Legal Briefs

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Harris v Miller

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Even casual readers of this column are aware that the liability of a surgeon or other supervising physician for the negligence of a nurse anesthetist depends on the facts of the case, primarily whether the surgeon or other supervising physician controlled the act of the nurse anesthetist which gave rise to the negligence. The principles governing the liability of a surgeon when working with a CRNA are the same as those governing the liability of a surgeon when working with an anesthesiologist. While there clearly are cases holding surgeons liable for the negligence of nurse anesthetists, there are also cases holding surgeons liable for the negligence of anesthesiologists. A review of appellate level cases reveals that because each case is decided upon its own facts, the courts have been far from consistent in holding whether surgeons are liable for the negligence of nurse anesthetists. There are cases where surgeons have been found to be in control and have been held liable, and there are cases where surgeons have been found not to be in control and have not been held liable.

Vicarious liability

In late January 1994, the Supreme Court of North Carolina decided the case of *Harris v Miller,* reversing a trial court's decision directing a verdict for the surgeon on the issue of vicarious liability. The North Carolina Supreme Court ruled that, based on the facts of this case, the jury should have been allowed to decide if there was sufficient evidence to hold the surgeon liable for the negligence of a nurse anesthetist. Decisions by appellate courts holding that directed verdicts should not be granted in primarily factual matters are neither surprising nor uncommon. If the issue to be decided is one that depends on the facts of the case, then the trier of the case, the judge or the jury, is almost always going to be allowed to consider the facts and render a verdict. Nonetheless, this case seems to have engendered a disproportionate interest, especially among anesthesiologists who have felt it incumbent to warn surgeons that the North Carolina Supreme Court has ruled that the surgeon was liable for the negligence of the nurse anesthetist. In fact, as stated above and as will be seen below, this is far from the case. All the court decided was that because the issue depended on the particular facts, among which was a significantly damaging hospital policy, it was inappropriate for the trial court to have kept the jury from determining those facts.

The facts of *Harris v Miller* are that a woman experiencing back pain went to an orthopedic surgeon for an operation. The operation was performed at a hospital where anesthesia was given by a nurse anesthetist. The hospital's anesthesia manual stated that *"Anesthesia care shall be provided by nurse anesthetists working under the responsibility and supervision of the surgeon doing the case... Administration of anesthesia shall be the sole responsibility of the surgeon and anesthetist involved, and it shall be their*

responsibility to select and administer a proper agent with proper techniques."

The facts, discussed by the North Carolina Supreme Court and set forth in this column, were the plaintiff's evidence and not necessarily the facts as will be found by the jury. The court wrote that "the operation appears to have been doomed from the start. . . ." The plaintiff claimed that the CRNA negligently performed the preoperative anesthesia evaluation, primarily in that the nurse anesthetist interpreted the patient's chest x-rays as negative when the patient had an enlarged heart and in that the nurse anesthetist failed to perform an electrocardiogram, despite the patient's mild obesity and history of high blood pressure. The nurse anesthetist used Demerol®, Innovar®, and Ethrane®, which can significantly lower blood pressure in patients with depressed cardiac function.

Surgery began at 8:05 AM, and the patient's blood pressure continued to drop after induction while her pulse rate rose dramatically. The nurse anesthetist believed that the patient was feeling pain and administered high dosages of Demerol and Innovar and continued to give high levels of Ethrane. He was unable to reduce the pulse rate, and the patient's blood pressure remained dangerously low. Postsurgery x-rays revealed that the endotracheal tube had slipped into the right lung, leaving the left lung unventilated. Unfortunately, the nurse anesthetist had not checked for bilateral breath sounds when he turned the patient after intubation.

Meantime, the orthopedic surgeon continued the operation, unaware of the problems with the patient's blood pressure or pulse rate. At about 8:40, the surgeon noticed an unusual amount of bleeding, which he was unable to stop. He instructed the nurse anesthetist to give blood, which after a delay of 40 minutes the nurse anesthetist eventually did. In the meantime, the patient's blood pressure continued to drop while the pulse rate continued to rise. At about 10:20, the plaintiff claimed that the patient's blood pressure had reached a level that was incompatible with normal brain functions. Moreover, the patient continued to bleed. The surgeon had succeeded only in identifying the source of the bleeding—a small hole in one of the vertebrae on which he had operated. He requested more blood and applied surgicell to the wound, which stopped the bleeding. Unfortunately, the surgeon removed the surgicell after 20 minutes. The bleeding then resumed, but the surgeon did not replace the surgicell. One of the plaintiff's experts testified that the surgeon had turned "a very bad situation into an irretrievable one."

Although the patient's blood pressure had dropped to levels incompatible with normal brain function at 10:20, the nurse anesthetist did not inform the surgeon that there was a problem until 11:10, by which time the patient had no discernible blood pressure or pulse. The surgeon made a partial closure of the back at 11:10 and devoted himself to the resuscitation effort. Blood pressure and pulse were restored, but the damage had already been done. The patient spent 8 months in rehabilitative hospitals before returning home. Her home was remodeled to meet her many needs; she was cared for almost exclusively by her husband for the next 5 years, and despite daily agonizing rehabilitation exercises, her health slowly deteriorated until she died, approximately 6½ years after the surgery.

At trial, the court granted the surgeon's motion for a directed verdict on the plaintiff's vicarious liability claim. The trial court believed that the evidence was insufficient to establish a master-servant relationship between the surgeon and the nurse anesthetist. The case was submitted to the jury on the sole issue of the surgeon's negligence, and the jury found in favor of the defendant that the surgeon was not negligent.

The trial judge's motion for directed verdict was appealed to the North Carolina Supreme Court. The Supreme Court reviewed prior North Carolina decisions. In *Jackson v Joiner* (236 N.C. 259, 72 S.E.2d 589, 1952), the North Carolina Supreme Court had ruled, in 1952, that the surgeon enjoyed the right to control merely because he was the "surgeon in charge." In *Harris v Miller,* The North Carolina Supreme Court ruled that North Carolina would not follow the captain of the ship theory set forth in *Jackson v Joiner. "Though the presumption that the surgeon in charge controls all operating room personnel may have been appropriate in an era in which hospitals undertook only to 'furnish room, food, facilities for operation, and attendance.'. . . it is no longer appropriate in this era."* The court noted that hospitals *"now exercise significant control over the manner in which their employees, including staff physicians, provide treatment. This is done through hiring criteria, training, formal practice guidelines, hierarchical supervision structures, peer review groups, and disciplinary measures."*

Borrowed servant rule

Instead, the theory for the 1990s is a doctrine referred to as the "borrowed servant rule." In our last column, we discussed the difference between independent contractors and employees. Both employees and independent contractors may be asked

to perform the same work for the same person. What distinguishes them? We saw that the relationship of employer/employee depends on control. Both employees and independent contractors can be asked to do a particular job, such as to administer anesthesia or handle someone's legal defense. But an employer can tell an employee not only what to do but how to do it. If a person can be told what to wear, what drugs to use, how to address patients or colleagues or similar details, this is evidence of an employment relationship. In other words, an employment relationship is distinguished by the employer's ability to control not only the result but also the methods of reaching the result.

It is the presence of control which leads to vicarious liability. If the employer has control of the actions, then the employer can avoid negligence through the exercise of that control. People who hire independent contractors cannot control the details of the contractors' behavior. It would be unfair to make them liable for the negligence of independent contractors because there would be nothing they could do to prevent the negligence. This distinction is the heart of the "borrowed servant rule"—*"Whether a servant furnished by one person to another becomes the employe* (sic) *of the person to whom he is loaned* [depends on] *whether he passes under the latter's right of control with regard not only to the work to be done but also to the manner of performing it..."*

Employees or independent contractors?

When nurse anesthetists work with surgeons, are they more like employees or independent contractors? Some state laws require that nurse anesthetists be supervised by a physician. However, the law is clear that statutes requiring supervision or direction do not require control. Nor is control required by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. In fact, there is no legal or regulatory requirement that a surgeon control a nurse anesthetist in any hospital, with or without anesthesiologists. There may still remain some surgeons who try to control every aspect of the operating suite. Those surgeons will likely be responsible for the negligence of their assisting healthcare practitioners (nurse or physician). But such control is voluntary; nothing requires it but the surgeon's own personality.

Harris v Miller highlights yet another way in which surgeons can be found to control nurse anesthetists. The surgeon could agree with the hospital not only to supervise but also to *control* the nurse anesthetist. Such an agreement could be outright (for example, as in *Harris v Miller* it could be set forth in hospital policy) or it could be implied.

"Thus, where the parties have made an explicit agreement regarding the right of control, this agreement will be dispositive... Absent such an agreement, inferences must be drawn from the circumstances surrounding the employment... Facts considered relevant include whether the lent servant is a specialist, which employer supplies the instrumentalities used to perform the work, the nature of those instrumentalities, the length of the employment, the course of dealing between the parties, whether the temporary employer has the skill or knowledge to control the manner in which the work is performed, and whether the temporary employer in fact exercises such control. Of these, the actual exercise of control is the most weighty." (*Harris v Miller,* 438 S.E.2d at 735)

To determine if the surgeon was a temporary employer, the court in *Harris v Miller* analyzed the surgeon's relationship to the operation. It noted that while hospitals now exercise significant control over operating room personnel, surgeons are no longer the only experts in the operating room. Some of the operating room personnel, such as anesthetists and technicians, may have expertise not possessed by the surgeon. Thus, the surgeon will in some cases be ill-equipped, if not incapable, of controlling the manner in which assisting personnel perform their duties.

Even where the surgeon does have the knowledge or skill to control assisting personnel, it may be impractical for him or her to do so given the necessity of focusing on the surgical procedure. Generally, he or she has *"no time to watch the anesthesiologist*(tist), *nurses, or other assistants, much less direct them in the performance of their duties.... Thus today the surgeon in charge may well have authority to direct only the tasks to be performed, not the matter of their performance. In light of the foregoing, we hold that surgeons should no longer be presumed to enjoy the authoritative control of a master over all who assist merely because they are 'in charge' of the operation."* That is, there will be no presumption of control; the facts of individual cases will have to be examined. By this passage, the court is specifically overruling the captain of the ship doctrine.

Starnes v Hospital Authority

The court then considered a prior North Carolina case, *Starnes v Hospital Authority,* 28 N.C. App. 418, 221 S.E.2d 733 (1976). In *Starnes,* a newborn was burned during a surgical procedure by an excessively hot water bottle, which had been placed under him to keep him warm during the surgery. Warming the infant during surgery was the re-

sponsibility of the nurse anesthetist. The plaintiff in *Starnes* alleged that the surgeon should be liable for the negligence of the anesthetist. The North Carolina Court of Appeals rejected the claim on the grounds that the surgeon had no responsibility for training or assigning the nurse anesthetist. The Appellate Court stated that where the negligence sought to be imputed is that of a specialist, like an anesthetist, surgeons should be exempt altogether from respondeat superior liability and held responsible only if they were negligent in supervising the specialist. Absent some conduct or situation that should reasonably place the surgeon on notice of negligent procedure, "we think the surgeon is entitled to rely on the expertise of the anesthetist."

In *Harris v Miller,* the North Carolina Supreme Court overruled a portion of the Appellate Court's determination in the *Starnes* case. The Supreme Court said that the Appellate Court could not assume that surgeons *never* enjoy the right of control over assisting specialists. Whether the surgeon has the right to exercise control depends on the facts of the case.

"[I]*t is clearly not the case that surgeons never enjoy authoritative control over such assistants. As in the case at bar* [the *Harris v Miller* case], *the surgeon may have agreed with the hospital to control the performance of the specialist in question. Or a surgeon may know more about a particular procedure than an assisting specialist and actively supervise the latter's performance, as where the surgeon is assisted by a relatively inexperienced resident physician... Therefore, consistent with traditional agency principles, we hold that a surgeon may be held liable under the doctrine of respondeat superior for the negligence of even a skilled assistant if the surgeon in fact possessed the right to control that assistant at the time of the assistant's negligent act regardless of whether the surgeon should reasonably have been aware of the negligent conduct to be imputed to him."*

Having announced the legal principles to be applied, the Supreme Court then turned to the facts of the case. It is important to note that in *Harris v Miller* the trial had *directed* a verdict by the jury. That is, the jury had never considered the issue and, therefore, had not made any determination of the facts based on the evidence. The Supreme Court assumed, for purposes of its analysis, that the patient's version of the events was true. If the plaintiff's version of the facts is assumed correct, is there sufficient evidence to justify sending the case to the jury? The court decided that taking the evidence of the plaintiff in the light most favorable to the plaintiff, there *would be* sufficient evidence for the case to have gone to the jury. The court did not determine that the surgeon was responsible for the negligence of the anesthetist. All it decided was that a jury should decide the facts.

What was the plaintiff's evidence? First, and most important, was the statement in the hospital's anesthesia manual that *"Anesthesia care shall be provided by nurse anesthetists working under the responsibility and supervision of the surgeon doing the case.... Administration of anesthesia shall be the sole responsibility of the surgeon and anesthetist involved and it shall be their responsibility to select and administer a proper agent with proper techniques."* The Court of Appeals interpreted this language as giving the surgeon the right of supervision, not control. But the North Carolina Supreme Court disagreed. Interpreting this statement most favorably to the plaintiff, it said that the hospital's manual could be interpreted to require the surgeon not only to supervise the anesthetic but to be responsible "to select and administer a proper agent with proper techniques." Therefore, the surgeon could be found by a jury to have not only the obligation of supervision but also the right to control the "techniques" used to administer the anesthetic. The court felt this was a crucial distinction. The bylaws could be interpreted as giving the surgeon the right to control not only the result (by ordering an anesthetic) but the means (the techniques used to administer the anesthetic) as well. By crossing the line from mere supervision to the ability to control anesthesia techniques, the surgeon would have been in a position to control acts giving rise to negligence and to be liable under the borrowed servant rule. The hospital's policy placed the surgeon in the position of the "employer" of the nurse anesthetist.

The court said there were additional facts to support this decision including the testimony of an anesthesiologist that when the emergency arose the surgeon had the right to control the anesthetist's every act, and the testimony of an orthopedic surgeon that if he were faced with the same emergency, he would "enumerate every one of the activities that the CRNA currently should be doing." (Again indicating that the surgeon was obligated to control the means as well as the result.) Even the surgeon who was the defendant admitted that in an emergency situation, it is the surgeon who directs the remedial measures taken by the anesthetist. As further evidence that the surgeon had the right to control the anesthetist, the North Carolina Supreme Court also noted that, in fact, during the operation the surgeon exercised control on at least one occasion when he ordered the nurse anesthetist to stop all anesthesia and give the patient 100% oxygen. *"Implementing corrective measures in the event of an adverse reaction to anesthesia is one of the functions of the anesthetist."* The court takes this as

evidence of a right of control—because he ordered the anesthetist to do something related to the administration of anesthesia on at least one occasion, the court jumped to the conclusion that the surgeon must have understood anesthesia and must have had control of the anesthesia throughout the operation.

Harris v Miller does not strike new ground in terms of law. Rather, it is totally consistent with what we had understood the law to be. A surgeon's liability for the negligence of an anesthetist (nurse anesthetist or anesthesiologist) or other "skilled assistant" continues to depend on whether the surgeon is controlling the activities which give rise to the negligence. Control is a question of fact and is not required by state licensing laws, JCAHO standards, or other official requirements. Under the principles announced in the case, surgeons are just as likely to be held liable for anesthesiologists as they are for nurse anesthetists. In *Harris v Miller,* hospital policy gratuitously and unnecessarily made the surgeon liable for the acts of nurse anesthetists.

Incorrect interpretation of facts

What is troubling, nonetheless, about *Harris v Miller* is something which is frequently bothersome in cases where an appellate court reverses a trial court's directed verdict. That is, the evidence which the appellate court cites appears to be so thin and strained as to be obviously wrong. It is hard to accept the court's argument that because the surgeon was given joint responsibility with the anesthetist for the "techniques" of anesthesia, the surgeon had the ability to control the anesthetist. Nor should a nurse anesthetist need a surgeon to take control because there was an emergency. In other words, what is troubling about *Harris v Miller* is not its statement of the law but its obvious incorrect interpretation of the facts.

In large part, this misstatement is attributable to the forum and manner in which the case came before the court. The court was obligated, for purposes of the appeal, to assume that if there was any possible interpretation of the facts which would justify the plaintiff's position, the court is obligated to send the case back to trial. To someone with any knowledge of anesthesia, the court's interpretation hardly seems to be capable of proof, and it would seem likely that sufficient proof could be introduced, except in increasingly rare circumstances, that surgeons do not control nurse anesthetists. *Harris v Miller* is troublesome, not because of the legal principle expressed but because the case came up in a way which forced the court to engage in a twisted interpretation of the facts.

Even though the court's interpretation of the facts is strained, the lesson to be learned is that hospital policies which unnecessarily impose burdens on surgeons (like those in *Harris v Miller*) beyond what is required by state law and patient care should be eliminated.