Legal Briefs

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Anesthesia and the surgeon's comfort

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Nurse anesthetists continue to advise us that some surgeons feel more comfortable working with anesthesiologists. These surgeons have been led to believe that they would have less liability if they work with anesthesiologists. In previous articles we have pointed out that the principles which govern the liability of a surgeon for the negligence of an anesthetist are the same whether the anesthetist is a CRNA or an MDA. Liability is not imposed because the surgeon carries out the statutory requirement of supervision. Liability of a surgeon is based on control; mere supervision is not enough. The same principle governs a surgeon's liability when working with an anesthesiologist. If the surgeon is in control of the procedure, the surgeon can be liable for the negligence of the anesthesiologist. Several recent cases illustrate these points.

Power to supervise and power to control

In *Harris v Miller,* 103 N.C. App. 312, 407 S.E.2d 556 (July 2, 1991), a CRNA was working with a surgeon in a hospital which did not employ any anesthesiologists. Despite various hospital forms, the court held that the surgeon was not liable for the negligence of a CRNA being supervised by the surgeon. A patient was intubated in the esophagus rather than the trachea. When the surgery began, blood pressure dropped and the heart rate rose causing the CRNA to mistakenly believe that the patient had not been sufficiently anesthetized. The CRNA increased the anesthetic and brain damage resulted.

The plaintiff claimed that the surgeon was vicariously liable for the negligence of the nurse anesthetist. The plaintiff attempted to prove that the surgeon possessed the right to control the work done by the nurse anesthetist by introducing the hospital's policy manual which provided that *"a nurse anesthetist works under the responsibility and supervision of the surgeon doing the case."*

The North Carolina Appellate Court pointed out, however, that the evidence relied upon by the plaintiff gives the surgeon the power only to supervise the nurse anesthetist. There is a distinction between the power to supervise and the power to control. The hospital policy manual did not constitute evidence of *control.*

The second argument made by the plaintiff was that because the informed consent form authorized the surgeon *"and/or such assistants as may be selected by him"* to perform the operation, the informed consent form constituted evidence of the surgeon's right of control. The court again disagreed stating that the informed consent form did not constitute evidence that the surgeon had the right to control the work or the manner of performing the work of the nurse anesthetists.

Finally, the plaintiff argued that various witnesses, including the surgeon, testified that the

surgeon has the ultimate responsibility for the quality of care given a patient. The court rejected this as well, pointing out that conclusions of medical personnel (even surgeons) about legal matters does not constitute proof that the conclusions are true.

"The fact that under some statement of policy a surgeon bears the 'ultimate responsibility' of care is not evidence that the surgeon has the right to control the manner in which all those involved in rendering care to the patient do their job.... Furthermore, it was established through plaintiff's own expert in this case that nurse anesthetists are highly trained and highly skilled.... There was testimony that the standard of care for a nurse anesthetist is the same as that for an anesthesiologist and that nurse anesthetists are experts in the delivery of anesthesia. This evidence is indicative that the surgeon and the anesthetist work as a team, each with his own area of expertise to achieve as a common end the successful completion of the surgery. It is reasonable that the surgeon would have a supervisory obligation to effect that end but, at least in this case, there is no evidence that the surgeon had the right to control the manner in which the anesthetist administered the anesthesia or performed the related functions of this job as set out by hospital policy. Therefore, [the nurse anesthetist] was not on this evidence, [the surgeon's] employee under the doctrine of Respondent Superior."

An important element in the court's determination was the fact that the surgeon did not have the right to select or discharge the nurse anesthetist.

The duty of care

Swierczek v Lynch, 237 Neb. 469, 466 N.W.2d 512 (Nebraska, 1991) is a case involving an anesthesiologist. Despite the "comfort" of working with an anesthesiologist, an oral surgeon could not avoid being a party to a lawsuit arising out of an anesthetic.

In previous articles we have pointed out that surgeons are needlessly concerned about choosing to work with nurse anesthetists or anesthesiologists because as a practical matter the plaintiff's injuries occur under circumstances where the plaintiff cannot know which members of the operating team may have been individually responsible for the negligence or error. Consequently, the surgeon is unable to have himself dismissed as a party to the suit whether the surgeon is working with a nurse anesthetist or an anesthesiologist.

In *Swierczek,* a patient was undergoing dental surgery. She complained that following the surgery she could not feel her hand, suffered abnormal sensations in both of her little fingers and parts of her palms and, ultimately lost use of her hands. Expert witnesses testified that the condition probably came as a result of pressure on the ulnar nerve during the operation. The plaintiff, a 52-year-old first grade teacher, was no longer able to play the piano or the organ and her hands took on a claw-like appearance. Both an anesthesiologist and a nurse anesthetist were involved in the anesthetic.

The plaintiff relied on the doctrine of Res Ipsa Loquitur or "the thing speaks for itself." Under this doctrine, if someone has exclusive control, and if something happens which ordinarily does not occur without negligence, the plaintiff does not have to prove that the physicians were actually negligent. In that case, "the thing speaks for itself." The oral surgeon asked the court to dismiss him as a party to the case on the grounds that he was not in the operating room at the time the plaintiff was moved from the cart to the operating table and that he had no responsibility for her transportation either to or from the surgical suite.

In the *Swierczek* decision, the court acted exactly as predicted: the court would not permit the oral surgeon to be dismissed as a party. *"The hospital and surgeon cannot escape liability by attempting to delegate the responsibility for activity in the operating room to the anesthesiologist or other staff present there. The duty of care owed by a physician is nondelegable, which means that an employer of an independent contractor... by assigning work consequent to a duty is not relieved from liability arising from the delegated duties negligently performed."*

The case shows that surgeons cannot feel insulated from lawsuits when they choose anesthesiologists to give their anesthesia.

Responsibility to attend to the patient

Finally, we come to the case of *Lanzet v Greenberg, et al.,* 126 N.J. 168; 594 A.2d 1309 (New Jersey, September 4, 1991), a most interesting case which should be read by all surgeons who find working with anesthesiologists "comforting."

The *Lanzet* case is not really a vicarious liability case but it has application to this area. The patient was 65 years old, weighed 340 pounds, and stood 5 feet, 6 inches. She had been diagnosed before the operation as having signs of congestive heart failure. The patient was to undergo cataract surgery. The surgeon was an ophthalmologist, assisted by another ophthalmologist. The surgery was to be performed under a local anesthetic, but an anesthesiologist was monitoring the patient to respond to emergencies involving her vital signs.

Because of the setup for ophthalmological surgery, the head of the table was filled by the surgeons. In fact, throughout the operation both of the ophthalmological surgeons had to maintain a constant focus on the patient's eyes. Only her upper

face was visible to the surgeons. On the morning of the surgery the patient had an elevated blood pressure which was treated with diuretics. During the surgery the patient's pulse dropped from 65 to 45. The anesthesiologist treated the patient with atropine. Twelve minutes later the pulse rate fell below 40; more atropine was given but the patient's pulse rate continued to drop. Ultimately, the patient became cyanotic and a code was called.

Surgeons who might be inclined to consider their anesthesia providers based on the "comfort" which an anesthesiologist might provide should consider the handling of the legal defense in this matter. *"Even at trial there seemed to be regrettable confusion about who was responsible for the patient's welfare when each of the physician-defendants appeared to point the finger of blame at the others, it led the jury to the inevitable conclusion that each of the physicians had failed in his or her responsibility to attend to the patient."*

Part of the "finger pointing" related to who had the authority to stop the operation. The anesthesiologist testified that it was the surgeon's decision to stop the operation although the anesthesiologist was certainly prepared to give his opinion if it was asked. The assistant surgeon who had spent the operation viewing the patient's eye through a twin set of binoculars testified that it was the role of the anesthesiologist to take charge of when a surgery can proceed and when it should stop.

The anesthesiologist also testified that *"I did suggest stopping the operation. Then, they see at what stage and whether it is safe for them to stop the operation and start resuscitation if needed or not."* The anesthesiologist also indicated that he had continually informed the surgeons of the patient's condition, advising them of the falling heart rate. Consequently, one is left with the picture of a patient becoming cyanotic with three qualified doctors in the room. As the court wrote, the patient *"seems to have had her heart attack in the wrong place and at the wrong time.... To sum up, there was clear evidence of neglect by the attending physicians in this case."*

There is a certain degree of risk in all of our activities. Surgeons who are reluctant to work with nurse anesthetists for fear that they are not competent to supervise a nurse anesthetist should also fear that they are not competent to collaborate with an anesthesiologist. Once more, the best advice to a surgeon is that the selection of an anesthetist should be based on the ability of the anesthetist and not on the irrelevance of who issues the anesthetist's license.