

LEGAL BRIEFS



Gene A. Blumenreich, JD
Nutter, McClennen & Fish, LLP
Boston, Massachusetts

Key words: Liability, standard of care, supervision.

NURSE ANESTHESIA STUDENTS AND LIABILITY

Recently a friendly school director pointed out that while I have written a number of articles on Certified Registered Nurse Anesthetists (CRNAs) and liability, I have not addressed the issues of liability and the nurse anesthesia student. As we will see, this topic raises issues of importance to students, their teachers, and to all nurse anesthetists who work with students.

From a legal standpoint, the most significant part of “nurse anesthesia student” is not “student,” but “nurse.” Nurse anesthesia students are registered nurses first. They are professionals under the law. Therefore, the principles that govern their liability are the same as the legal principles that establish liability for nurse anesthetists, and the liability of those who work with them are the same as the legal principles that establish liability for those who work with nurse anesthetists. Since anesthesia is a specialty area, students are held to the standard of care of anesthesia. Although things can go wrong in anesthesia without someone being at fault, for CRNAs and students alike, the rule of thumb is that there is liability for anything that goes wrong unless it was appropriately disclosed in the process of informed consent. The shortsighted things that are done in anesthesia—fail-

ure to comply with statutes, adoption of policies that are not followed, and the failure to inform patients of the risks and choices of anesthesia—will cause the same problems for students as they will for CRNAs.

But nurse anesthesia students are not CRNAs. They are students and in the process of learning. There is an old expression (which is much more eloquent than my recollection of it) that we avoid mistakes through experience, but the only way to get experience is to make mistakes and learn from them. However, common sense tells us that you do not allow people to get experience under circumstances that would endanger the lives of others. Students should not be put in positions where their inexperience endangers patients' safety. This requires that they work closely with more experienced CRNAs and that certain duties may be beyond their capabilities, even if these duties are routinely carried out by CRNAs.

An overall observation is that I was surprised how few cases there are that involve students. In large part, I believe this is a tribute to the dedication of those who direct nurse anesthesia schools and the care that they use to assign students to procedures that give them experience without endangering patients.

Ericson v O'Connor

Because nurse anesthesia students are professionals, a malpractice case against a student is just like a malpractice case involving a CRNA. A plaintiff has to establish the applicable standard of care

through expert testimony, must show that the defendant failed to meet the standard of care, and that the defendant's failure caused damage. In *Ericson v O'Connor* (1994 W.L. 6855 [Minn. App.], an unpublished opinion), the Minnesota Court of Appeals affirmed the propriety of summary judgment in a case in which a patient suffered a broken dental bridge. The patient only sued the anesthesiologist even though a surgeon, a CRNA, a student, and several nurses were present in the operating and recovery rooms during the period in which the injury occurred. The trial court dismissed the case despite the broken dental plate and the participation of the student because the plaintiff had failed to introduce evidence of the applicable standard of care.

Parker v Vanderbilt University

As we all know, surgeons are not automatically liable when working with a nurse anesthetist nor are they automatically exonerated when working with an anesthesiologist. The courts do not look at the status of the anesthesia provider but at the degree of control that the surgeon exercises over the acts of the anesthesia provider. In general, surgeons do not have liability when they control the result or ultimate outcome of anesthesia (“Keep him still!”), but they do when they control the means and methods of anesthesia (“Give him 50 mg of Anectine!”). This rule also applies to students. In fact, in one of the major cases that underlies our analysis of the surgeon liability issue, *Parker v*

Vanderbilt University (767 S.W. 2d 412, Court of Appeals of Tennessee, 1988), a student was involved in the patient's care. The Parker case involved an esophageal intubation by a student that, unfortunately, went undetected by the CRNA supervising the student.

The appellate court in *Parker v Vanderbilt* discussed whether the hospital, the chief of the anesthesia department, and the surgeons who were involved in the patient's care could be held liable for the esophageal intubation. The court refused to follow the "Captain-of-the-Ship" doctrine. Considering the liability of the individual defendants, the court refused to hold the hospital's chief of anesthesia liable, finding that the nurse anesthetists, including the student, were not his "servants," meaning that the chief did not control the means and methods used to administer the anesthesia. In a similar fashion, the court considered whether the surgeons controlled the means and methods of the anesthesia or whether they merely had control over the ultimate outcome. In reaching its conclusion that the surgeons were not liable for the negligence of the student nurse anesthetist, the court relied on the fact that the student was a registered nurse who had hospital privileges and had already performed 52 intubations. While the student testified that she believed that the surgeons could control her actions, the court rightly pointed out that this belief referred to the general chain in command structure and related only to the right to control the result. Unlike the student, the court realized that the surgeons had no power to control the means and methods of inserting an endotracheal tube. The court

concluded that there was no basis on which to hold the surgeons liable for the anesthesia mishap, even one involving a student.

Lauro

These principles also were applied by a Rhode Island court in a case decided in 1999. In *Lauro* (739 A. 2d 1183, Rhode Island, 1999), a patient undergoing an operation to alleviate carpal tunnel syndrome suffered an abrasion to the cornea of her right eye. Anesthesia was provided by a student being supervised by an anesthesiologist. As in the *Parker v Vanderbilt* case, the plaintiff argued that the surgeon should be held liable either under Captain-of-the-Ship or because the surgeon controlled the anesthetic and therefore had vicarious liability. The court dismissed the case holding that Rhode Island had never adopted Captain-of-the-Ship and that the proof that the plaintiff had offered of the surgeons' control of anesthesia related to control of the result and not control of the means and methods of anesthesia. The plaintiff's prime evidence of the surgeon's control over anesthesia was the fact that the surgeon testified that he required an anesthetist (from the context, the surgeon probably meant an anesthesiologist) or a nurse anesthetist to be in the room during any operative procedure. The plaintiff argued that this showed that the surgeon had the right to control the anesthesia team in the operating room. While the Rhode Island court does not refer to the distinction between control of the results and control of the means and methods, as in *Parker v Vanderbilt*, the Rhode Island court determined that evidence of requiring the anesthesia team to be present did not show that the surgeon controlled the work or the conduct of

the team. Thus, as in *Parker v Vanderbilt*, the court is essentially saying that control of the result is not evidence of control over the means and methods. The surgeon was not liable for the negligence of the anesthetist, even when the anesthetist was a student. Unfortunately, for the surgeon, the court nonetheless sent the case back for further proceedings in the trial court because of questions over the sufficiency of the informed consent obtained by the surgeon.

Moultrie

Of course, there is no magic exemption just because someone is working with a student either. For example, in *Moultrie* (280 S.C. 159, 311 S.E. 2d 739, South Carolina, 1984), a student was being supervised by an anesthesiologist. In the middle of the case, the anesthesiologist was relieved by another anesthesiologist who was already supervising another nurse anesthetist. Near the end of the surgery, one of the surgeons told the student to turn off the nitrous oxide. The patient shortly began to experience difficulties. When the anesthesiologist was summoned, he discovered that the oxygen valve had been turned off, and the patient was receiving pure nitrous oxide. During the course of the trial, the judge dismissed the case against the surgeons, and the jury returned a verdict of \$100,000 against the anesthesiologist and the hospital. The appeals court sent the case back for further proceedings by the trial court because the trial court had erred in refusing to hear testimony as to the national standard of care for anesthesiologists.

Why does the anesthesiologist in *Moultrie* face possible liability while the surgeons in *Parker* do not? One can argue in the *Moultrie*

case that a student should have sufficient training to be entrusted with turning off the nitrous oxide knob on an anesthesia machine. The court treated the issue as a question of fact to be decided by the jury. It is hard to speak authoritatively about this decision without knowing more specifics about the factual circumstance. However, an anesthesiologist, unlike a surgeon, has sufficient knowledge to control the means and methods with which the student administered anesthesia, the test for liability. In addition, although not discussed in *Moultrie*, the student's supervisor was already busy doing something else. A student is not a CRNA and cannot be treated as just another CRNA. A student may be a professional, but the student is still there to learn. The potential of liability in *Moultrie* may reflect the question of whether the student's supervisor was giving the student adequate attention.

Worthy

Just as with CRNAs, if a hospital adopts policies or there is an applicable statute, it must be complied with, whether the anesthetist is a student or a CRNA. One of the most troublesome cases involving nurse anesthetists was the *Worthy* case (254 Georgia 728, 333 S.E. 2d 829, 1985). At the time, Georgia had a statute that provided that anesthesia "may also lawfully be administered by a Certified Registered Nurse Anesthetist, provided that such anesthesia is administered under the direction and responsibility of a duly licensed physician with training or experience in anesthesia." In the *Worthy* case, a student was giving anesthesia and was being supervised by a physician assistant. The Georgia courts

held that supervision by a physician assistant did not meet the requirements of the statute. Although the statute applied to CRNAs and the student was not a CRNA, the court held, nonetheless, that the statute was applicable. It does not make sense that the legislature would require that a CRNA be supervised by a physician but at the same time permit a student, lacking the training of a CRNA, to be supervised by a physician assistant. Logically, one would expect a student to be subject to greater supervisory requirements than a CRNA, not less. What has always been intriguing about the *Worthy* case is that because negligence is assumed from the violation of the statute, the plaintiff did not have to introduce any evidence of negligence. We cannot know whether anyone was negligent or not. There was an adverse result at the same time that a statute was not being followed. That alone was sufficient to impose liability.

There are several interesting aspects of the *Worthy* case that should be heeded by educational programs and those who work in educational programs. The hospital, the educational program, the student nurse anesthetist, the physician assistant who was supervising the student nurse anesthetist, and the anesthesiology group that was supposed to be supervising anesthesia were all potentially liable for the negligence per se. The court expressed doubt as to liability only with respect to the surgeon. The court said that there was insufficient evidence as to whether the surgeon had an obligation to investigate whether the assembled team was comprised of legally qualified people. As to the surgeon, the case would have to go back for further determination.

A question raised in the *Worthy* case was what was the appropriate standard of care for nurse anesthesia students? An argument was made that the student should be held only to the standard of care and skill of a second-year student. The court said simply that it rejected this contention. Thus, students are held to the standard of CRNAs. Anesthesia is a specialty and those who practice it are held to the standard of care of the specialist. Students attend educational programs in order to learn the skills and knowledge of the specialty. They are not just another set of anesthesia hands. If a student does not yet have the skills and knowledge to perform a particular function, the student should not be performing the function. Educational programs must keep in mind the levels of skill and training possessed by students when assigning them.

Hampton

In *Hampton* (576 So. 2d 630, 1991), a patient complained of shortness of breath and hyperventilation. She was placed in the hospital's medical intensive care unit. At 3:00 AM, the nurse on duty discovered that the patient's endotracheal tube had been pulled out. An oxygen mask was placed on the patient, and the anesthesia department was called to reintubate the patient. The call was a "code" or emergency. Three to 5 minutes later a student responded to the code. The hospital had a written policy allowing students in their first year to respond to code calls with the supervision of a CRNA. However, the student was not accompanied by a CRNA. The student's first attempt to intubate the patient resulted in an intubation in the esophagus rather than the trachea. The student immediately

recognized the problem, removed the tube, ventilated the patient, and tried again. Again, the student intubated the patient in the esophagus. At this point the patient went into cardiac arrest. Cardiopulmonary resuscitation was begun, and the student was successful in intubating the patient on the third attempt. The trial court found that the hospital's policy of allowing students to respond to emergency calls was below the standard of care but that the student had not been negligent, and, therefore, the inappropriate policy had not caused any damage. The Louisiana Court of Appeals reversed the decision. Although the student had not been negligent, the court said that it was more likely that a more experienced CRNA would have been able to intubate the patient more rapidly. Therefore, the trial judge's conclusion that the policy of permitting a student to respond to a code had not caused any damage was incorrect. The case was sent back to the trial court for further determination.

Aubert

Thirteen years before the *Hampton* case, the Louisiana Supreme Court had decided *Aubert*, another case involving the same hospital (363 So. 2d 1223, Court of Appeals of Louisiana, 1978). The facts of *Aubert* were simple. A woman died following childbirth under general anesthesia. She was cared for by a first-year resident in anesthesiology and a nurse anesthesia student. But the real fact of the *Aubert* case is that it was decided in a very peculiar fashion. A jury determined the liability of the individual defendants, the anesthesiologist resident, and the student nurse anesthetist, while a judge decided the liability of the hospital. Despite

the common belief that juries are more sympathetic to plaintiffs than are judges, the jury found that the individual defendants were not liable, while the court concluded "I must follow my own conviction" and found, as a fact, that the hospital's employees, the anesthesia resident, and the student were negligent and that the hospital was liable. Because of the inconsistency of the jury and judicial verdicts, the case was appealed to the Louisiana Court of Appeals. The appellate court reviewed the evidence and determined that there was no manifest error in either verdict allowing them to stand, inconsistent or not. Among the facts discussed by the appellate court was the considerable expert testimony that the training provided to the resident and the student "was adequate for them to handle the assignment. Indeed, not even plaintiff's experts disputed this."

Both *Hampton* and *Parker v Vanderbilt* are based on an esophageal intubation. In *Parker v Vanderbilt*, the court did not find the hospital negligent but it did in the *Hampton* case. How does the *Hampton* case differ from *Parker v Vanderbilt*? In *Parker v Vanderbilt*, the court favorably referred to the 52 intubations by the student as an indication of the student's experience. In *Aubert*, no one even challenged the student's training. Yet, in *Hampton*, despite 200 intubations previously performed by the student and testimony that the student had been taught the technique of intubation, the court referred to the student as a "beginner." While it did not find fault with the student, it held that the hospital's policy of permitting students to respond to codes was wrong. I am not sure there is a satisfactory explanation of why 52 intubations in one case were

enough while 200 intubations in another was not. Whether a student is sufficiently experienced is a question of fact. Maybe the difference in outcome merely reflects different sensitivities among the judges. While courts generally defer to each other on explanations of law (and when the courts are in different states, they do not even need to do that), conclusions from factual patterns in any one case are not binding on other courts even when apparently the same factual patterns appear.

Obviously, students differ from CRNAs because their education is not yet complete, and they do not have the experience of a CRNA. There is, however, one distinguishing characteristic that may help to resolve the contrary results of the *Aubert*, *Hampton*, and *Parker* cases, and that is the seriousness of the activity. While there may be no such thing as a routine anesthesia case, in *Aubert* and *Parker* the patient was a relatively healthy patient, not in distress. These were the kinds of cases that someone might appropriately assign as a learning experience to a student nurse anesthetist. *Hampton*, on the other hand, was a code. The plaintiff was already in distress and short of breath. A delay in securing an airway could be anticipated to cause severe problems. The margin of error in *Hampton* was significantly smaller than the margin of error in either *Aubert* or *Parker*. While courts do not give us the luxury of discussing why their results differ, perhaps the court's adverse decision reflects its dislike for the hospital's policy. (Even with that distinction, I find *Hampton* puzzling. My understanding is that available personnel respond to codes as soon as possible. Was it not better to have a student

attempt an intubation than to have done nothing until a CRNA or an anesthesiologist arrived?)

Laverick v Childrens Hospital

There is yet one more case that presents a peculiar problem that may be of interest to educational institutions, and it was suggested by *Laverick v Childrens Hospital Medical Center* (43 Ohio App. 3d 201, 540 N.E. 2d 305, 1988, Court of Appeals of Ohio). A school had made arrangements with a hospital so that its anesthesia student nurse trainees could be sent to the hospital to obtain experience in pediatric anesthesia. As part of the agreement, the school agreed to indemnify the hospital for any damage suffered by the hospital caused by the students. The students were assigned to cases where they were supposed to be supervised by the hospital's anesthesiologists, a private group. During one of the cases, a young child was overdosed with Forane (isoflu-

rane) gas. Although the child was resuscitated, she failed to recover and died a few days later. The child's parents sued the hospital, the students, and the supervising anesthesiologists. The anesthesiologists claimed that because of the indemnification agreement from the school in favor of the hospital, the anesthesiologists group should have no liability. The court held that the school and the hospital were intending only to allocate risks involved in the training program between themselves and were not intending to impose liability on the school that may be incurred by third parties. While the court decided the case in favor of the school, educational programs may want to note the danger of broad language in agreements with hospitals. It would be best to avoid putting an educational program into a position where it could be sued by negligent third parties who should have been protecting it.

Opportunity for inconsistent decisions

As we know, courts find the area of anesthesia very confusing and despite their dependence on expert testimony and their deferential to the profession in terms of setting the standard of care, there is still opportunity for inconsistent decisions. This is just as true of the case law involving students as it is of CRNAs in good standing. The legal principles remain the same for nurse anesthetists and for student nurse anesthetists, but the courts recognize that there are differences between the two. Student nurse anesthetists are not merely another pair of hands in a hospital's anesthesia department; they are at educational institutions to learn, to be guided, to be protected, and not to be exploited. Like the courts, those who schedule and supervise students also must recognize their differences from CRNAs.