975, p. 200). It must be proven that the employer has the right to control the conduct of the employee in the performance of duties. This doctrine does not absolve the employee of liability, but only includes the employer in a shared liability (Streiff, 1975, p. 63).

The first expansion of respondeat superior was the "borrowed servant" doctrine. This stated that the services of an employee can be loaned to a third person, for a temporary period of time, for the

performance of specified tasks and/or functions (Kucera, April 1980, p. 163). Almost all states uphold that the loaned servant is in the control of the borrowing employer. The application of the borrowed servant doctrine for hospital employees is based on the "captain of the ship" concept, which states that while in the operating room, the surgeon is responsible for everything that happens (Streiff, 1975, p. 65).

Although these doctrines of liability sound straight forward, the states all seem to differ in their approach to liability (Kucera, 1978, p. 162). It is well established that each individual is liable for his/her actions. What seems more difficult to establish is who, if anyone, is liable with the individual performing the negligent act?

The problem is in what constitutes control (Kucera, April 1980, p. 163). According to one source, to establish control, the court looks to whether or not the master can hire, fire, determine salary, pay it, and set forth working hours. If this control is established, it matters not if the control was exercised (Quimby, 1979, p. 108). And from another source, the true test of borrowed servant is whether the master is actively exercising

supervision and control (Medico-Legal Implications, 1978, p. 385).

One of the earliest applications of this doctrine was in 1945 in California. In this case, an injury occurred to the patient due to poor positioning during surgery. The surgeon was ultimately found guilty under the captain of the ship concept (Yberra v Spanquad, 154 P. 2d 687). Another case upholding the captain of the ship was in Pennsylvania in 1949. The surgeon was liable for acts committed by an intern (McCounel v Williams, 65 A 2d 243).

To further illustrate the apparent confusion, as far back as 1936 in Halligan v Prindle et al (Halligan v Prindle et al, 62 P. 1075) the physician was held not liable for a nurse who was not his employee when he had no knowledge of her carelessness and the lack of care was not apparent to him.

Another confusing aspect to the liability issue is charitable immunity of hospitals. Charitable immunity was first applied 100 years ago in Massachusettes to protect hospitals and other charitable institutions from law suits which might diminish their assets (Warren, 1978, p. 9). Although many states have now abolished this immunity of hospitals from suits, in 1959 this doctrine was affirmed in Arkansas (Hilton v Sisters of Mercy of

St. Josephs Hospital, 351 S.W. 2d 129). But to contradict this ruling, in Bing v Thornig (Bing v Thornig, 143 N.E. 2d 3), the hospital was liable for the actions of its employees.

The general rule now is that a hospital is not liable for carelessness of nurses in the care of the patient when she is carrying out the orders of a physician (Hyatt, 1971, p. 328). The hospital must show it used due care in the selection of nurses, which is very difficult to do since it is sometimes very hard to assess the educational experience of nurse. If the nurse met all hospital requirements for employment and is then negligent in performing ordinary duties, the hospital is liable for the nurse's actions (Hyatt, 1972, p. 646). The physician, on the other hand, has the right to assume that the nurse employed by the hospital is competent (Hyatt, 1972, p. 741). In a case as far back as 1916, the surgeon was not liable for a nurse's acts since he was unaware of her lack of experience and skill and was not required to instruct her in her ordinary duties (Morrison v Henke, 160 N.W. 173).

One can easily see by the cited cases that confusion exists in the area of liability. There are many more cases that can be cited to show

accountability in the medical field. The legal concept of imputed negligence is in the process of evolution and while confusion still prevails, certain trends are forthcoming (Kucera, April 1980, p. 162). The nurse anesthetist, like all professionals, share an individual obligation with regards to his or her actions in the course of rendering health care. He/She is obligated to care as best as possible and cannot merely follow the orders of the physician without being liable. This nurse anesthetist must question orders which appear unclear or erroneous and must seek a second opinion if agreement cannot be reached with the physician (Kucera, 1978, pp. 630-632).

In 1965 in Texas, a surgeon was found not liable for a nurse anesthetist under respondeat superior because he did not order the anesthesia which was used, but he was found liable under the captain of the ship concept (McKinley v Tromley, 386 S.W. 2d 564). In yet another case, Sessel v Muhlenberg Hospital (Sessel v Muhlenberg Hospital, 306 A. 2d 474), the surgeon was not liable for the nurse anesthetist because the surgeon cannot hire or fire or establish policies for the nurse anesthetists.

The nurse anesthetist may be found by the court to be an independent contractor. If qualified in accordance with the American Association of Nurse

Anesthetists, he/she may be far more knowledgeable than the surgeon and thus be considered an independent contractor since physician control is lacking (Cozales, 1978, p. 104).

Judicially, a nurse is defined as a "person trained to take care of the sick, aged, wounded or injured and to assist a physician or surgeon, sometimes acting in the capacity of an independent contractor and at other times as an employee" (Morris, W., 1981, p. 110).

Since anesthesia involves the diagnosis and treatment of a patient, it is the practice of medicine and must be done under the supervision of the physician. More and more the courts are recognizing that the nurse anesthetist is more knowledgeable about the anesthesia than the physician. This leaves a dichotomy—if the surgeon is not liable, is the nurse anesthetist practicing medicine or is anesthesia not the practice of medicine (Dornette, 1972, p. 421)?

> Since administration of anesthetics is an area of great physical danger to the patient and an area of legal danger to the nurse, the nurse should be particularily conversant with the nursing law of her own state with respect to the administration of anesthetics, and when she does have authority, she should do so only under the supervision of a physician. The courts will then decide who is liable (Sarner, 1968, p. 9).

Figure 3, page 35, shows the typical legal relationships of the nurse anesthetist employed by a hospital.

Insurance

It is an accepted fact that malpractice and negligence exists. By 1975, malpractice had reached almost epidemic proprotions (Kittrie, 1975, p. 26). More than 7 out of 100 who are admitted to a hospital can expect to be injured by the treatment they receive and 29% of all these accidents are caused by negligence (Guenther, 1978, p. 26).

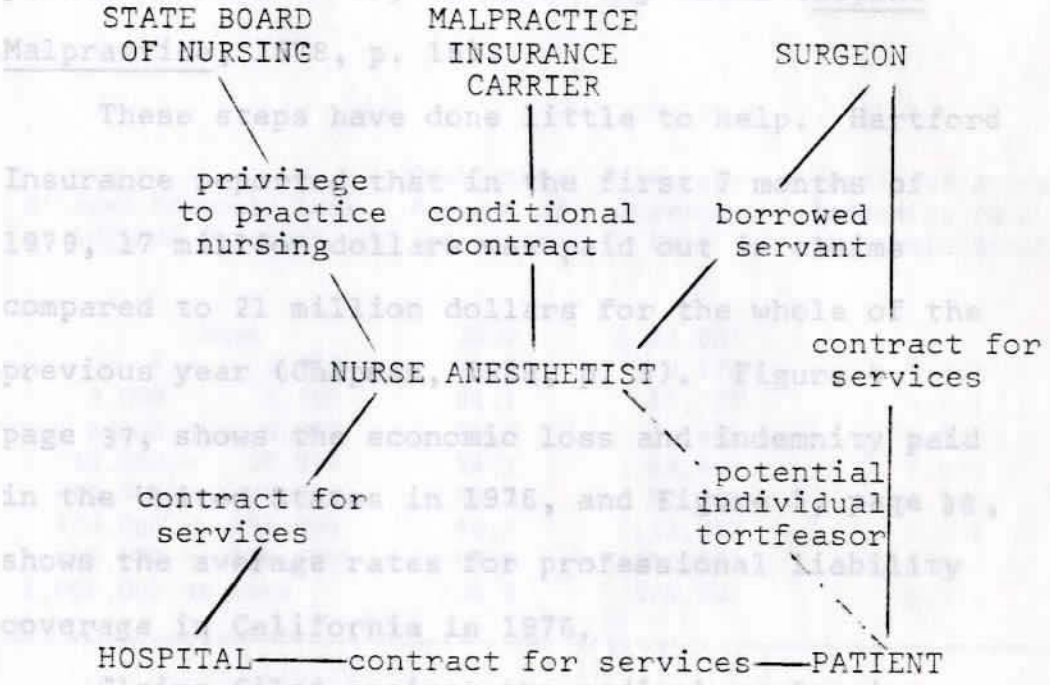
In 1960, the total malpractice premiums equalled 60 million dollars (Medical Malpractice, 1977, p. 19). By 1970, these premiums had risen to 370 million (Jacobs, 1978, p. 373). These rates equalled approximately a 550% increase and accounted for 7738 claims filed, which was an increase of 75% from the previous four years (Lipson, 1976, p. 1; Appendix Report, 1973, p. 610).

It was during the middle 1970's that the malpractice crisis reached its peak. At no time in the history of the United States had state legislatures moved with such unanimity or with greater rapidity than they did to confront the malpractice problems. Between 1974 and 1976, every state in the union had passed a malpractice law, but most were ambiguous in

Figure 3

WHO'S LIABLE?

TYPICAL LEGAL RELATIONSHIPS OF THE NURSE ANESTHETIST EMPLOYED BY THE HOSPITAL



Typically the nurse anesthetist is employed by the hospital. Yet, in most situations, she becomes the borrowed servant of the surgeon when the doors of the operating room close and the operation commences. As in the case of the physician, the nurse anesthetist must obtain a license to practice (nursing) from an agency of the state government. She has contracts for services with the hospital and for malpractice insurance with an insurance carrier. Her relationship with the patients to whom she gives anesthetic agents is an indirect one only, unless of course she commits a negligent act which injures the patient.

Source—Bullough, B. The Law and the Expanding Nursing Role. New York: Appleton-Century-Craft, 1980, 422.

nature (Guenther, 1978, p. 233). Screening panels and review boards were established (Legal Side of Medicine Report, April 1979, p. 1). Defensive medicine appeared with physicians ordering all possible tests to try to stall any suits (Beyond Malpractice, 1978, p. 16).

These steps have done little to help. Hartford Insurance reported that in the first 7 months of 1979, 17 million dollars was paid out in claims compared to 21 million dollars for the whole of the previous year (Chapman, 1980, p. 9). Figure 4, page 37, shows the economic loss and indemnity paid in the United States in 1976, and Figure 5, page 38, shows the average rates for professional liability coverage in California in 1976.

Claims filed against the medical profession continue to rise and insurance costs spiral. In spite of this, the malpractice suit performs two important functions: It deters the physician from lax, careless or negligent behavior; and it compensates the patient as a consequence of the negligence of hospital, physician, or ancillary health care personnel (Medical Malpractice, 1977, p. 1).

Unfortunately, the compensation is not equal. If it were, it would be less of a concern. The unequal distribution of claims makes it difficult to

Figure 4

Economic Loss and Indemnity Paid

Alleged Economic Loss of Injured Persons*	Cumulative Percent of Incidents	Average Indemnity Paid	Ratio of Average Indemnity Paid to Economic Loss**
None	38.0	$ 22,001	
1 - 2,999	71.1	8,177	5.5:1
3,000 - 5,999	81.1	18,325	4.1:1
6,000 - 9,999	86.0	30,641	3.8:1
10,000 - 39,999	94.2	48,443	1.9:1
40,000 - 99,999	96.3	81,015	1.2:1
100,000 - 499,999	99.5	153,857	0.5:1
500,000 - 999,999	99.9	271,517	0.4:1
1,000,000 or more	100.0	474,297	0.5:1

Source: NAIC Malpractice Claims, data obtained from Table 25a, p 103

*Includes medical expense, unspecified "other" expense, and loss of wages; these figures represent both current losses as well as anticipated future losses

**This was computed using the average indemnity paid and the midpoint of the range of economic loss

Source—Beyond Malpractice: Compensation for Medical Injuries. Washington, D.C.: National Academy of Sciences, 1978, 15.

AVERAGE RATES FOR $1 MILLION/$3 MILLION PROFESSIONAL LIABILITY COVERAGE IN THE SOCAP AREA

(In dollars)

Class	Description	Hartford, 1972	Travelers, Jan. 1, 74-Jan. 1, 75	Travelers (proposed), Ju. 1, 75	Travelers (proposed), Jan. 1, 76	Travelers (actual), Jan. 1, 76	SCPIE,[a] Jan. 1, 76
I	Allergy, neurology (without electric shock), pediatrics	872	720	1,735	4,306	3,080	2,120
II	Diagnostic radiology (without angiography), gastroenterology, general practice (no surgery), internal medicine		1,296	3,123	7,783	5,544	3,840
III	Diagnostic radiology (with angiography), ophthalmology, pulmonary diseases	1,763	2,164	5,215	12,972	9,252	6,440
IV	Dermatology (including radiology), therapeutic radiology	1,516-2,179	2,824	6,806	16,946	12,076	8,400
V	General practice with surgery, otolaryngology (except plastic surgery)	2,274	3,724	8,975	21,404	15,924	10,680
VI	Colon and rectal surgery, otolaryngology (including plastic surgery), urology	3,051	4,740	11,423	27,241	20,268	13,560
VII	Anesthesiology, emergency medicine, general surgery, nurse anesthesiology	3,051	5,356	12,908	30,708	22,904	15,320
VIII	Obstetrics, gynecology, neurosurgery, thoracic surgery	3,355	6,304	15,193	36,239	26,956	18,080

SOURCE: Data supplied by the California Medical Association (updated).

NOTE: The area covered by the SOCAP group insurance plan consists of San Luis Obispo, Santa Barbara, Ventura, Kern, Los Angeles, San Bernardino, and Orange counties.

[a]Includes contribution plus premium for claims-made policy. After the first year, the contribution is eliminated and the full amount is the premium (same total).

Source—Lipson, A. J. Medical Malpractice: The Response of Physicians to Premium Increases in California. California: Rand, 1976, 104.

Figure 5

plan for the settlements. This has resulted in large losses for the carriers in the last few years with resultant increases in premiums to the health care provider, and therefore, increased costs to the patient (Koscieszа, November 1980, pp. 1-3).

In a recent study done by the Department of Health, Education, and Welfare on all claims over $1500, it was shown that 70% of all anesthesia injuries resulted in permanent disability or death (Althouse, February 1980, p. 60). Also of interest is the fact that in 1/10,000 anesthesia cases something will go wrong without any negligence (Guenther, 1978, p. 67).

The nurse anesthetist, as well as all health care providers, must remember that anything that is done can result in a lawsuit if something goes wrong. These professionals, as a first rule, must give good health care (AANA Annual Meeting, Tape 1981).

CHAPTER 3

THEORETICAL ORIENTATION

Should the surgeon be legally liable for the actions of the nurse anesthetist, or should the nurse anesthetist stand alone in defense of his/her own actions? At this time, according to the previously cited literature review, the surgeon, the hospital, and the nurse anesthetist can all be liable for the negligent acts of the nurse anesthetist. The surgeon can be held liable as the captain of the ship or as the master of the borrowed servant (McKinley v Tromly 386 S.W. 2d 564). The hospital can be held accountable under respondeat superior (Kucera, 1980, p. 162). The nurse anesthetist, of course, is liable since every professional bears accountability for his/her own negligent acts. No other legal doctrine can remove this liability from the person performing the negligent acts if the acts are within his/her skill level (Kucera, April 1980, p. 162).

The problem posed by this is that the surgeon may resent this accountability feeling he/she is not qualified to assume control and direction of the anesthesia. This could result in the decreased use of Certified Registered Nurse Anesthetists as

a source of anesthesia.

When the doctrines of respondeat superior and captain of the ship were first used, anesthesia was in its infancy, and surgeons often taught the nurse how to administer the drugs (Bakutis, 1953, p. 8). Now the Certified Registered Nurse Anesthetists are highly trained and educated nurses who have completed a two year post basic nursing course in anesthesia with a certain minimum number of cases in each speciality. He/She has had a heavy class load of anesthetic agents, anatomy and physiology of the various systems of the body, and has passed a national qualifying examination (Council on Accreditation, 1980, p. 16). This is the person in the operating room suite who knows the anesthesia. It is not the surgeon.

The borrowed servant concept of respondeat superior states that the master must direct or control, or must at least have the authority to direct and control, the servant (Kucera, April 1980, p. 163). By law, the surgeon has the authority to do this with the Certified Registered Nurse Anesthetist, but through my own experience, I know he/she usually does not. Many surgeons might have some anesthesia experience, but at best, this is usually a resident rotation lasting between one and six months. What

is learned during this period is more of the life saving techniques for maintenance of a patent airway. I do not feel that this physician, although probably very adept at surgery, could possibly be able to direct or control the actions of the Certified Registered Nurse Anesthetist. Another reason is that the surgeon is probably too busy doing the surgery to be bothered with the anesthetic problems. Most Certified Registered Nurse Anesthetists do keep the surgeon informed, and will ask for advice when needed, but never have I observed any nurse anesthetist ask a surgeon which anesthetic agent to use. The surgeon, I'm sure, would look bewildered and suggest that the nurse anesthetist handle it.

This leads the author back to the same problem: What will happen if this liability remains on the surgeon? I believe the use of nurse anesthetists will decrease. In most large health care institutions, there are both physician anesthetists, called anesthesiologists, and nurse anesthetists on the anesthesia staff. The surgeon usually has the option to choose physician anesthesia if he so chooses. Many times the condition of the patient or the type of case influences this choice. If a patient is particularly ill and in poor physical condition, the chance of complications

is greater. Also, some operative procedures, for instance neurosurgery and open heart surgery, have more risks associated with them. It is on these cases the surgeon must think of the chance of litigation. It certainly seems appropriate that the surgeon would want to free himself of as much liability as possible. If a physician anesthetist is administering the anesthetic, this person can assume his own liability, and therefore, the surgeon will not be accountable for anesthetic mishaps (Jacobs, 1978, p. 179).

The problem arises due to the definition of the practice of medicine and what constitutes the nursing scope of practice. Referring to the three directions cited for revising nurse practice acts, one can see that those states with more liberal scopes of practice give their nurse anesthetists more legal ground on which to work. Those states without these definitions put their nurse practitioners, especially nurse anesthetists, in a "legal limbo". Since the practice of medicine is basically defined as the diagnosis and treatment of symptoms, anesthesia administration would constitute this. But nurses cannot practice medicine. They can only follow a physician's direct order. Therefore, the physician must be liable (Hyatt, 1972, p. 734).

I believe that the first step must be uniform nurse practice acts listing specifically each nurse practitioner and the scope of practice. If this legal authority is given, maybe the courts will see fit to unburden the surgeon of this added liability.

I will attempt to prove that most surgeons do not feel that they should be liable for the nurse anesthetist, that they are not qualified to direct and control the anesthesia, that the Certified Registered Nurse Anesthetist is better qualified educationally than they are, and that this imputed liability does influence their choice of who administers the anesthetic. I believe that as long as there is the possibility that the person giving the anesthetic has been chosen by any method other than his/her ability, the best interests of the patient have not been served.

CHAPTER 4

RESEARCH METHODS

Through my research I want to prove that those people most closely associated with the nurse anesthetist, the surgeon and the anesthesiologist, feel that the nurse anesthetist should be individually liable for his/her own actions and that failure to do so could result in decreased use of the Certified Registered Nurse Anesthetist.

The first method of research that I will use is content analysis. This refers to a technique of systematic examination of secondary data and consists of isolation of units or indicators of phenomena in which I am interested (Forcese,1973, p. 186). The steps include defining the phenomena and the units of investigation which should lead to specification of the operational indicator of these categories. Indicators must be identified so they can be counted. The most preferable indicators are words (Forcese, 1973, p. 186).

The advantages of content analysis are: it provides a systematic examination of usually biased material; and it guards against inadvertent biases.

The disadvantages are: many times the documents selected may not provide the most appropriate reflection of the items under study, and the researcher may not be in a position to determine which source is most representative; and if scoring is done, the scoring methods almost always have an arbitrary element which must be eliminated to be effective (Babbie, 1973, p.35). I will use the content analysis method of research in law cases, periodicals, government documents, and insurance claim reports. In the law cases, my indicators will be the words—nurse anesthetist; respondeat superior; captain of the ship; and borrowed servant. I do not plan to score the items analyzed, but rather, determine the direction the law is turning in relation to the indicator words.

The second method of research that I will use is examination of existing data. This method offers me the possibility of making certain assumptions by collecting information from already existing data. The great advantage of this method is economy. There is no cost to the researcher. There are two important disadvantages though. The first is that the method is limited to data already researched, which may not adequately represent all the variables of interest. The second disadvantage is that this method involves ecological fallacy, which means it is very difficult

to determine the relationship between the variables (Babbie, 1973, p. 35). In an effort to eliminate some of these problems, I will limit my research to laws and law cases which are stated as fact, without anyone's interpretation, and I will use insurance reports which are not published by insurance companies. In this way, I will not have to determine what is fact and what is the author's biases.

The next method of research I will use is a survey. Survey research has three objectives: description, which is used to make a descriptive assertion about some population; explanation, which may make explanatory assertion; and exploration, which is used as a search into a particular topic (Babbie, 1973, pp. 57-59).

A survey can be used to study anything that a researcher chooses. Whatever it is that is being studied is called the unit of analysis and should always be described in advance so that the sample design and data collection methods do not prohibit the appropriate analysis (Babbie, 1973, pp. 60-61). In my survey, I will have three units of analyses: surgeons, anesthesiologists, and Certified Registered Nurse Anesthetists.

I will use two of the basic survey designs. The first is the cross sectional survey. In this method, data is collected at one point in time from a sample of the larger group (Babbie, 1973, p. 62). This cross sectional survey will be done with parallel types. This means that three groups will be researched so that I might compare the results (Babbie, 1973, p. 66). They are parallel in the fact that they all have some responsibility for the patient during a surgical procedure.

I will also use a trend study, which is a longitudinal survey. This type of research is done by researching a population over a period of time (Babbie, 1973, p. 63). I will do research on court decisions and insurance settlements and compare them over time to see how they have changed. I will also review the trend of nurse anesthetist population to see if their ranks are growing.

Before taking a survey, the population sample must be picked. A sample is picked because it is more economical and less time consuming than surveying the whole population (Babbie, 1973, p. 73). The essence of sampling is the selection of a part from the whole in order to make inferences about the whole. The success of any sample lies in its accuracy in

reflecting the state of affairs of the whole population (Forcese, 1973, pp. 121-122). There are two basic types of sampling: probability and nonprobability (Babbie, 1973, p. 76). I will use probability sampling, which is a method in which every member in the population has a known probability of being selected. It will be a random sample, meaning that each individual in the population has an equal chance of being selected in the sample (Forcese, 1973, p. 123). Although this sample will not be perfectly representative, it is more representative than other types because biases are removed, and I will be able to estimate the accuracy of my sample (Babbie, 1973, p. 78).

My population will be the Missouri organizations of the three groups mentioned—anesthesiologists, surgeons, and Certified Registered Nurse Anesthetists. To be more accurate with my populations, I will use the members of the Missouri College of Surgeons, the members of the Missouri Chapter of the American Society of Anesthesiologists, and the members of the Missouri Association of Nurse Anesthetists. I will obtain a printed membership list, listing each member alphabetically, from which to pick my sample. I will use a systematic sampling method in which every kth element is picked for the sample. To prevent any biases on

my part, I will pick the first name at random. This is called a systematic sample with a random start (Babbie, 1973, p. 92). The one danger in this method is that the list might be arranged in a cyclical pattern which could make it impossible to get a random sample (Babbie, 1973, p. 93). I will, therefore, examine each list to make sure this does not occur. I will choose a number from 1-10 from a hat and that number will be the random starting name on each list. I will survey 10% of each population so every 10th name after the random number will be chosen. The actual number of questionnaires sent will be 23 to the Missouri Chapter of the American Society of Anesthesiologists, 46 to the Missouri College of Surgeons, and 57 to the Missouri Association of Nurse Anesthetists.

The construction of a self-administered questionnaire is very important to its success. The questions can be either open ended, unstructured, or close ended, structured. In the close ended questions, all possible answers are given for the respondent to choose from. These type of questions provide for greater uniformity of responses, and make it easier to process (Babbie, 1973, p. 140).

The chief shortcoming of closed ended questions is that the responses offered may not cover all answers. The researcher must always remember to allow for all possible answers, and the answers should be such that the respondent can choose only one answer (Babbie, 1973, p. 141). I will use a structured question with only two possible answers—yes or no. The questions should be clear, without double barreled meanings, and short and relevant, without negative or biased terms (Babbie, 1973, pp. 143-144).

The general format of the questionnaire is also relevant. It should start with an introductory statement and clear concise instructions for completing it (Babbie, 1973, p. 150). The questions should appear uncluttered and should be ordered since the appearance of one question can affect the answers to subsequent ones (Babbie, 1973, p. 147). Like categories should be grouped together. Efforts should be made to keep questions short and limited to high quality data. Each question should be able to be justified as to relevance to the concept the researcher is interested in obtaining. Questionnaires that take longer than 30 minutes to complete will cause many people to lose interest (Forcese, 1973, p. 164). The most interesting question should be used first. This

makes the respondent want to answer the question (Babbie, 1973, p. 150).

To aid in receiving a good response, self-addressed, stamped envelopes should be included. The longer the respondent delays in returning the questionnaire, the less likely he is to return it. The acceptable return rate is 50%. Anything above this is very good (Babbie, 1973, pp. 160-165).

It is important that the questionnaire is reliable and valid. Reliability refers to the extent to which a study can be duplicated by another researcher. The easier it is for a second researcher to get the same results, the more reliable is the study. Validity refers to the extent to which the questions really measure what one thinks they do. Both of these can be measured by the use of a pretest (Forcese, 1973, pp. 165-166).

A pretest is an initial test of one or more aspects of the study design, administered to a small group of subjects (Babbie, 1973, p. 205). After the administration, the questions should be checked for clarity, inability to answer, multiple answers, qualified answers, and direct comments (Babbie, 1973, p. 214). I will administer a pretest to a small group of each classification of populations.

CHAPTER 5

RESEARCH FINDINGS

During my content analysis and review of existing data, I found decisions reflecting various opinions. As far back as 1909 in the United Kingdom, the court considered it impossible that the administrator of anesthetics could be a servant as he was a professional, employed by the hospital to exercise his profession to the best of his ability according to his own discretion. In exercising it, he was considered in no way under or bound to obey the directions of the hospital (Hellyer v St. Bartholomew, 2 K.B. 820).

The Americans did not agree with this entirely. In this country, the nurse anesthetist is considered a nurse practitioner and requires a degree of supervision by a physician, although the amount of supervision and control varies from state to state (Cazalas, 1978, p. 105). In all cases that I researched, the nurse anesthetist was never liable alone.

As stated earlier, in a case in 1936 in California, the physician was found not responsible for the actions of a nurse who was not his employee since he had no

knowledge of her carelessness and had no connection with the event that caused the injury (Hallinan v Prindle et al, 62 P. 1075).

In 1948 in Clay v Christiansen (Clay v Christiansen, 83 N.E. 2d 644), the surgeon was acquitted of liability for burns a patient suffered from the cautery which the scrub nurse had set up; and in 1950 in California, a surgeon was held not liable for the death of a child during anesthesia, because the nurse anesthetist was an employee of the hospital and not the surgeon (Cavero v Franklin General Hospital, 223 P. 2d 471).

Again in 1954, a surgeon was acquitted of liability for the actions of the nurse anesthetist on several grounds. The nurse anesthetist was the agent of either the hospital or the surgeon. Since the surgeon did not know who would be assigned, and since he had not hired her, and had no knowledge of her capabilities, he was not considered in control (Kemalyen v Henderson, 277 P. 2d 372). New York confirmed this ruling in the same year when the hospital had to assume liability (Bing v Thornig, 143 N.E. 2d 3).

Some of the more recent cases in which the surgeon was freed of liability include a suit against

the hospital and surgeon for an injury resulting from an injection given by a nurse. The court states that the surgeon is not liable for negligence of hospital nurses, attendants, or interns who are not his employees unless: They perform work or duties for him under his supervision and control; he is negligent in permitting her to attend the patient; or the negligent acts were performed under conditions where, in the exercise of ordinary care, he could or should have been able to prevent those injurious effects and did not do so (Burns v Owens, 459 S.W. 2d 303). In 1973, a case involving a nurse anesthetist was decided in favor of the surgeon. In this case, action was brought for damages done to the teeth during the intubation. The court ruled that the nurse anesthetist did not become the legal servant or agent of the physician merely because she received instructions from him on work to be done. Since he did not undertake control, he was not liable (Sesselman v Muhlenberg Hospital, 306 A. 2d 474).

One of the most pertinent cases was in 1974 where action was brought against the hospital, the nurse anesthetist, and the surgeon for the wrongful death of a person who died from lack of oxygen after surgery. The arguement for the surgeon was that before being a borrowed servant, an employee must be

loaned with his consent and must become wholly subject to control and direction of the second employer and be free from the control of the first employer. Since the personnel of the hospital and their abilities are not known by the surgeon, he has no voice in the selection of the personnel, and he has his own responsibility, he should not be liable (Foster v Englewood, 313 N.E. 2d 255).

On the other side of the issue are various cases where the surgeon was found liable. In 1942, the surgeon was found liable for the acts of a subordinate on the basis of the captain of the ship concept (St. Paul-Mercury Indemnity Company v St. Joseph Hospital, 4 N.W. 2d 637). In 1952 and 1956, this was upheld with a nurse anesthetist. The surgeon was liable because "he usually directs the types and methods used" (Jackson v Joyner, 725 S.E. 2d 589; Swigerd v City of Ortonville, 75 N.W. 2d 217). In 1965, a suit was filed against the surgeon for alledged malpractice for negligence by the nurse anesthetist in the administration of the anesthetic for a nine year old boy. The first verdict was in favor of the defendant, but upon appeal, the court held that although the nurse anesthetist was an employee of the hospital, she was at that time under the control of the surgeon who was the captain

of the ship. The rationale was that anesthesia was the practice of medicine, and therefore, a physician had to be directing the nurse anesthetist. The surgeon was not liable under respondeat superior, but under the captain of the ship concept (McKinley v Tromley, 386 S.W. 2d 564).

In 1969 in Virginia, the courts ruled that the nurse anesthetist could be the borrowed servant of the surgeon if he selected the kind of anesthetic to be administered and told the nurse anesthetist when to start (Whitfield v Whittaker Memorial Hospital, 169 S.E. 2d 563).

In 1965 and 1974, as Texas and Illinois retreated from the captain of the ship, other states adopted compromise theories requiring demonstration of control and at least a negligent act or omission on the part of the surgeon in the supervision of his assistants. This implies that the surgeon with the nurse anesthetist will not be held liable simply because of his presence, but rather only for his failure to control when control is required (Kucera, April 1980, p. 164). The nurse anesthetist, like every professional, is obligated to care to the best possible extent and should try to be in agreement with the surgeon (Kucera, 1978, p. 630). If the nurse

anesthetist must carry out orders that are contrary to good care, objections must be noted in the chart after getting a second opinion (Kucera, 1978, p. 630). The nurse anesthetist is legally liable for the adequacy of his/her own performance of both the nursing functions and the medical delegated functions, and may be found by a court to be an independent contractor if qualified in accordance with standards of the American Association of Nurse Anesthetists since surgeon control would be lacking (Council on Accreditation, 1980, p. 1; Cazalas, 1978, p. 104).

My research into the insurance industry showed that the cost of insurance and the number of claims have risen dramatically in the last 20 years. In 1968, 50 cents of the insurance dollar went for determining fault and 27 cents went to the injured person (Kittrie, 1975, p. 27). By 1975, according to a United States subcommittee on health, 25% of insurance dollars were spent on advertising, 33% returned to the patient, and 50% of this going to the lawyer (Jacobs, 1978, p. 53). The National Association of Insurance Commissioners reported in 1978, a 28% jump in claims between 1976 and 1978, and for the 20 months ending in April of 1978, the average cost of a closed claim was $34,081, which was up 38% from the previous two year period (Chapman,

1980, pp. 8-12). The average defense cost is also up by about 73% (Kosciesza, November 1980, p. 2).

In 1977, the California Medical Association sponsored a study on medical insurance feasibility. They found that 80% of the total injuries were temporary; 6.5% were minor permanent; 3.8% were major permanent; and 9.7% were fatal (Jacobs, 1978, p. 373). The total claims settled in court between 1975-1976 were 4557 and were settled for $23,912,773 with the average claim being $5,247. Of these claims, 2294 were against physicians, and 1981 were against hospitals. The average anesthesia settlement in 1975 was $92,686 with a total of $24,747,100 paid for 267 claims (Jacobs, 1978, p. 378).

During 1976, doctors and hospitals paid 1.5 billion and 1.75 billion respectively for malpractice insurance premiums with the average malpractice premium per doctor of 6% of their average gross income, equalling a cost per patient of $7/year (Guenther, 1978, p. 22).

This increase number of claims has caused several things to happen: there has been a decreased number of applicants to medical schools; there has been a decreased number of physicians who specialize in high risk specialities; there has been a migration

of physicians from areas in counties with high premiums to those with low premiums; there has been a decreased number of part time physicians; there has been a decrease in the performance of surgery; there has been an increase in the cost of care; there has been a decrease in the number of young physicians who go directly from training into solo fee for service practice; and there has been an increase in physician slow downs or strikes (Medical Malpractice, 1977, p. 32).

It has been found that 4% of all operation connected deaths related to the administration of anesthesia, and 2/3 of these were preventable (Supply, Need, and Distribution, 1980, p. 1). Most cases against anesthesia personnel are either little ones, like tooth damage or other things associated with intubation, or large ones, like brain death or death (AANA Annual Meeting, 1981).

In 1972, there were 11,853 physician anesthesiologists in the United States. This represented 3.7% of all physicians in the United States. This does not say whether they were board certified. There were 12,162 nurse anesthetists of which 99% were certified. In 1980, there were 18,000 Certified Registered Nurse Anesthetists in the United States (Supply, Need, Distribution, 1980, pp. 2-3).

Before sending the questionnaire, a pretest was done on samples from the three groups. Five of each group were tested to see if the questionnaire was easily understood and if the questions were answerable. There being no apparent problems, I proceeded with the mailed survey.

The questionnaire which was sent consisted of eight questions; seven of which were answerable by yes or no. Figure 6, page 62, is a copy of the questionnaire. Ten percent of the membership lists of the three groups were contacted. The numbers sent were: Missouri Chapter of the American Society of Anesthesiologists—234 members—23 sent; Missouri College of Surgeons—460 members—46 sent; Missouri Association of Nurse Anesthetists—575 members—57 sent. Figure 7, page 63, shows a graph of the daily returns.

The returns from the surgeons totaled 60% or 24 returns; the nurse anesthetists were 63% or 36 returns; and the anesthesiologists were 42.8% or 9 returns. Although, this 42.8% does not constitute a valid majority, the results will be shown here with a discussion later as to why the responses were so few. Figures 8, 9, 10, pages 64-66, show the results of the questionnaires.

Figure 6

Dear Doctor:

I am involved in research for my Master degree thesis. I am researching anesthesia liability. You have been chosen at random to receive this questionnaire. Would you please answer each question by marking an "x" in the appropriate space and then return it in the enclosed self-addressed, stamped envelope. Of course, anonymity is quaranteed. I appreciate your help in this project. Thank you.

Beverly Krause

QUESTIONNAIRE

ANESTHESIA LIABILITY

		yes	no
1.	Should a staff anesthesiologist be held liable for the actions of a Certified Registered Nurse Anesthetist?	( )	( )
2.	Do you feel that you, as captain of the ship, should be liable for the actions of the CRNA?	( )	( )
3.	Do you feel that CRNAs should be individually liable for their own actions?	( )	( )
4.	Do you think that you are knowledgeable enough about current anesthesia practices to be held liable?	( )	( )
5.	Is the CRNA educationally qualified to be accountable for his/her own actions?	( )	( )
6.	Does your liability for CRNAs influence your preference for MDAs vs. CRNAs?	( )	( )
7.	Do you feel the courts are absolving the "Captain of the Ship" doctrine?	( )	( )

8. Who IS liable for a CRNA?
   ( ) CRNA
   ( ) hospital
   ( ) surgeon

Figure 7

RETURNS

October	28	-	mailed
October	29	-	none
October	30	-	3
October	31	-	17
November	1	-	Sunday
November	2	-	8
November	3	-	10
November	4	-	5
November	5	-	3
November	6	-	4
November	7	-	2
November	8	-	Sunday
November	9	-	3
November	10	-	4
November	11	-	Holiday
November	12	-	2
November	13	-	3
November	14	-	1
November	15	-	Sunday
November	16	-	1

Figure 8

CRNA QUESTIONNAIRE RESULTS

Dear CRNA:

I am involved in research for my Master degree thesis. I am researching anesthesia liability. You have been chosen at random to receive this questionnaire. Would you please answer each question by marking an "x" in the appropriate space and then return it in the enclosed self-addressed, stamped envelope. Of course, anonymity is quaranteed. I appreciate your help in this project. Thank you.

Beverly Krause

QUESTIONNAIRE

ANESTHESIA LIABILITY

		yes	no
1.	Should a staff anesthesiologist be held liable for the actions of a Certified Registered Nurse Anesthetist?	(6)	(28)
2.	Do you feel that you, as captain of the ship, should be liable for the actions of the CRNA?	(5)	(30)
3.	Do you feel that CRNAs should be individually liable for their own actions?	(26)	(8)
4.	Do you think that you are knowledgeable enough about current anesthesia practices to be held liable?	(31)	(3)
5.	Is the CRNA educationally qualified to be accountable for his/her own actions?	(7)	(29)
6.	Does your liability for CRNAs influence your preference for MDAs vs. CRNAs?	(25)	(6)
7.	Do you feel the courts are absolving the "Captain of the Ship" doctrine?	(27)	(5)

8. Who IS liable for a CRNA?
   (28) CRNA
   (9) hospital
   (11) surgeon

Figure 9

SURGEON QUESTIONNAIRE RESULTS

Dear Doctor:

I am involved in research for my Master degree thesis. I am researching anesthesia liability. You have been chosen at random to receive this questionnaire. Would you please answer each question by marking an "x" in the appropriate space and then return it in the enclosed self-addressed, stamped envelope. Of course, anonymity is quaranteed. I appreciate your help in this project. Thank you.

Beverly Krause

QUESTIONNAIRE

ANESTHESIA LIABILITY

		yes	no
1.	Should a staff anesthesiologist be held liable for the actions of a Certified Registered Nurse Anesthetist?	(17)	(6)
2.	Do you feel that you, as captain of the ship, should be liable for the actions of the CRNA?	(3)	(20)
3.	Do you feel that CRNAs should be individually liable for their own actions?	(15)	(6)
4.	Do you think that you are knowledgeable enough about current anesthesia practices to be held liable?	(3)	(20)
5.	Is the CRNA educationally qualified to be accountable for his/her own actions?	(17)	(4)
6.	Does your liability for CRNAs influence your preference for MDAs vs. CRNAs?	(7)	(15)
7.	Do you feel the courts are absolving the "Captain of the Ship" doctrine?	(10)	(10)

8. Who IS liable for a CRNA?
   (19) CRNA
   (7) hospital
   (7) surgeon

Figure 10

ANESTHESIOLOGISTS QUESTIONNAIRE RESULTS

Dear Doctor:

I am involved in research for my Master degree thesis. I am researching anesthesia liability. You have been chosen at random to receive this questionnaire. Would you please answer each question by marking an "x" in the appropriate space and then return it in the enclosed self-addressed, stamped envelope. Of course, anonymity is quaranteed. I appreciate your help in this project. Thank you.

Beverly Krause

QUESTIONNAIRE

ANESTHESIA LIABILITY

		yes	no
1.	Should a staff anesthesiologist be held liable for the actions of a Certified Registered Nurse Anesthetist?	(5)	(4)
2.	Do you feel that you, as captain of the ship, should be liable for the actions of the CRNA?	(3)	(6)
3.	Do you feel that CRNAs should be individually liable for their own actions?	(6)	(3)
4.	Do you think that you are knowledgeable enough about current anesthesia practices to be held liable?	(4)	(6)
5.	Is the CRNA educationally qualified to be accountable for his/her own actions?	(1)	(9)
6.	Does your liability for CRNAs influence your preference for MDAs vs. CRNAs?	(7)	(3)
7.	Do you feel the courts are absolving the "Captain of the Ship" doctrine?	(6)	(2)

8. Who IS liable for a CRNA?
   (5) CRNA
   (2) hospital
   (3) surgeon

CHAPTER 6

RESEARCH CONCLUSIONS

It is hard to draw any firm conclusions from my research. The one point that is absolute is that the incidence of malpractice suits has increased in the last 10 years with a resultant increase in malpractice insurance premiums and increase in dollar amounts of settlements. Every field of medicine, including anesthesia, has been affected by this malpractice crisis, and the increased cost has been passed on to the patient with resultant increases in health care costs.

Evaluating the law case judgements is somewhat more difficult. One factor is decidedly clear, and that is that the nurse anesthetist is liable for his/her own actions. There have been decisions both for the surgeon and against the surgeon in relation to his liability for the nurse anesthetist. It seems that the factor in the decisions is whether the surgeon exerts control over the nurse anesthetist. Just because the physician has the authority to control and direct does not mean this control is exercised. If it is not, the nurse anesthetist uses his/her own judgement. Whether this constitutes the practice of

medicine is still undecided. In some states, this is legal under the nurse practice act. In others, it is completely illegal for the nurse to do this.

It appears that many states wish to absolve the surgeon of this added accountability. These are the states which have the expanded role for the nurse practitioner. They are getting away from the captain of the ship concept. These people realize that the education of the nurse anesthetist is such that he/she is much better qualified to handle the anesthesia than is the surgeon.

Most probably, the final decision rests with who has the greatest ability to make monetary restitution. According to J. Lipofsky, Attorney at Law, respondeat superior and the captain of the ship doctrine will always be upheld since nurses in general do not have the same monetary assets available. Mr. Lipofsky says that "...the person with the deepest pocket will always be jointly responsible" (Lipofsky, Lecture, 1981).

The questionnaires results were inconclusive on some points. First, it was interesting to note that both the surgeons and anesthesiologists felt that an anesthesiologist should be liable for the nurse anesthetist, while the nurse anesthetists did not feel

this way. The physicians' responses are probably due to the fact that all those surveyed are from Missouri which does not have an expanded nurse practice act to cover "the practice of medicine" by nurses. The nurse anesthetists' responses are likely to represent their independence. In recent years, there has been much discussion about the independence of the nurse anesthetist. Most nurse anesthetists do not wish to be supervised by an anesthesiologist, and feel if liability was imposed on the anesthesiologists this would imply supervision.

All three groups were in agreement on the question of surgeon liability. They all felt that this was not appropriate.

There was a consensus on the question of nurse anesthetist individual liability. This is a direct contradiction to what the physicians said in the first questions. If they feel that an anesthesiologist should be liable as in question one, how can they say that the nurse anesthetists should be individually liable?

The question on surgeon knowledge of anesthesia was also interesting. The nurse anesthetists thought the surgeons were knowledgeable enough to assume liability, but stated earlier that surgeons should not be liable. The other two groups felt that he was not

knowledgeable enough. I was surprised to find that the nurse anesthetists felt this way. My hypothesis would indicate otherwise. Could this be a reaction to anesthesiologist's supervision? If the surgeon remains liable, the anesthesiologist would not be.

On the question of educational qualifications of the nurse anesthetists, the anesthesiologists felt that the nurse anesthetist was not qualified enough. This was a very predictable response since there has been an ongoing debate between the American Association of Nurse Anesthetists and the American Society of Anesthesiologists concerning the training of nurse anesthetists. The anesthesiologists have questioned the quality of the education and have pushed to get involved in the training of the nurse anesthetist. The surgeons felt just the opposite. Again, this came as no surprise. The surgeon obviously would like to rid himself of the liability. They can hardly say that the nurse anesthetist should be liable, and then say he/she is not qualified. The nurse anesthetists' answers to this question were shocking. Somewhere in Missouri, there are 15% of the Certified Registered Nurse Anesthetists who do not think they are educationally qualified. How can one do a life threatening job that he feels he is not qualified to do?

Question six concerning surgeon preference for who administers the anesthetic came out as expected, except for the surgeon group. It is very hard to interpret this response. From my experience, when a physician who normally uses a nurse anesthetist requests an anesthesiologist, it is usually on an extremely ill patient. In view of the surgeons' answers, I can only assume that this is because the surgeons feel that the physician anesthetist is a better anesthetist and not because of liability. This may or may not be true.

Question seven responses were as anticipated—everyone feels that there is a decreased use of the captain of the ship concept.

Looking at the responses to question eight on who is liable for the nurse anesthetist showed me a number of things. Fourteen percent of the nurse anesthetists did not even know that they were liable for their own actions; 52% thought that they were liable alone; 8% thought the hospital was liable alone; and the rest were a mixture of the nurse anesthetist plus the hospital or surgeon.

Referring to the surgeons' answers, 33% thought they held no liability; 8% thought they alone were liable; and 8% thought only the hospital was liable.

The rest felt that a combination of the three choices were liable.

The anesthesiologists also had a mixture of answers. Eighteen percent thought that only the nurse anesthetists were liable, and 18% thought only the hospital was liable. Obviously, there remains much confusion over liability. Very few people are sure who is liable, even when it is that person himself.

My hypothesis of a decrease in the use of the Certified Registered Nurse Anesthetist if the liability of the surgeon is not removed has not been proven. I do believe that I have shown a decreased use of the captain of the ship concept by the courts with more liability placed on the hospital and the nurse anesthetist.

CHAPTER 7

SUMMARY AND RECOMMENDATIONS

I have tried to prove that there is a need to remove the liability for the nurse anesthetist's actions from the surgeon. I felt that this was essential for the continued use of the nurse anesthetist, feeling that the surgeon would tend to shy away from them, rather than accept liability. I have not proven this with my research, but I feel that this is the result of the research and not due to an incorrect hypothesis.

The anesthesiologists did not respond to the questionnaire in an amount great enough to make it valid. I can only speculate as to why this happened. Maybe the first question threatened them. The first question in any self-administered questionnaire should not be threatening. This might have discouraged them from answering, or maybe liability is something they do not wish to discuss.

To anyone else attempting to research this topic, I would recommend a different approach to the physician. An interview might be more effective since they might feel more obligated to answer. I found

that many people avoid discussing law suits, and information from hospitals is almost impossible to obtain. Thus, it is almost impossible to project what will happen.

I do believe that the Certified Registered Nurse Anesthetists must push for inclusion in their states' nurse practice acts. This will be the first step towards legality of their practice. They must make their plight known to the members of the legislature. Informing the surgeons of what this might mean to them could stimulate them to help in this fight. It certainly behoves the nurse anesthetist and the surgeon to protect themselves legally. This legal protection imposes legal responsibilities to the patient which will result in greater protection for all parties.

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