On Your Behalf …
Legislative and Practice Affairs Division

Everyone I Know

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In 1968, after losing the general election to Richard Nixon, George McGovern and his supporters were stunned and visibly shaken. To them, the loss seemed inexplicable. The country was mired in a highly unpopular war, and McGovern's platform of withdrawal from Vietnam had such popular appeal that the Republicans were also in support of ending the war. Such observations bolstered so-called "Popular Wisdom," which foretold a McGovern win by landslide. In this case, of course, Popular Wisdom turned out to be terribly wrong. Our purpose here, however, is not to dissect this loss, but rather to use it as an instrument to learn about what such collective "Wisdom" says about the future of our own profession, and how much faith, if any, to put in that wisdom.

Regardless of the specific source of one's information, the future of anesthesiology is painted in some color palate that includes multiple shades of gray and black. Dire warnings about collapsing compensations, the dearth of academic productivity, the encroachment by nurses and other para-professionals—all collectively create a popular notion that the future of anesthesia looks bleak. Our path forward through this thicket of obstacles has been written about in multiple venues, and the resultant Wisdom (Popular, of course) holds that we simply need to follow those highly detailed recipes and what ails us will, in some manner, evaporate. Sadly, as Mr. McGovern learned in 1968, Popular Wisdom is a fickle companion, and throughout history, her reassuring and seductive siren has lured many to their peril. Such Wisdom pays no mind to the emotional investments we may make in it, nor does it much care for our grand plans based upon such investments. What can we learn, then, from Mr. McGovern and his certain win that can perhaps help us to better prepare for our own future?

Shortly after the general election had ended, the *New York Times* printed an interview with a prominent New York socialite, philanthropist, and ardent McGovern supporter. In that interview, a well-heeled, well-connected, and well-known woman expressed shock, disbelief, anger, and fear over the fact that her candidate, *the certain winner,* had in fact, lost. "[I] never saw it coming," she was quoted as saying and more interestingly, "*Everyone I know* voted for him, how could he have lost!" This anecdote is instructive for anesthesiologists and brings us one step closer to seeing how the collective group consciousness has read our tea leaves. The same words also offer us valuable lessons as we think about our political efforts in both the CSA and the ASA. What this woman was making clear was that she, and other McGovern supporters (her friends and socialite companions), were living, and speaking, in an echo chamber. Everyone she knew agreed with her; therefore, they *must* be in the majority. No doubt this woman, and her cohort, committed an intellectual error of enormous proportions. How sad, we say, as we mock this woman for her seclusion; nay, her ignorance. We wish we could tell her that their "reality" was actually a very poor surrogate for the actual world—a world in which George McGovern was not "destined" to win the White House—and in that world, McGovern supporters were in the small minority. How many people do we—readers of the *CSA Bulletin,* members and directors and leaders of the CSA—know, and how many are in our echo chamber? But we get ahead of ourselves here. This answer shortly.

Of more interest, we believe, are that these highly visible lessons from 1968 and the McGovern echo chamber are lost on politicians of each successive generation. In 1948, the popular wisdom just *knew* that Dewey was going to defeat Truman, so that a Chicago newspaper would want to get a jump and print that story early made perfect sense. In 1960 we *knew* that a Catholic, and the son of the Munich appeaser, Joseph Kennedy, would never, *ever* win the White House. In 1976, there was no chance that a peanut farmer from Georgia would defeat the incumbent Republican president, no matter how much his pardon of Richard Nixon rankled the Democrats. In 1992, a man widely regarded as a womanizer and political naif could never unseat a President with approval ratings hovering in the mid-80s, and most recently, John Kerry was being called Mr. President by his staff in the evening hours of the 2004 general election because they, too, just *knew* that the son of that squanderer of the 1992 election would, like his father, squander his reelection. In every instance, the crowds yelled "Impossible!" The refrain heard in all the losing camps was similar: How could popular wisdom be so wrong? How, indeed? The lesson: Embarrassment and ready availability of history seem to offer neither safety nor guidance for politicians. The question for us: Do these observations offer anesthesiologists any safety or guidance?

Given that a large fraction of the CSA and ASA activities are political, this question is more than a mere intellectual exercise. We, physicians, are playing in the realm of politicians and it behooves us to understand them, their strengths, and their weaknesses. It is required that we pay attention to **their** political lessons—so that we can better know what motivates their actions and, it is hoped, we can then avoid the same mistakes ourselves. We need to ask ourselves this question, because if we do not, then it is highly likely that as we "play" politics, we will find ourselves succumbing to the siren song of Popular Wisdom no less soundly than these professional politicos have done time and time again. That we are engaged in politics is beyond question. That we are in much need of a serious discussion about the platform from which we proffer our arguments is not so evident to most in our specialty, and to our leadership. Our belief in the need for that discussion was born at the CSA Annual House of Delegates meeting in June of this year. For it was there that we realized that perhaps we were in an echo chamber.

During the meeting, The ASA Associate Director for Federal Affairs (ADFA) was speaking and he was simultaneously boasting of strong membership across the CSA and the ASA, while also informing us of our poor political representation in state (GASPAC) and national (ASAPAC) political action committees. He was admonishing *us, members of the CSA, sitting in the room with him,* to make a note of this fact. Curious, we thought. Why would he be telling us this, and not the masses of clinicians that are not PAC supporters? As he continued to tell us of the major battles looming in Congress, of the Four Horsemen of our Apocalypse—Medicare reimbursement rates, the academic teaching rule, the encroachment of nurses further into our world, and the use of our drugs by non-anesthesiologists—we looked around at all of the GASPAC ribbons hanging from badges and scratched our heads. He was rallying us, the members of the CSA House of Delegates, with fire and brimstone and passion and data. It was all very moving, all very right, all very clear. We all agreed with him—more has to be done, more resources, more work. The crowd all agreed—current, future, and past presidents of the CSA, the president of the ASA, delegates, directors, and plain old members. *Everyone we knew agreed with that speech.* Everyone we knew. It was, we were saddened to realize, an echo chamber.

The following morning we were having breakfast with this very bright, very motivated and very passionate ADFA, and he again reminded us how fewer than 15 percent of anesthesiologists nationally make political contributions to anesthesia related PACs. We, then, having heard this number the day before, asked him: "What about the other 85 percent? Why aren't they giving?" His

silence was all the answer we needed because it served to crystallize for us our fears of the night prior. This was the perfect example of George McGovern's agony in slow, forward motion. The 15 percent of like-minded persons all talking, *to one another!* Our passion, our emotion, our efforts, our anger, our certitude of our cause—and no one to disagree with us. What is the lesson here? Like Dewey in '46 and Kerry in '04, and all the others in between, regardless of how much we might think we are right, we are, in fact, the minority. The lesson for our profession: *we will lose as well.*

Some may argue, at this juncture, that in fact we are wrong because a small, vocal minority can indeed effect change and perhaps even win. Our small group could, in fact, be such a vocal minority. Allow us to disabuse people of that argument before too much emotion gets vested in it. The reasoning that a small, vocal minority with a clear message can eventually induce change is smoke and mirrors. Such an outcome, short of the use of force, can only be true under one condition: that a majority eventually agrees with that minority. The minority, regardless of their passions and emotions and certitude, affect nothing unless the majority comes to agree with them. History's political landscape is littered with the remains of vocal and passionate minorities who could have effected change—but failed to win the majority. The Federalists, Whigs, Copperheads, Free-Soilers, Silver Bugs, Isolationists, Progressives, Socialists: all footnotes. What is the "lesson" here for our profession? Obviously, our political organizations have yet to craft a message that speaks to the whole. Crafting that message is beyond the scope of this article; but highlighting the need for such a message is not. There will be no forward progress until the minority engages the majority. If physicians cannot engage their own, how can they expect to sway the public? We are losing the war of sound bites within our ranks and outside them. Stepping outside our echo chamber is imperative. We better find out what those other 85 percent are thinking. We had better talk more to them and less to ourselves, and learn that, *"Everyone I Know"* is very, very far indeed from Everyone.

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Anesthesia Groups and Peer Review: The Benefits and Burdens

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Introduction

Many anesthesia groups have expressed interest in adopting formal peer review procedures for policing their own members in the hope of obtaining legal protections intended to encourage formal peer review. Although legal protections for peer review are available, anesthesia groups need to understand the burdens that go along with formal peer review benefits. Analyzing the benefits and burdens of peer review is complicated by the fact that different rules apply under California and federal law. Peer review laws can protect reviewers and those providing information to the reviewers. They can also ensure peer review information is not subject to discovery in a lawsuit by an interested third party such as a plaintiff in a medical malpractice action. However, certain formalities and procedural requirements must be observed to ensure that the statutory protections are available. The protections are not available in all cases. In some cases, the cost of securing the protections may not be worth the trouble. This article will discuss the benefits and burdens of peer review undertaken by anesthesia groups to determine if they want to pursue the protections available.

Privileges and Immunities

The statutory protections available for peer review under California and federal law are both "privileges" and "immunities." There is an important distinction between these protections for reviewers, those providing information to the reviewers, and those under review. A *privilege* generally limits access to information and more specifically prohibits a litigant from obtaining documents or statements through discovery in litigation. By contrast, *immunities* protect individuals and entities from liability to a third party. For example, a privilege could prevent a reviewer from having to give sworn testimony in a deposition or at trial on what was said and done during a peer review procedure. An *immunity* could protect that same reviewer from liability to a physician who is sanctioned following peer review. Generally, federal law affords broader and better *immunity* for reviewers, while California law provides better *privileges* than federal law.

The California Civil Code provides *immunity* from liability for members and persons providing information to the members of any peer review *committee* that reviews the quality of medical services rendered by physicians and surgeons as long as certain fairness standards are met. (Civ. Code §§ 43.7(b), 43.8.) However, a "peer review committee" does *not* include a medical group and generally is limited to medical staffs and professional societies. Accordingly, these Civil Code provisions do not protect peer review by an anesthesia group as distinct from the anesthesia department or division of a hospital medical staff. An evidentiary privilege is available to a peer review *body* under Evidence Code section 1157 so that neither "the proceedings nor the records of… peer review body, as defined in Section 805 of the Business and Professions Code,… shall be subject to discovery." (Evid. Code § 1157(a).) A "peer review body" includes a committee organized by a medical group employing *more than 25 physicians* that is charged with "reviewing the quality of professional care provided by members or employees of that entity." (Bus. & Prof. Code § 805(a).) Some larger anesthesia groups may meet the more-than-25-member threshold, but most anesthesia groups will not.

Federal law provides for *immunity* from damages for a "professional review action" by a "professional review body" that extends to both reviewers and those providing information to the reviewers if certain fairness standards are met. (42 U.S.C. § 11111.) A "professional review body" includes a "group medical practice" regardless of the number of physicians in the group. (42 U.S.C. § 11151(4)(A)(ii), (11).) Accordingly, the protections available under federal law are broader, in that they extend to any anesthesia group, while the California protections apply only to groups of more than 25 physicians. A "professional review action" is one that involves the "competence or professional conduct of an individual …, and which affects (or may affect) adversely the clinical privileges … of the physician." A professional review action includes a decision not to take action against the physician being reviewed. (42 U.S.C § 11151(9).) Although federal law provides some evidentiary protections to medical peer review, the scope of its application in California is not nearly as clear as the *privilege* available under California Evidence Code section 1157. (See Fed. R. Evid. 501.)

Procedures and Reporting

The privileges and immunities described above are the benefits of formal peer review by anesthesia groups. The burdens of peer review to anesthesia groups are the substantive and procedural requirements that have to be observed to ensure that the protections are available. Another burden is the obligation to report to the Medical Board of California certain sanctions imposed following peer review.

Under California law, when a "peer review body" takes an adverse action for "medical disciplinary cause or reason," this necessitates the filing of an "805 report" with the MBC. These adverse actions include termination, restrictions, or suspension. (Bus. & Prof. Code § 805(b).) "Medical disciplinary cause or reason" means "that aspect of a licentiate's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care." (Bus. & Prof. Code § 805(a)(6).) No 805 report needs to be filed unless the suspension, restriction or termination of the physician under investigation results, and such sanction is imposed for medical disciplinary cause or reason. (See Bus. & Prof. Code § 805(b).) As long as no 805 report needs to be filed, no formal hearing must be offered to the individual under investigation. (Bus. & Prof. Code § 809.1.)

Under federal law (as with California law), certain procedures ensuring the fairness to the physician under review must be observed and a report must be filed with the MBC if "action that adversely affects the clinical privileges of a physician" results. (42 U.S.C. § 11133(a)(1)(A).) This includes the right of the physician being sanctioned to a fair hearing procedure. The federal law contains far less detail on the substantive and procedural protections afforded to the individual than does California law. (42 U.S.C. § 11112.) Strictly adhering to the California requirements should ensure compliance with the federal requirements in most, but not necessarily all, situations.

Case Study

The application of the peer review laws to anesthesia groups can be better understood by analysis of a hypothetical case study. Consider the situation of an anesthesia group organized as a medical corporation with 20 anesthesiologist members. The anesthesia group holds an exclusive contract in a closed anesthesia department. One of its members may be described as a "disruptive physician." He is abrasive to hospital staff and has been "written up" several times by nurses for offensive behavior. He has arrived late for cases on more occasions than all other 19 members of the group combined and once failed to respond to a page when on call, asserting he never got the message. The other members of the group concede that this individual's clinical skills are good, but tolerance for his troublemaking with other members of the medical staff, nurses, and hospital administration has worn thin. Given his contentious nature, there is concern within the group that if he is dealt with harshly as a result of his disruptive behavior, he is likely to respond with a lawsuit. The anesthesia group would like to be rid of this disruptive physician and wants to terminate the individual in a manner that creates the least likelihood of successful legal challenge by the physician.

Contrasting Protections

Under California law, there is little protection available to the anesthesia group acting independently, as opposed to an anesthesia department or division within the hospital's medical staff. As an anesthesia group—and not as a component of the medical staff—any review and action by the group would not be action by a "peer review committee" as that term is defined in Civil Code § 43.7(b), so no immunity from liability would be available under that statute. The privilege under Evidence Code § 1157 would not be available because the anesthesia group acting independently of the medical staff does not fit the definition of a "peer review body," since it does not have more than 25 physician members. Accordingly, California law provides no privileges and no immunities for the formal peer review undertaken by this anesthesia group.

By contrast, protection may be available under federal law. Under federal law a "professional review body" includes a "group medical practice" without requiring any minimum number of members. Still, to fit within the federal statute and its protections, the review has to involve the "competence or professional conduct of an individual … which affects (or may affect) adversely the clinical privileges … of the physician." If the sanction imposed is termination by the anesthesia group holding an exclusive contract, it would clearly affect the clinical privileges or membership in the group adversely. The only question, then, is whether the sanction is based on the competence or professional conduct of the individual. Note that, under the federal peer review law, professional conduct must be conduct that "affects or could affect adversely the health or welfare of a patient or patients." (42 U.S.C. § 11151(9).) This touches on the larger and perhaps more significant question of whether disruptive behavior affects patient care. The tendency is to find that disruptive behavior by a physician does affect patient care if it affects that individual's ability to work cooperatively with others in the efficient and proper delivery of care. In this situation, where the conduct also involves the failure to respond to a page, it should be that much easier to find that the behavior affects patient care.

Notice and Hearing Requirement

Assume that after an in-depth investigation and assessment of the disruptive physician's conduct, which includes taking statements from nurses and surgeons about the individual's conduct, the anesthesia group decides to terminate the physician for his past disruptive behavior, asserting it negatively affected patient care. If the anesthesia group simply gave notice of its finding to the individual and immediately terminated him, no protections would be available under the federal law because the individual was not offered a hearing. Even if the anesthesia group concluded termination was reasonable and appropriate in the furtherance of high quality care, had undertaken reasonable

steps to find out the true facts of the matter, and termination was, in fact, the appropriate sanction given the nature of the problem, protections would not be available unless the physician was given notice and an opportunity for a hearing. (42 U.S.C. § 1112(a).) Accordingly, the group should give formal written notice to the physician of the reason for its proposed action, advise the physician that he has a right to request a hearing, and briefly describe the hearing. The physician would need to be given at least 30 days to respond. If the physician indicated that he wanted to take advantage of his hearing rights, the hearing would be held within 30 days of notice from the physician. The hearing would have to be conducted before an appropriate arbitrator or arbitration panel. The disruptive physician would have the right to representation by an attorney; have a record of the proceedings made; call, examine and cross-examine witnesses; and present relevant evidence. The disruptive physician would also be entitled to receive a written statement of the arbitrator's or panel's findings. (42 U.S.C. § 1112(b).) If the arbitrator or panel upholds the finding by the anesthesia group, then the anesthesia group, its members, and persons giving evidence against the disruptive physician should be immune from damages in any lawsuit under California or federal law, with some limitations. (42 U.S.C. § 11111(a).) If the action were challenged later by the disruptive physician as a violation of civil rights laws, the immunities would not extend to any liability found in that action. The immunity should, however, protect the group and others from the more typical wrongful termination, defamation, or other non-civil rights action that might be brought. Of course, these protections are only available if the group reports its sanction of the disruptive physician to the MBC. (42 U.S.C. § 11133(c).)

Other Alternatives

The time, expense, and other hassles of following the formal peer review procedures to ensure limited immunity under federal law for this anesthesia group need to be assessed in light of the other alternatives available to the anesthesia group in dealing with the disruptive physician. One among these alternatives would be to pursue peer review through the hospital's medical staff. If this were done, then those privileges and immunities discussed above under California law would apply because it would involve a "peer review committee" as that term is defined in California Civil Code § 43.7(b) for purposes of the immunities and a "peer review body" for purposes of the evidentiary privileges available under Evidence Code § 1157. Additionally, and perhaps just as significantly, the costs and hassles of the process would be borne by the medical staff, as opposed to being borne by the anesthesia group directly.

Another alternative that may be available to the group, if it decided not to use the medical staff peer review for political or other reasons, is termination of the

disruptive physician "without cause." Whether this alternative is available depends on the physician's contract with the anesthesia group. Despite the possibility of abuse, most physician employment agreements include provisions allowing the group to terminate without cause. Many "without cause" termination provisions require the affirmative written approval of a majority or even a super majority of the other members of the group. This helps ensure this powerful right is not abused by a small leadership group and instead is used only when it represents the will of the majority or even the vast majority of the group. If the anesthesia group in this example had such a provision in its agreement with the disruptive physician, it could have exercised its right to terminate without cause, assuming that action had the support of the requisite number of group members. In this circumstance, neither the California nor federal privileges and immunities would have applied, but in order to prevail in a subsequent lawsuit, the disruptive physician would have to get over the hurdle that his agreement clearly stated he could be terminated without cause. This would not eliminate the possibility of a lawsuit for wrongful termination, but at least it avoids the situation where the anesthesia group has to explain its reasons for termination and prove that those reasons were valid. This alternative to peer review also avoids the potential problem of having the arbitrator or panel overturn the group's decision if the physician demands his rights to a fair hearing proceeding. It is certainly possible to conclude that approval of even a super majority of the group membership is not a reasonable alternative to the fair hearing procedures required in formal peer review from the individual physician's perspective. Nevertheless, anesthesia groups that have a without cause termination provision in their contracts need to be aware of this option.

Anesthesia groups that decide to undertake formal peer review need to consider carefully the limited application of the California privileges and immunities, the limited nature of immunities available under federal law, and the potentially burdensome steps that must be followed in order to ensure the protections apply.

CRNA Scope of Practice under California Law

By William E. Barnaby, Esq., CSA Legislative Counsel, and William E. Barnaby, III, Esq., CSA Legislative Advocate

I. Introduction

The lawful scopes of practice of professions licensed by the State of California are set forth in statutes enacted by the California Legislature. Most of these statutes are found in the California Business and Professions (B&P) Code. The various licensing boards [e.g., Medical Board of California (MBC) for physicians and Board of Registered Nursing (BRN) for registered nurses] regulate the professions under their jurisdiction but have no legal authority to expand the scopes prescribed by statute. Some of the most heated controversies of every legislative session are over proposed scope of practice changes—often termed "turf battles."

The basic purpose of scope of practice laws is to protect the public by assuring that licensed professionals meet minimum competency standards through appropriate education, training, and testing.

Among licensed health professionals, physicians have the broadest, virtually unlimited, lawful scope of practice. The Medical Practice Act can be found in the B&P Code commencing at § 2000, with the activities authorized specified in § 2051:

> *The physician and surgeon certificate authorizes the holder to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions.*

The Nursing Practice Act (NPA) is set forth in the B&P Code commencing at § 2700, with the authorized functions of registered nurses (RNs) delineated in § 2725. Similarly, the Vocational Nursing Practice Act begins at § 2840 and the permissible duties of licensed vocational nurses (LVNs) are specified in §§ 2860 and 2860.5.

Many nursing activities, including the use of anesthesia, are clearly limited by law to being performed pursuant to either the order or direction of a physician.

To clarify a point of frequent inquiry, **California law does NOT permit Certified Registered Nurse Anesthetists (CRNAs) to administer anesthesia without supervision or direction by physicians or other practitioners (dentists and podiatrists) whose own lawful scopes of practice specifically allow the administration of anesthesia.**

Although the exact term "supervised by a physician" is not used in the NPA relative to CRNAs, other synonymous terms—having the same force and effect—are employed, to wit: "ordered by a physician" and "directed by a physician," as explained below.

II. CRNAs Have NO Separate Scope of Practice under California Law

Pursuant to B&P Code § 2833.6, CRNAs have no separate scope of practice under California law. Therefore, their only lawful authority to function is the same as any Registered Nurse under B&P § 2725. More specifically, the authority for CRNAs and RNs to administer any medication, including anesthesia, is stated in B&P § 2725(b)(2). That statute includes within the lawful practice of registered nursing "**the administration of medications and therapeutic agents,** necessary to implement a treatment, disease prevention or rehabilitative regimen **ordered by and within the scope of licensure of a physician, dentist, podiatrist …** (emphasis added)."

For example, a permit system under the Dental Practice Act specifies that dentists must possess a special permit to use general anesthesia or conscious sedation in their offices. CRNAs have been limited by the Dental Board to administer only those forms of anesthesia for which the dentist possesses the required permit, and only then upon the "order" of the dentist (see B&P § 1646.1).

III. Controlled Substances and Lawfully Authorized Prescribers

All anesthetic agents are either controlled substances or dangerous drugs available only upon a prescription or order of an individual lawfully authorized to prescribe such medications. **RNs and CRNAs are not authorized to lawfully prescribe medications.** California law (B&P § 4059) limits the authority to prescribe to physicians, dentists, podiatrists, veterinarians (for some limited drugs and purposes), optometrists and naturopathic doctors. Hence, nurses, including CRNAs, have no independent ability to access anesthetic agents for any purpose. They may do so only pursuant to the order or prescription of an individual lawfully authorized to prescribe medications—meaning, in most

cases, a physician. **While Certified Nurse Midwives (CNMs) and Nurse Practitioners (NPs) are not lawfully allowed to prescribe medications independently, they may order medications under physician supervision. (B&P §§ 2746.51 & 2836.1.)**

IV. Unprofessional Conduct under the NPA

B&P Code § 2762 makes it "unprofessional conduct" for any nurse, including a CRNA, to "obtain or possess in violation of law, or prescribe, or ***except as directed*** **by a licensed physician and surgeon, dentist or podiatrist administer to himself or herself or furnish or administer to another any controlled substance as defined … or any dangerous drug as defined"** (emphasis added).

Thus, it is unprofessional conduct for a CRNA to administer an anesthetic agent except "as directed by a physician." Unprofessional conduct is grounds for sanctions against the license to practice, including revocation. ***This directly contradicts the assertion that CRNAs may administer anesthesia in California without physician direction, AND further contradicts CRNA assertions that they are "licensed independent practitioners."*** CRNAs may be "licensed independent contractors," but that designation is not relevant to health practitioner scopes of practice governed by the B&P code.

V. Other Relevant Statutes and Administrative Regulations

A. B&P Code § 4019 defines "order" for the purpose of acquiring drugs for hospital patients as an "order by a practitioner authorized by law to prescribe drugs, shall be the authorization for the administration of the drug from hospital floor or ward stocks …"

B. Title 22, Code of California Regulations, § 70263(g), relative to acute-care hospitals provides as follows:

> "No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe or furnish . … The order shall include the name of the drug, the dosage and the frequency of administration, the route of administration, if other than oral, and the date, time and signature of the prescriber or furnisher. … Verbal orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish and shall be recorded promptly in the patient's medical record, noting the name of the person giving the order and the signature of the individual receiving the order. The prescriber or furnisher shall countersign the order within 48 hours."

[**Note**—When this regulation was revised in 1996 to add the term "furnisher" by the Department of Health Services, it was explained in Addendum I, Summary of Comments and Department Responses [see page 53] as follows:

"The Department clearly understands that only physicians may ***prescribe,*** *and that physician's assistants, nurse practitioners, and nurse midwives may* ***furnish*** *drugs and devices* [emphasis retained]."]

VI. Relevant Attorney General Opinion

By formal, published opinion (67 Ops.Atty.Gen.122, 4-5-84), California's chief legal officer analyzed several issues relative to anesthesia and the lawful scope of nurse licensure. At the outset, the Attorney General noted "the scope of practice of the nurse anesthetist is the same as the scope of practice authorized by his or her license as a registered nurse." After reviewing the evolution of the applicable statutes, relevant case law and prior A.G. Opinions, this Opinion stated: **"We conclude that a registered nurse may administer an anesthetic, general or regional, under the authority of subdivision (b) of section 2725 when a physician, dentist or podiatrist, acting within the scope of his or her license, orders such nurse to administer the same to a particular patient."**

The Opinion went on to hold that CRNAs may ***not*** (emphasis added) administer anesthesia pursuant to a "standardized procedure" or a protocol that governs the care of any number of patients meeting specified criteria. The authority granted by B&P Code § 2725(b) [now § 2725(b)(2)], it was stated, "is limited to orders by the doctor on an individualized patient basis and is based on the doctor's judgment as to the treatment necessary for a particular patient."

Since the underlying applicable statutes have remained **substantially unchanged**[1] since this Opinion was rendered in 1984, it remains valid to this day. At the time it was issued, CRNAs embraced the holding that both regional and general anesthetics were available for their use, but they seem to have ignored the critical qualifiers—as "ordered," or as "directed," by a physician, dentist, or podiatrist.

VII. Federal Medicare Conditions of Participation for Anesthesia Services

Every hospital and ambulatory surgical center (ASC) that participates in the federal Medicare program must abide by numerous, very specific Conditions of Participation. For anesthesia services the specific conditions are stated in

regulations. For ASCs the standards are set forth in 42 C.F.R § 416.42; for hospitals, 42 C.F.R. § 482.52; and for Critical Access Hospitals, 42 C.F.R. § 485.639. In each of these settings, **a CRNA may administer anesthesia, but only "under the supervision of the operating practitioner" unless the state has exercised the "opt out" exemption from physician supervision requirement, which California has not.**

Reference

[1] In 2003, a supposedly non-controversial BRN "sunset extension" bill, SB 358, was enacted that added new B&P Code § 2725(e), which stated, in pertinent part:

"No state agency other than the board may define or interpret the practice of nursing…"

This provision was discovered by interested parties, including CSA, CMA, and others, only after the supposedly noncontroversial "sunset extension" measure had been signed into law. When later queried, the Chief Consultant to the Senate Business and Professions Committee (where the bill originated) said the provision was intended only to deal with a dispute between the BRN and the Department of Health Services and clearly was not intended to grant additional authority to the BRN that it previously did not have. In any event, the significance of the new subsection (e) was legally limited, since it is the California Legislature which sets, establishes, and determines lawful scopes of licensure, a function that the B&P Code does not delegate to healing arts licensing bodies. Moreover, the California Supreme Court has held that the courts have final responsibility for interpretation of statutes when there has been no clear delegation of authority to an administrative agency. See *Yamaha v. State Board of Equalization.* (19 Cal.4th, 1, 1998.)