
Legal Briefs

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Standard of care

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The field of anesthesia is unique in healthcare because its two separate providers, anesthesiologists and nurse anesthetists, are direct competitors. Each is a separate profession; yet, there is only one standard of care and that standard must be adhered to by both nurse anesthetists and anesthesiologists. That there is only one standard of care is not intuitively obvious. Most of the public, including lawyers, judges, and members of the legislature, do not realize that there is one standard of care. This lack of knowledge can be problematic for nurse anesthetists. In the Appellate Court decision in the *Lacroix* case (947 S.W. 2d 941, Texas, 1997), an appellate court in Texas allowed itself to uphold an inconsistent jury verdict that found the nurse anesthetist was not negligent, but the hospital was liable for violating its own policy of providing anesthesiologist supervision. However, a consideration of the nature of anesthesia, court decisions in malpractice cases, and the reality of practice leads to the inescapable conclusion that there is only one standard of care in anesthesia.

The nature of anesthesia

Clearly, no one in healthcare is as familiar with what can go wrong in anesthesia as nurse anesthetists. Unlike members of the public, nurse

anesthetists can easily evaluate the qualifications of anesthesia providers. Therefore, when you or a member of your family has needed anesthesia in the past or if you or a member of your family might need anesthesia in the future, who would you ask to give anesthesia? If you are like most nurse anesthetists I know, you have a list of persons whose work you respect and whom you would ask to administer anesthesia to yourself or your loved ones. This list might include both nurse anesthetists and anesthesiologists. If you examine your list and those of other nurse anesthetists and try to identify the qualities and characteristics of the providers whom they selected, the type of license and the nature of the degree are irrelevant. What most nurse anesthetists look for in a provider is vigilance and organization. Yes, anesthesia requires a great deal of education, but it has been clear to me for some years that programs for both nurse anesthetists and anesthesiologists do a very good job of educating.

To understand what makes an exceptional anesthetist, you have to consider the negative: what goes wrong in anesthesia? The studies on anesthesia care show that most anesthesia incidents are avoidable and relate, not to a lack of education, but to a lack of vigilance. The most common anesthesia incidents consist of intubation in the esophagus rather than the trachea and disconnection from the anesthesia machine. These are not problems which require massive amounts of education to un-

derstand and avoid. Moreover, these are not problems which either practitioner, nurse anesthetist or anesthesiologist, would be more or less likely to make. These are human problems; they reflect the outer limit of human providers to concentrate and to remain vigilant. Neither anesthesiologists nor nurse anesthetists have a monopoly on vigilance.

Anesthesia incidents happen to both providers and each provider has the same types of incident. The only double standard in anesthesia is not the standard of care but the level of public scrutiny when an anesthesia incident involves a nurse anesthetist rather than an anesthesiologist.

Whatever studies there are in the field of anesthesia do not show any difference in the quality of care as between nurse anesthetists and anesthesiologists.¹ If there were any difference in the *standard* of care, it would be reflected in the *quality* of care. Since there is no measurable difference in the quality of care between nurse anesthetists and anesthesiologists, both providers must be providing care with the same standard of care.

Court decisions

How do courts look at the two providers? Both nurse anesthetists and anesthesiologists are professionals. This means that because the courts do not understand what they do, the court designates them as "professionals." Professionals set their own standard of care. When the courts need to find out what that standard is, expert testimony establishes what the standard of care is for any particular circumstance.

Even though there are two professionals who administer anesthesia, members of the professions are qualified as expert witnesses to describe the standard of care, not just for their profession, but for anesthesia as a whole. In *Carolan v Hill*, (553 N.W. 2d 882, Iowa, 1996), the plaintiff underwent surgery to treat severe reflex esophagitis. Following the operation, the plaintiff began experiencing pain and numbness in his arm and finally he brought suit against his surgeon and anesthesiologist claiming improper positioning and padding of his arm during the administration of anesthesia during surgery. [The next time a surgeon suggests he will not get sued if he uses an anesthesiologist, be sure to mention this case.]

The plaintiff planned to offer a nurse anesthetist as his expert witness. Just prior to trial, the defendants filed a motion to exclude the nurse anesthetist from testifying. The Iowa statute that governs expert testimony is, unfortunately, not as clear as it could be. The statute allows "*a person to qualify as an expert witness and to testify on the issue of the appropriate standard of care if the person's medical or*

dental qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case." (Iowa Code Section 147.139) The question is whether a "person" other than a physician has "medical qualifications" that relate directly to the "medical problem or problems at issue and the type of treatment administered in the case."

The trial court agreed with the defendants and ruled that a nurse anesthetist could not testify as to the standard of care required of an anesthesiologist. However, the Supreme Court of Iowa interpreted the provision as permitting *anyone* with the proper background to testify. Had the legislature "wanted to restrict expert testimony to physicians and dentists, it easily could have done so." Even a nonphysician can have "medical" qualifications. Having determined that the statute did not bar the nurse anesthetist from testifying, the issue under the statute was whether the nurse anesthetist had qualifications that relate directly to the medical problem or the problems at issue and the type of treatment administered in the case. The Supreme Court of Iowa determined that the nurse anesthetist did. The nurse anesthetist had 27 years of practice and had delivered anesthesia to approximately 17,000 patients (unknown to the court, the nurse anesthetist was shortly to receive the American Association of Nurse Anesthetists' annual award for Outstanding Practitioner of the Year). Therefore, the Supreme Court of Iowa determined that a nurse anesthetist met the qualifications of the statute and was capable of testifying as an expert witness as to the standard of care in anesthesia not only for nurse anesthetists but for physician anesthetists as well.

The courts have recognized nurse anesthetists as expert witnesses in other cases, as well. In *Young v Department of Health and Human Resources*, 405 So. 2d 1209 (Louisiana, 1981), a nurse anesthetist was appealing his dismissal. The issue was whether the nurse anesthetist had met "the basic standards and minimum requirements of performance of a nurse anesthetist. . . ." Both the department and the nurse anesthetist offered expert testimony from anesthesiologists as to the standard of care in anesthesia. In addition, the department also introduced the testimony of nurse anesthetists as to standards at the hospital where the nurse anesthetists worked. The plaintiff's counsel objected to the testimony of nurse anesthetists. The court ruled that nurse anesthetists could be expert witnesses. In this single case, the court accepts, interchangeably, testimony from anesthesiologists and nurse anesthetists as to the standard of care in anesthesia which a nurse anesthetist must meet.

In *Goodman v Phythyon*, 803 S.W. 2d 697 (Tennessee, 1990), a patient sued his ophthalmologist for negligence during cataract surgery. The anesthesiologist had difficulty getting the patient to remain still. The operation had been stopped at several points so that the patient could be rendered immobile. Although the nurse anesthetist advised the surgeon that the operation could proceed, the plaintiff again became uncooperative and attempted to move off the operating table which resulted in damage to his eye. The ophthalmologist was sued for negligence. At trial, an anesthesiologist was permitted to testify as to the standard of care in anesthesia for both anesthesiologists and nurse anesthetists. However, the anesthesiologist did not claim to be knowledgeable about the practice of surgery and ophthalmological surgery. Since the issue in the case was the negligence of the ophthalmologist, the appellate court ruled the anesthesiologist could not testify because the anesthesiologist did not claim expertise in ophthalmology. This left only the testimony of the ophthalmologist that he could rely on the assurance of the anesthetist team that the patient was under control and properly sedated. There being no other evidence of his negligence, the case against the ophthalmologist was dismissed.

In *Webb v Jorns*, 473 S.W. 2d 328 (Texas, 1971), two surgeons were sued when their patient went into cardiac arrest on the operating table. The patient offered the testimony of a medical expert witness that the patient had died of an overdose of halothane. There was no evidence that the nurse anesthetist had delivered a dosage greater than 1½% which even the plaintiff's expert had indicated was an acceptable level. The discussion is not whether a nurse anesthetist would have used a higher or lower amount. The expert's testimony was that, absent some special circumstance, it would have been negligence to have used a higher concentration of halothane whether the anesthesia provider was a nurse anesthetist or an anesthesiologist.

In *Yoos v Jewish Hospital of St. Louis*, 645 S.W. 2d 177, (Missouri, 1983), a nurse anesthetist administered a spinal anesthetic to a patient having a hip replacement. Testimony indicated that the spinal anesthetic agent had risen in the spine to a point where it had some effect on the patient's breathing. During the course of the operation, the patient complained of pain in the hip; and when narcotics would not relieve the pain, it became necessary to administer a general anesthetic. After the operation, the patient remained comatose. At trial, the plaintiff's expert, John Adriani, MD, a well-known

anesthesiologist, testified that it was negligence for the anesthetist to permit the spinal anesthetic to rise to the level it did.

There were several interesting aspects of the case. The first was that the Missouri Court of Appeals determined that the standard of care was "that degree of care, skill and proficiency which is commonly exercised by the ordinary skill, careful, and prudent *physician* engaged in a similar practice under the same or similar conditions." [Emphasis added.] Here, specifically, the court adopted the standard of care which would be required of a physician. Once more, this demonstrates the existence of only a single standard of care in anesthesia. The second interesting thing is that Dr. Adriani testified that it was negligent to fail to supervise a nurse anesthetist when the nurse anesthetist is giving a spinal anesthetic [again, a totally unwarranted statement], but this was ignored by both the trial court and appellate court.

Dr. Adriani, for many years, was the anesthesia director of a well-known school for nurse anesthesia at Charity Hospital in New Orleans. Five years before the *Yoos* case, he was a defendant in another case which involved both an anesthesiologist resident and a student nurse anesthetist. In *Aubert v Charity Hospital of Louisiana*, (363 So. 2d 1223, Court of Appeal of Louisiana, 1978), the plaintiff died after childbirth by cesarean section under a general anesthetic. Suit was brought against the hospital, the anesthesia resident, the student nurse anesthetist, and Dr. Adriani, the director of the Department of Anesthesiology, and his deputy director.

The structure of the trial was unusual. The jury heard the case against the individual defendants and found none of the individual defendants negligent. However, the claim against the hospital was tried to the judge, not the jury. Both judge and jury had heard the same evidence, but the jury determined that the individual defendants were not negligent, while the judge disagreed. The judge did not reverse the jury's verdict against the individual defendants. But because he found that the anesthesia resident and student nurse anesthetist were negligent, he ruled that the hospital was liable. The expert opinion which the judge believed suggested that there had been a negligent intubation into the esophagus. Even though disputed, the same testimony was introduced on the conduct of both anesthesiologist and nurse anesthetists.

In *Aubert*, there is no discussion of alternative standards because one provider was a physician and the other a nurse. An intubation into the esophagus is negligence no matter who performs

it, and the failure to discover is negligence no matter who fails to observe it. The irony of the case is that although neither the anesthesiologist resident nor the student nurse anesthetist were experienced, the court held that Dr. Adriani did not need to provide immediate supervision and, therefore, was not negligent. In *Yoos*, Dr. Adriani, testifying as an expert witness, took a much harsher view of supervision even when the anesthetist was experienced.

In *Cornfeldt v Tongen*, 262 N.W. 2nd 684 (Minnesota 1977), a patient was diagnosed with cancer of the stomach. Routine, preanesthetic laboratory tests suggested an abnormality. Although additional tests were available which would have revealed that the patient was suffering from hepatitis, the surgeon and the anesthesiologist assumed that the tests showed that the cancer had spread to the liver. The anesthesiologist used halothane for the anesthetic agent, and the patient ultimately died from liver failure. An autopsy showed no evidence of cancer (which the court deemed immaterial because, with the pathologist's diagnosis of cancer, an operation had to have been performed). The jury rendered a verdict in favor of the surgeon and the anesthesiologist, but this reflected the fact that the court excluded evidence from the plaintiff's six expert witnesses.

One of these expert witnesses was a nurse anesthetist. The trial court judge apparently ruled that the nurse anesthetist could not testify because the nurse anesthetist was not licensed to practice medicine. The Supreme Court of Minnesota ruled first that the competence of a witness to testify on a particular matter is a question of fact peculiar within the province of the trial judge. The ruling of the trial judge will not be reversed unless it is based on an erroneous view of the law or clearly not justified by the evidence. However, the court also said that licensing statutes should have no direct application to the qualification of expert witnesses. Therefore, the nurse anesthetist should have been a competent expert witness. The trial court was wrong to exclude the nurse anesthetist's testimony simply because the nurse anesthetist was not licensed to practice medicine. Going further, the supreme court pointed out that the plaintiff was going to ask the nurse anesthetist whether the anesthetic was appropriate in the circumstances. The supreme court said this was the wrong question. The issue in the case was whether the defendant anesthesiologist's actions conformed to accepted medical practice. Since this was not *exactly* what the nurse anesthetist was being asked, the nurse anesthetist's testimony was properly excluded.

It is difficult to justify the outcome of *Cornfeldt*

v Tongen to any but the most die-hard legal metaphysicians. A patient who should have had a 90% chance of walking out of a hospital is dead because a surgeon and an anesthesiologist neglected to order appropriate tests. The trial court and the appellate court are hung up in the most remote of legal niceties. How could an anesthesiologist have used halothane on the patient without first ruling out hepatitis? The Minnesota Supreme Court would have accepted the testimony of a nurse anesthetist on what constitutes accepted medical practice. Again, this reflects a recognition that nurse anesthetists are aware of the standard of care in anesthesia. Only because the plaintiff's attorney intended to ask the wrong question, the nurse anesthetist was not permitted to testify.

The reality of practice

It is not surprising that the standard of care should be the same for nurse anesthetists and anesthesiologists. Anesthesia personnel want the best outcomes for their patients. Nurse anesthetists and anesthesiologists are permitted a great deal of initiative and discretion in what they do to achieve this outcome. Neither group, and no individual anesthesia provider, will knowingly follow practices or procedures which lead to bad outcomes or which unnecessarily endanger the lives or the well being of their patients. Thus, as advances are made in the field of anesthesia, they are adopted by both nurse anesthetists and anesthesiologists throughout anesthesia. It is remarkable, when one stops to think about it, how quickly pulse oximeters and other monitoring devices were accepted in anesthesia. Within a very short time period, they became the standard of care because it became obvious that they reduced whatever risk there might have been to anesthesia patients.

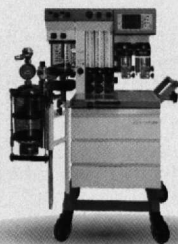
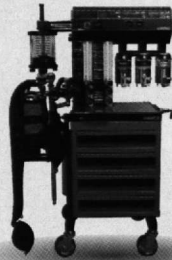
The fact that nurse anesthetists and anesthesiologists compete so directly provides a motivation to follow the very best practices. This competition has created the remarkably high, unified standard of care in anesthesia. That there is a unified standard of care can best be seen in the fact that studies cannot find a difference in outcome by provider. Nurse anesthetists are accepted as experts in anesthesia and are permitted to testify as to the unified standard of care. The unified standard of care is found in the reality of practice and recognized by the courts and the legal system.

REFERENCE

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