
Legal Briefs



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A surgeon's liability for the anesthesia administrator: The law according to Dr. Modell

An editorial, "Who is Captain of the Anesthesia Ship?", appeared above the name of Jerome H. Modell, MD in the July 1986 issue of *Archives of Surgery*. The editorial purported to describe legal aspects of a surgeon working with an anesthesiologist and a surgeon working with a CRNA. The conclusions stated by Dr. Modell in the editorial run counter to the cases discussing these legal issues.

The courts do not look at the status of the anesthesia administrator but at the degree of control the surgeon exercises over the administrator

First, Dr. Modell asserts that the status of the anesthesia administrator determines whether the surgeon will be held liable for the negligent administration of the anesthetic. The courts, however, do not look at the status of the anesthesia administrator but at the degree of control the surgeon exercises over the administrator—whether that administrator is a CRNA or an MD. Courts examine surgeons' liability on a case-by-case basis. The issue in each case is to what extent the surgeon has control over the anesthesia administrator. Thus, a court may render different conclusions for cases that each involve a surgeon working with a CRNA—or, for that matter, a surgeon working with an anes-

thesiologist—if the surgeon controlled the CRNA in one case but not in another.

Dr. Modell states that when an "anesthesiologist personally administers anesthesia . . . clearly only the anesthesiologist should be held responsible for the quality of anesthetic care." The legal cases, however, do not support this assertion. In *Schneider v. Einstein Medical Center*, 390 A.2d 1271 (Penn. 1978) and *Kitto v. Gilbert*, 570 P.2d 544 (Colo. 1977), the courts in each case found the surgeons liable for the negligence of the anesthesiologists because the surgeons were in control of the anesthesiologists' actions. There are a variety of other theories on which a surgeon can be held liable for the anesthesiologist's actions, including negligent selection of the anesthetist and failure to take appropriate action after observing the negligent action.

Case law does not support the assertion that without medical direction from an anesthesiologist, the surgeon "automatically becomes responsible"

Second, Dr. Modell claims that when a surgeon works with a CRNA without medical direction from an anesthesiologist, the surgeon "automatically becomes responsible." Again, the case law simply does not support Dr. Modell's assertion. A physician or authorized

provider is *not automatically liable*. The question, as in the cases of a surgeon working with an anesthesiologist, is whether the surgeon was in control of the acts of the CRNA. This is a factual inquiry and not a conclusion of law.

Moreover, numerous cases hold that mere supervision or direction is insufficient evidence to hold a surgeon liable. See, for example, *Baird v. Sickler*, 69 Ohio St.2d 652 (1982); *Foster v. Englewood Hospital*, 19 Ill. App.3d 1055 (1974); *McCullough v. Bethany Medical Center*, 235 Kan. 732 (1984); *Elizondo v. Tavaréz*, 596 S.W.2d 667 (Texas, 1980); *Whitfield v. Whittaker Memorial Hospital*, 210 Va. 176 (1969).

It is clear from the case law that in order for a surgeon to be liable for the acts of the anesthesia administrator, the surgeon must be in control of the administrator's actions and not merely be supervising or directing the administrator. In *Baird v. Sickler*, 69 Ohio St.2d 652 (1982), the Ohio Supreme Court, after an extensive review of the decided cases, found no cases where a surgeon was held liable for the negligence of a CRNA based solely on the surgeon's statutory obligation of supervision.

Overlapping functions exist between the practice of nursing and medicine

Third, Dr. Modell states that a surgeon "automatically becomes responsible" for the CRNA administering anesthesia because the CRNA is not licensed to practice medicine. We have seen, however, that the surgeon does *not* "automatically become responsible." Moreover, Dr. Modell adopts a common fallacy frequently found in discussions about relationships among health care professional groups.

The fallacy, simply stated, is that when an act is considered the practice of medicine only doctors are authorized to perform it. However, there are overlapping functions between the practice of nursing and the practice of medicine, just as there are overlapping functions between the practices of medicine and dentistry, medicine and psychology, and medicine and pharmacology. A health care practitioner is authorized to perform any of the functions within his or her scope of practice as set forth in the state statutes and regulations.

Licensing laws are designed to protect the public and not the members of a profession. Their purpose is not to establish monopolies but to describe areas in which members of a profession may practice. Many

state medical practice acts specifically allow professionals with different licenses to compete for services to the extent their lawful functions overlap.

The administration of anesthesia is a lawful function that overlaps the practice of medicine and practice of nursing. Thus, anesthesia administrators legally may be doctors, nurses or dentists, among others. CRNAs are, therefore, practicing nursing and not medicine, in terms of licensing, practice and history.

Lack of anesthesia training by the surgeon not a logical factor in liability determination

Fourth, because a surgeon's liability depends on control, the fact that the surgeon lacked specific training in anesthesia would not logically be a factor in determining the surgeon's liability. In fact, in at least one case, the court emphasized that the surgeon was not an expert in anesthesia as a rationale for not finding liability. See *Kemalyan v. Henderson*, 277 P.2d 372 (Wash. 1954).

No difference in the anesthesia outcome regarding the quality of care rendered by an anesthesiologist and the quality of care rendered by a CRNA

Another incorrect presumption underlying Dr. Modell's conclusions on a surgeon's liability is that the difference in the level of education between an anesthesiologist and a CRNA affects the quality of care in the anesthesia outcome. All of the studies with which we are familiar reach the opposite conclusion: there is no difference in the anesthesia outcome regarding the quality of care rendered by an anesthesiologist and the quality of care rendered by a CRNA. Anesthesia seems to be an area where, beyond a certain level, outcome is only minimally affected by medical knowledge but is greatly affected by factors such as attention, concentration, organization and the ability to function as part of a team; factors towards which all professions strive but over which no profession may claim a monopoly.

The most frequent cause cited for major injury in anesthesia claims is hypoxia resulting from three principal causes: ventilator disconnect, esophageal intubation and inadequate oxygen in the breathing mixture. How much education is required to eliminate these types of accidents? Is it not a greater injustice to deny a surgical patient superior care due to speculations about legal liabilities that do not exist?