LEGAL BRIEFS

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ANOTHER ARTICLE ON THE SURGEON'S LIABILITY FOR ANESTHESIA NEGLIGENCE

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In the years I have served as General Counsel for the American Association of Nurse Anesthetists (AANA), no subject has received more of my attention than the question of a surgeon's liability for the negligence of a nurse anesthetist. It is pretty remarkable that I should have devoted so much attention to this subject when you consider how safe anesthesia has become. The incidence of a major anesthetic problem has become so rare that most surgeons will spend their entire careers without ever seeing one. So, why are surgeons so concerned? In the mid-1980s, an increase in the number of anesthesiologists led to increased competition between nurse anesthetists and anesthesiologists. Occasionally, some anesthesiologists would tell surgeons that it would be better to work with anesthesiologists than nurse anesthetists to avoid liability. One anesthesiologist wrote that no surgeon "should" be held liable when working with an anesthesiologist but "a surgeon or dentist *automatically* becomes responsible whenever a nurse administers anesthesia without medical direction by an anesthesiologist [emphasis added]." As a legal matter, I knew that the courts did not decide questions of liability based on what state agency happened to issue the provider's license. The courts impose liability only when a surgeon controlled the procedure or participated in the negligence; not simply because the surgeon was working with, or supervising, a nurse anesthetist. Most importantly, I had read enough cases to know that liability was anything but automatic. Nonetheless, even if the warning was inaccurate and unjustified, as a marketing strategy, it worked all too well. Nurse anesthetists needed real answers to counter a threat to their practices.

I have tried to provide accurate information about this subject. To show that liability was not automatic, my columns have described case after case where surgeons were not held liable for the negligence of the nurse anesthetists they were working with or supervising. To show that the same principles were used to determine liability of surgeons for negligence of anesthesiologists and nurse anesthetists, I even provided lists of cases where surgeons got sued or were held liable for anesthesia mishaps when they worked with anesthesiologists. Instead of providing conclusions, I have given citations so that my accuracy and honesty would not be a factor. Anyone could look at the cases to see if I had accurately reported what the court decided.

Despite these efforts, the marketing campaign has continued, and surgeons continue to be concerned about liability when working with Certified Registered Nurse Anesthetists (CRNAs). Since the cases I have cited cannot be denied, they are dismissed as old or stale. Well, practicing law is not like selling fish. Fresher cases are not necessarily any better than old ones, unless the law is changing. And, the law in this area is not changing. Liability is based on control. That legal concept predates the discovery of anesthesia, the American Revolution, and the birth of Christopher Columbus. The law's tradition of basing liability on control can be found in laws adopted by Charlemagne in the 9th century and even those described in the Bible. Cases have different outcomes, not because the law changes, but because the principles of the law are applied to different factual patterns. The factual patterns may change from case to case, but the courts continue to apply the same principles. The same principles that determine the liability of surgeons for errors of nurse anesthetists also determine the liability of surgeons for the negligence of anesthesiologists. When these cases are read, you see the courts examining the facts: What control did the surgeon have over the anesthesia? Was the surgeon aware of the patient's condition? Would a reasonable surgeon faced with the same facts have done things differently? If the anesthesiologists were right and liability was automatic, why do the courts have to spend so much time struggling

with the facts? Moreover, are nurse anesthetists being punished for their success? Anesthesia is so safe that the number of anesthesia cases reaching appellate courts is small to begin with, and finding a steady stream of cases is difficult indeed.

What is dated are not the cases—they are based on solid legal principles—but the false conclusion that working with a nurse anesthetist rather than an anesthesiologist automatically determines a surgeon's liability. It was untrue 30 years ago, it was untrue 20 years ago, it is untrue today, and tomorrow it will still be untrue.

A surgeon's liability for anesthesia was not an issue when surgeons were "captain of the ship." The captain of the ship doctrine simply assumed that the surgeons controlled (and was liable for) everything that went on in the operating room (including anesthesiologists and nurse anesthetists) and did not permit any evidence to contradict the surgeon's ability to control what happened in the operating room. That assumption may never have been true, but it certainly became less and less true as operations became more complex. Eventually, courts refused to follow it as they became more and more aware that the success of surgery depended on a number of highly educated individuals, working cooperatively toward a successful conclusion. Unfortunately, by the time captain of the ship had died out, nurse anesthetists had been forced to defend themselves against charges that they were illegally practicing medicine by describing their collaborative practice setting as one where they were "supervised" or "directed" by a surgeon. Thus, the nurse anesthetists were not practicing medicine because they were engaging in a nursing function while the surgeon made whatever medical decisions might be required. This approach had been incorporated into the licensing laws of several states. The fall of captain of the ship roughly coincided with a dramatic increase in the number of anesthesiologists. Anesthesiologists trying to find an advantage in the newly competitive world of anesthesia seized on this previously immaterial distinction as the cornerstone of a campaign to urge surgeons to use anesthesiologists because only in this way, the argument went, would surgeons avoid being caught up in lawsuits over anesthesia mishaps.

There were two fallacies to this argument that surgeons ignored in the emotional phobia over liability. One was legal: supervision did not lead to liability. Liability was based on control. A surgeon could supervise a nurse anesthetist without being in control. No legal doctrine equated supervision with control or liability.

Second, from a medical standpoint, anesthesia was becoming much safer and just as the law did not look at who issued the provider's license to determine liability, neither did anesthesia mishaps. Anesthesia mishaps, while rare, appeared to occur with the same frequency whether the administrator was an anesthesiologist, a nurse anesthetist, or a team of both providers.

So, at the very time surgeons were being told to avoid nurse anesthetists if they did not want to be automatically liable for anesthesia mishaps, what the courts were really looking at was evidence of the surgeon's control. The surgeon was liable for an anesthesia mishap only if the surgeon was in control of the process or procedure that led to the mishap and otherwise the surgeon was not.

Moreover, in their newly generated concern over the type of license held by their anesthesia providers, surgeons missed another important legal lesson. To be held liable, the surgeon had to have a very specific type of control. The difference between an employee, for whose negligence there is liability, and an independent contractor for whose negligence there is no liability, is not just control, but control over the way the job is done. An employer has the right to control an employee not only as to *what* shall be done but also *how* it shall be done. On the other hand, when someone supervises an independent contractor, he or she can control the *result* (the "what") but not the details and means (the "how"). A surgeon would rarely have the knowledge to control the details and means by which anesthesia is administered. In fact, in some cases in which surgeons have been held liable for the negligence of an anesthetist, the surgeon has admitted to being in control but has confused control of the results with control of the details and means. For example, "Keep the patient relaxed, quiet, and don't let the patient move!" is control of the results. On the other hand, "Let's administer 200 mg of anectine because this patient is quite overweight," or "This looks like a difficult airway. Do an awake fiberoptic intubation!" are examples of control of the details and means. There is a huge difference between having ultimate control of the ways and means (and being liable) and having control over the ultimate result (for which there is no liability).

> Where an employer is interested only in the results, and the contracting party independently determines the details of the method by which the desired results are obtained, an independent contractor relationship exists and the rule of *respondeat superior* does not apply. *Drennan v Community Health Investment Corporation* (905 S.W.2d 811, Texas, 1995)

Liability depends on the facts of the case

The principles governing the liability of a surgeon working with a nurse anesthetist are the same as those governing the liability of a surgeon working with an anesthesiologist. Courts do not look at the status of the anesthesia administrator but at the degree of control the surgeon exercises over the manner in which the administrator—whether that administrator is a CRNA or an anesthesiologist—provided the anesthetic. Thus, a court may render different conclusions for cases that involve a surgeon working with a CRNA—or, for that matter, a surgeon working with an anesthesiologist—if the surgeon controlled the CRNA in one case but not in another. A surgeon is not *automatically* liable when working with a CRNA, nor is the surgeon immune from liability when working with an anesthesiologist. In order for a surgeon to be liable for the acts of the anesthesia administrator, the surgeon must be in control of the details and means used by the anesthetist and not merely be supervising or directing the administrator.

Surgeons have been held not liable for working with CRNAs

There are many cases in which courts have found that the surgeon was not in control of the CRNA and, therefore, not liable for the negligence of the CRNA (Table 1).

Even in cases in which the surgeon was held liable, there is often evidence of individual wrongdoing on the part of the surgeon. Although some states require that a CRNA may administer anesthesia only under the supervision or direction of a physician, mere supervision does not establish "control" nor create liability. As the Court stated in *Voss v Birdwell* (188 Kan. 643 at 655, 364 P.2d 955 (1961):

> In determining whether a person is the servant of another it is necessary that he not only be subject to the latter's control or right of control with regard to the work to be done and the manner of performing it, but that this work is to be performed on the business of the master or for his benefit. Actual control, of course, is not essential. It is the right to control which is determinative. On the other hand, the right to supervise, even as to the work and the manner of performance, is not sufficient; otherwise a supervisory employee would be liable for the negligent act of another employee though he would not be the supervisor or master of that employee in the sense the law means it. (Restatement, Agency 2d, § 220[1], [1958]; *Yorston v Pennell*, Appellant [1959], 397 Pa. 28, 39, 153 A.2d 255).

Other cases also have held that mere supervision or direction of a CRNA is insufficient evidence to hold a physician liable for the CRNA's negligence. 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 Tavarez*, 596 S.W.2d 667 (Texas, 1980); *Parker v Vanderbilt*, 767 S.W. 2d 412 (Tenn., 1988); and *Whitfield v Whittaker Memorial Hospital*, 210 Va. 176 (1969).

Table 1. Cases in which surgeons have been held not liable for working with CRNAs

Cavero v Franklin Benevolence Society (223 P. 2d 471, California, 1950)
Fortson v McNamara (508 So. 2d 35, Florida, 1987)
Franklin v Gupta (567 A. 2d 524, Md, 1990)
Goodman v Phythyon (803 S. W. 2d 697, Tennessee, 1990)
Hughes v St. Paul Fire and Marine Insurance Company (401 So.2d 448, Louisiana, 1981)
Kemalyan v Henderson (277 P. 2d 372, Washington, 1954)
Pierre v Lavallie Kemp Charity Hospital (515 So. 2d 614, La., 1987)
Thomas v Raleigh General Hospital (358 SE 2d 222, W. Va., 1987)
Sesselman v Mulenberg Hospital (306 A.2d 474, New Jersey, 1954)
Starcher v Byrne (687 So. 2d 737, Mississippi, 1997)
Carlson v Javurek (526 F. 2d 203, SD, 1975)

Surgeons have been held liable for working with anesthesiologists

Working with anesthesiologists rather than CRNAs does not insulate surgeons from liability. As we have noted, the legal principles that determine liability are the same whether the surgeon works with an anesthesiologist or a CRNA, and the outcome depends on the facts of the case. As one would expect, there are numerous cases where surgeons have been sued when working only with anesthesiologists and surgeons have been held liable for anesthesia mishaps when working with anesthesiologists (Table 2).

Clearly, surgeons should not pick their anesthesia providers on the basis of licensure. If proof is needed, consider *Herrington v Hiller*, 883 F.2d 411 (U.S. Ct. of App., 5th Cir., 1989). A 448-bed hospital with the only obstetrical unit in 60 miles refused to institute 24-hour anesthesia coverage because it would have meant the hospital would have had to let CRNAs place epidural catheters. The hospital refused, presumably,

Table 2. Cases involving anesthesia mishaps in which surgeons were sued when working with anesthesiologists

Chism v Campbell (250 Neb. 921; 553 N.W.2d 741, 1996)
Kerber v Sarles (542 N.Y.S.2d 94; 151 A.D.2d 1031, 1989)
Costell v Toledo Hospital (98 Ohio App. 3d 586; 649 N.E.2d 35, 1994)
Adams v Childrens Mercy Hospital (848 S.W.2d 535, 1993)
Brown v Bozorgi (234 Ill. App. 3d 972; 602 N.E.2d 48, 1992)
Ruby Jones v Neuroscience Associates, Inc. (250 Kan. 477; 827 P.2d 51, 1992)
Seneris v Haas (45 Cal. 2d 811; 291 P.2d 915, 1955)
Szabo v Bryn Mawr Hospital (432 Pa. Super. 409; 638 A.2d 1004, 1994)
Tiburzio-Kelly v Montgomery (452 Pa. Super. 158; 681 A.2d 757, 1996)
Bert v Meyer (663 N.Y.S.2d 99, 1997)
Robertson v Hospital Corporation of America (653 So.2d 1265, Court of Appeals of Louisiana, 1995)
Menzie v Windom Community Memorial Hospital (774 F.Supp. 91, USDC Conn., 1991)
Thompson v Presbyterian Hospital (652 P.2d 260, Okla., 1982)
Dunn v Maras (182 Ariz. 412; 897 P.2d 714, 1995)
Medvecz v Choi (569 F.2d 1221, U.S. Ct. of App., 3d Cir., 1977)
Carolan v Hill (553 N.W.2d 882, Iowa, 1996)
Vogler v Dominguez (624 N.E.2d 56, Ind., 1994)
Quintal v Laurel Grove Hospital (62 Cal.2d 154; 397 P.2d 161, 1965)
Schneider v Einstein Medical Center, 390 A.2d 1271 (Penn. 1978)
Kitto v Gilbert, 570 P.2d 544 (Colo. 1977)

to follow the recommendations of the American Society of Anesthesiologists in its 1983 Statement on Regional Anesthesia. The plaintiff went to the hospital to give birth at 3:00 AM. The attending physician ordered an immediate cesarean section. Because the hospital did not have 24-hour anesthesia coverage, there was a delay in the start of the procedure while an anesthetist was called and came to the hospital. The child was deprived of oxygen that the parents blamed on the delay, caused, in turn, by the hospital's anesthesia politics. The trial court would not let the parents tell the jury why it had taken so long to start the cesarean section. The US Court of Appeals disagreed and ordered a new trial. The district court was wrong to keep evidence from the jury that the hospital had refused to provide 24-hour anesthesia coverage because of anesthesia politics.

Efforts to eliminate supervision from the HCFA* rules

As most of us know, the continued misrepresentation of the surgeon's liability for negligence of the anesthetist led the AANA to seek reformation of the regulatory framework. Constant attacks on CRNAs as illegally practicing medicine at the turn of the 20th century had led nurse anesthetist leaders to seek protection by having some licensing laws provide that when a nurse anesthetist administered anesthesia under the supervision of a physician, the nurse anesthetist was practicing nursing, not medicine. When in the 1980s that concept was corrupted and the requirement of supervision was used as a tool to restrict CRNA practice, AANA leadership tried to educate surgeons on the law but increasingly felt backed into a corner. There were few options since surgeons simply ignored accurate information in favor of simplistic but inaccurate descriptions of their liability. Reluctantly, AANA leadership decided that if supervision was going to be used to restrict CRNA practice, then AANA would have to seek the elimination of supervision.

While the AANA's efforts were misunderstood as a plan to expand scope of practice, in reality, all the AANA wanted was to preserve existing CRNA practice. It was not the path AANA had wanted to take but every alternative to convince surgeons that liability was not an issue had been foreclosed. The obvious place to start was where the supervision issue mattered most—its effect on reimbursement in the federal Medicare rules. We know the outcome. Even more misinformation was thrown at nurse anesthetists and when the battle finally ended, both AANA and anesthesiologists were forced to accept a compromise neither side wanted. The requirement of supervision was retained but individual state governors could, if requirements were met, cause their state to "opt out" of the supervision requirements. Today, 14 states have opted out of the Medicare supervision requirement and some progress is being made to realize the AANA's goal—to secure for future nurse anesthetists the ability to continue to work collaboratively

* HCFA is the Health Care Financing Administration, which is now known as the Centers for Medicare & Medicaid Services or CMS.

as part of the surgical team, providing safe, quality anesthesia services to the American public.

American Jurisprudence Proof of Facts

Recently, I have become aware of an example of the headway we are making. There has been a major change in the *American Jurisprudence Proof of Facts* and its section on anesthesia. *American Jurisprudence Proof of Facts* is a legal compendium that is useful in finding cases but is not given the same respect among courts as decided cases themselves. Its article on anesthesia (8 *AmJur* POF 2d, p. 570), published back in 1976, cited several cases in which surgeons were not held liable for the negligence of nurse anesthetists. Nonetheless, the authors somehow concluded: "However, it is still true that in almost all cases either as a result of negligent failure to supervise, or from application of general principles of vicarious liability, surgeons are usually held liable for negligence of nurse-anesthetists." (8 *AmJur* POF 2d, p. 601) I always doubted the accuracy of the statement. For one thing, no authority for the statement was ever given. No one ever acknowledged counting the cases, either. In addition, it was clear from the article itself that there were many cases in which surgeons had been held not to be liable for the negligence of nurse anesthetists. Like many other irritating and unfair aspects of this subject, the statement was often quoted by those attempting to restrict the practice of nurse anesthetists. It was sometimes even cited as if it were authority by the courts. (See, for example, *McCullough v Bethany Medical Center* (235 Kan. 732; 683 P. 2d 1258, 1984)).

In July 2006, American Jurisprudence released the 2006 Supplement for *Proof of Facts*, and the article on anesthesia was supplemented by the following statement: "This article has been superseded by the following articles: Anesthesia Malpractice, 6 *AmJur* Proof of Facts 3d 1." The new article no longer says that surgeons "are usually held liable for negligence of nurse anesthetists." In fact, the new article is a much better reflection of the reality of the anesthesia marketplace. The new article refers to the modernization of nursing practice statutes, the broadening scope of CRNA responsibilities, and points out that CRNAs administer a variety of anesthetics without supervision. The article even notes that "Because some CRNAs perform this procedure [spinals] frequently, they usually can perform the procedure efficiently and more safely than many anesthesiologists....often the CRNA must make critical decisions when supervised by a physician with no anesthesia training." (6 *AmJur* POF 3d § 3).

> Traditionally, physicians and hospitals have been held vicariously liable for the nurse's negligence under the theories of agency or respondeat superior. However, since studies have shown the absence of a significant difference in the quality of care delivered by nurse anesthetists and anesthesiologists, many states have now expanded by statute the scope of the CRNA's responsibilities. Today, courts recognize that the CRNA and the anesthesiologist do not perform mutually exclusive functions. In fact, it is often realized that the difference between practicing medicine and nursing cannot always be articulated with certainty. Like the anesthesiologist, the nurse [anesthetist] may be in a position to make life-or-death decisions for the patient. (6 *AmJur* POF 3d §27)

Conclusion

One would like to think that anesthesia personnel would be selected on some basis that relates to the quality of care they provide rather than some muddled impression of how the surgeon can reduce the exposure to liability. Unfortunately, concerns relating to the success of the surgery and the well-being of the patient have all too often been made secondary to what the surgeon wrongly believes will reduce malpractice claims. The truth is that surgeons cannot be guaranteed immunity from anesthesia mishaps no matter who they work with. Moreover, liability and immunity are not automatic in the case of either provider. Surgeons concerned with liability should find the safest provider, an inquiry that has never depended on the agency issuing the provider's license. As *Herrington v Hiller* shows, allowing politics to dictate the choice of anesthesia provider protects neither the patient nor the surgeon.