Legal Briefs

GENE A. BLUMENREICH, JD
AANA General Counsel
Nutter, McClennen & Fish
Boston, Massachusetts

LaCroix case

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This column has often addressed the liability of hospitals, surgeons, and others for the negligence of nurse anesthetists. This question is important to nurse anesthetists because some physicians have been led to believe that liability for a Certified Registered Nurse Anesthetist (CRNA) may be a reason not to work with nurse anesthetists. As we have said many times, the principles governing a physician's liability for the negligence of a nurse anesthetist are the same as those governing liability for the negligence of an anesthesiologist. It is not the status of the anesthesia provider which determines liability but the degree of control exercised over the provider, nurse anesthetist or anesthesiologist.

Supervision, where required, is insufficient to cause a physician to be liable, and there are numerous cases where courts have ruled that a supervising physician was not liable for the negligence of a nurse anesthetist. However, we now discuss the June 27, 1997, Texas Court of Appeals decision upholding a jury award against a Texas Hospital for damage to a patient under the care of a *non-negligent* nurse anesthetist (*Denton Regional Medical Center v LaCroix*, 947 S.W.2d 941, (1997)). At trial, the jury found that the nurse anesthetist was not negligent but awarded approximately $10 million in damages against the hospital for the patient's injuries. Rather than admit that the jury's verdict against the hospital was inconsistent with its determination that the care providers were not negligent, the Texas Court of Appeals in Fort Worth came up with an unfounded theory reflecting the biased and self-promotional testimony of anesthesiologists who testified against the hospital and the CRNA. They testified that if the hospital had provided anesthesiologist supervision, the patient would not have been injured. The Appeals Court was obviously confused by the testimony, and its decision contains a number of negative statements regarding nurse anesthetist practice.

Facts of the case

The facts of the case are fairly straightforward. Kathy LaCroix went to the hospital for the birth of her first child. Her anesthesia was administered by a nurse anesthetist employed by an anesthesiologist group which held an exclusive anesthesia contract with the Women's Pavilion of the hospital. Anesthesia for the remainder of the hospital was provided by another anesthesiologist group. A nurse anesthetist placed a catheter and began Mrs. LaCroix on Marcaine® [bupivacaine] using an epidural pump. Mrs. LaCroix's blood pressure dropped and the nurse anesthetist turned off the epidural pump and gave ephedrine. The pump was later turned back on. The obstetrician decided to do a cesarean section, Marcaine was discontinued and Mrs. LaCroix was switched to Nesacaine® [chloroprocaine].

By the time that the cesarean section began, Mrs. LaCroix was complaining of breathing difficulties, but they were not severe enough to keep her from speaking. When a pediatrician arrived to

care for the newborn child, he noticed that Mrs. LaCroix was having difficulty breathing but the nurse anesthetist believed it was just nerves. Just before the incision, Mrs. LaCroix seemed to experience a seizure.

The CRNA had difficulty establishing an airway because Mrs. LaCroix's teeth were clenched shut. The nurse anesthetist put Mrs. LaCroix to sleep, intubated her and called for one of the anesthesiologists. The CRNA initially made an esophageal intubation but she removed the tube and successfully intubated Mrs. LaCroix. The baby was delivered, not breathing. When the obstetrician closed the cesarean section incision, Mrs. LaCroix's blood pressure and pulse dropped. Shortly thereafter, Mrs. LaCroix went into full arrest. When Mrs. LaCroix was taken to the recovery room, her tongue was swollen out of her mouth and she had significant swelling of her airway, neck, face, and eyes. Although eventually Mrs. LaCroix was resuscitated, she suffered irreversible brain damage and she is now permanently disabled.

AANA and the Texas Association of Nurse Anesthetists

Mrs. LaCroix and her husband sued a number of people. She settled with the CRNA and the anesthesiologist group but continued her suit against the hospital. At the end of the trial, the jury issued a verdict of approximately $10 million against the hospital but in response to specific questions posed by the trial court, answered that the nurse anesthetist had not been negligent. When the case was appealed, the American Association of Nurse Anesthetists and the Texas Association of Nurse Anesthetists joined in an amicus curiae brief arguing that a hospital should have no liability for anesthesia care when the anesthesia provider was not negligent. However, the century old "turf battle" between nurse anesthetists and anesthesiologists played a major role in the bizarre decision of the appellate court to uphold the jury verdict. The appellate court's decision shows a lack of understanding of the role and capabilities of nurse anesthetists. Unfortunately, this lack of familiarity was also coupled with a willingness to ignore Texas law and what appears to be a commitment, based on emotion rather than logic, to uphold an inconsistent jury verdict.

The anesthesia group providing care in the Women's Pavilion did not provide anesthesia anywhere else in the hospital. The hospital's anesthesia was controlled by another anesthesiologist group which had adopted anesthesia policies and procedures severely restricting CRNA practice. Under the anesthesia department's policies, CRNAs could provide anesthesia care "only under the direct and personal supervision of the physician." "Supervision" was defined so narrowly that an anesthesiologist, or in some cases, another supervising physician had to be physically present or immediately available.

These policies did not improve patient care

These policies were not followed when Mrs. LaCroix received anesthesia. Our experience has been that this type of policy is a "disaster waiting to happen." These policies do not improve patient care; no study has ever shown that they are effective. They do not reflect the standard of care in Texas and they are not required by Texas law; they are not required by the federal Medicare program nor by the Joint Commission on the Accreditation of Healthcare Organizations. Texas law does not even have a supervision requirement for nurse anesthetists. Physicians and other knowledgeable healthcare practitioners recognize that policies which prevent CRNAs from being able to practice to the full extent of their capabilities do not improve patient care and sometimes ignore them. The only class of practitioner who pays close attention to them are plaintiff malpractice attorneys.

At trial, the head of the anesthesia department testified that he brought to the attention of the hospital's administrator the fact that the anesthesiologists in the Women's Pavilion were not personally supervising the nurse anesthetists. The head of the hospital's anesthesia department, a rival anesthesiologist, then testified to several matters which while regularly and clearly refuted by the AANA and this column, were accepted by the Appellate Court as being correct. These included misinformation about legal requirements for supervision and the position of the Joint Commission on the Accreditation of Healthcare Organizations.

The *LaCroix* case is an outstanding example of what is wrong in having restrictions on CRNA practice. When something goes wrong, even in the absence of any proof of negligence, it gives the plaintiff's malpractice lawyer an argument not otherwise available. In *LaCroix*, the argument was the plaintiff's entire case and it resulted in a $10 million jury verdict. The hospital found itself in a position where it had not complied with its own requirements for delivering anesthesia care. The jury, the trial court and the Appellate Court were obviously sympathetic with an innocent young mother who now has an intelligence quotient (IQ) no higher than 76.

The jury determined that the nurse anesthetist was not negligent. But the jury evidently wanted someone to pay for Mrs. LaCroix's damage

and the hospital was certainly a convenient target. It is, however, logically inconsistent to hold the hospital liable for damages for an anesthesia incident when the anesthesia personnel were not negligent.

When a judgment based on a jury verdict is appealed, the Appellate Court is obligated to uphold the jury verdict if there is any legal theory by which it can justify the jury's verdict. Other than emotion and sympathy, there would seem to be no such basis in the *LaCroix* case. However, the Fort Worth Court of Appeals of Texas invented its own theory. It began by reciting the evidence and testimony which had been given in the case, much of which was the usual outlandish "political" arguments recited by some anesthesiologists that nurse anesthetists should not administer anesthesia unless closely supervised by an anesthesiologist. Unfortunately, the Court of Appeals neglected to introduce these facts with the explanation that it was *required* to assume they were true, nor did the Appellate Court even bother to acknowledge that these statements were not legal conclusions but merely the testimony most favorable to the jury's inconsistent verdict. Thus, at the very start of its decision, the court indicates that the evidence showed that *"an anesthesiologist is the most highly trained person who practices anesthesia"* and that *"nurse anesthetists may administer anesthesia but only under the medical direction or the supervision of the physician. Nurse anesthetists can not practice medicine."*

Texas law does not require supervision

Under Texas law, it is simply not true that nurse anesthetists may administer anesthesia only under the medical direction or supervision of a physician. Under Texas law, a CRNA may administer anesthesia free of any physician supervision. While a hospital may voluntarily require that CRNAs be supervised by a physician or by an anesthesiologist, there is nothing in the law which requires it. The anesthesiologists who testified for the plaintiff said that anesthesiologist supervision of nurse anesthetists was the standard of care, but this was incorrect as a matter of law. Texas law reflects the legislature's intent to permit CRNAs to practice without physician supervision. As a matter of law, a rational court would have had to rule that the Texas statute *prevents* a court from finding that anesthesiologist supervision is the standard of care. While a hospital may choose to have anesthesiologist supervision, or even anesthesiologist care, this does not create or change what the legislature has created as the standard of care.

The court determined that the hospital, by failing to follow its policy of anesthesiologist supervision, had breached its duty to Mrs. LaCroix. The hospital was liable for its own direct obligation to the patient, not as a result of the actions of the anesthesia providers. The court's decision is incredible because it fails to recognize that there is only one standard of care in anesthesia. Anesthesiologists and nurse anesthetists do not do different things when they administer anesthesia. They do the same things and they are expected to do them with the same care and results. While an individual practitioner may make an occasional error, neither nurses nor doctors have a monopoly on care or vigilance, nor for that matter, error or negligence. If an anesthesiologist would have done something in a particular circumstance, then so should a nurse anesthetist. If the nurse anesthetist was not negligent, then even if an anesthesiologist had been present, the care provided to Mrs. LaCroix would have been the same.

How could a reasonable jury award damages against the hospital for the absence of an anesthesiologist when it would not have affected the outcome? It was on this point that the court engaged its most absurd conclusions. To justify its decision, the court reviewed testimony of various anesthesiologists testifying for the plaintiff as expert witnesses. While the anesthesiologists could not themselves agree on what had gone wrong, they were unanimous in their conclusion that the nurse anesthetist was negligent for having missed it. They also agreed that if an anesthesiologist had been present, the anesthesiologist would have easily recognized what their fellow expert anesthesiologists could not agree to and would have taken appropriate steps. This testimony is, at best, mere speculation. Expert testimony is supposed to have some scientific basis. But the testimony relied on in the LaCroix case was not within the proper scope of expert testimony.

There is no scientific evidence whatsoever that anesthesiologists provide better care than nurse anesthetists. What scientific evidence there is says there is no proof that the care of either provider is superior. Unscientifically, this conclusion seems obvious because if anesthesiologists provided better care, there would be no profession of nurse anesthesia. There should have been no expert testimony of "facts" which have no scientific basis. The anesthesiologists' testimony was speculative and untestable and should have been excluded as a matter of law. The testimony relied on had been offered to show that the CRNA was negligent and her negligence caused the injury. However, if the jury did not find the CRNA to be negligent, it must not have believed the testimony. Nevertheless, the Appellate Court, in its effort to uphold

the jury verdict, no matter how inconsistent, attempted to justify the result on the grounds that the jury could have believed expert anesthesiologist's testimony that if an anesthesiologist had been present the accident would not have occurred.

Decision was incorrect

The Appellate Court decision in the *LaCroix* case is simply incorrect. The court was badly mistaken in its conclusions concerning the standard of care that a nurse anesthetist should be supervised by an anesthesiologist. This is an incorrect statement since Texas law is quite to the contrary. It will also come as a shock to Texas' rather substantial population of nurse anesthetists who practice without anesthesiologist supervision. It did not matter what expert testimony was offered. The Texas legislature has determined that nurse anesthetists can administer anesthesia without supervision, and no court can establish a different standard.

Anesthesiologists should not have been permitted to offer unscientific testimony for which there was no evidence, and they should not have been permitted to testify to a standard that contradicted Texas law. Finally, the case does great harm in failing to distinguish between facts which the court feels obligated to accept as true on the one hand and law and reality on the other. Because the nurse anesthetist was not a party to the case, statements by anesthesiologists that "anesthesia is the practice of medicine" were permitted to go unchallenged and unexplained. This does not make them true nor does it make them the law of Texas.

Hospitals should remove restrictive policies

Where do we go from here? Much of the opinion is dependent on the unique facts applicable to this case. The hospital is appealing this ruling to the Texas Supreme Court. Nonetheless, we continue to urge, as we said in our article on *Harris v Miller* (*AANA Journal*, June 1994), hospitals which have restrictive CRNA policies should immediately remove them. There is no benefit to be derived; practitioners recognize that the policies are unneeded and sometimes ignore them. Untoward anesthesia events can occur even without negligence. Should an unavoidable event occur, as appears to have been the case in *LaCroix*, hospitals with policies that restrict CRNA practice are simply inviting lawsuits from patients whether or not the hospital thinks they adhere to them. If you are aware that your hospital has this type of policy, you should suggest that it immediately change the policy to avoid this kind of liability.