
Legal Briefs

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Supervision

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The legal profession, including the courts, have had difficulty understanding what nurse anesthetists and other health care professionals do. The result of this lack of understanding can be seen in the deference which courts give to the health care professions in general. Health care practitioners are made "professionals." Their care is judged not on the basis of what a reasonable individual would do but on what other members of their profession would do. When the standard of care of professionals is questioned, expert testimony is introduced to establish what conduct is expected from them. Periodically, courts come to inappropriate conclusions reflecting not only their own lack of understanding but the inadequate understanding of the parties themselves.

Bonner

In *Doctors Hospital of Augusta, Inc. v Bonner*, (195 Ga. App. 152, 392 S.E. 2d 897, 1990), neither the court, the lawyers nor the supervising physician showed any understanding of what is required to supervise a CRNA. The patient was a 38-year-old practical nurse who weighed 250 pounds and was 5 feet tall. She required arthroscopic surgery. The hospital had an exclusive contract with an anesthesiology group to provide anesthesia services. The anesthesiology group used nurse anesthetists, whether the nurse anesthetists were employees or independent contractors was to be litigated. As the

surgery was being completed, the patient suffered a laryngospasm. The nurse anesthetist tried to ventilate the patient using, what the experts claimed, based on the patient's size, were inadequate dosages of Anectine® (succinylcholine). As the nurse anesthetist attempted to ventilate the patient, a circulating nurse asked the "floating anesthesiologist" to come into the room. The patient was reintubated, but there was evidence that this intubation was made in the esophagus and that the patient's size made it difficult for the improper intubation to be discovered. After a 5-minute wait, the anesthesiologist decided to reintubate, at which time the patient's breath sounds began to improve. Unfortunately, by this time it was too late; the patient was declared brain dead within a week.

A jury found in the plaintiff's favor and the hospital and anesthesiologist group appealed the jury's decision. This decision was entered by the Court of Appeals of Georgia. The Court of Appeals of Georgia is not Georgia's highest court, and the case may be on appeal to the Supreme Court of Georgia. The Appeals Court does not make clear what issue the court thinks it is deciding. At the beginning of the court's analysis, the court correctly phrases the issue as whether "*there had been a failure to exercise the degree of care generally required in the administration of anesthesia.*" Normally, in a malpractice case, a plaintiff introduces evidence of the standard of care, evidence that the care the plaintiff received was less than that required by the standard of care and evidence that the plaintiff has been

injured by the lack of appropriate care. In the *Bonner* case, both the plaintiff's lawyer and the Appeals Court found a shortcut. Without even a turn signal, the court tries to avoid introducing a large part of the evidence by making the *Bonner* case match another anesthesia case, *Central Anesthesia Assoc. v Worthy*, (254 Ga. 728, 333 S.E. 2d 829, Ga., 1985), discussed in this column in April 1986.

Central Anesthesia Assoc. v Worthy was a case where an anesthesia student had been supervised by a physician's assistant, although the Georgia statute at the time required supervision "by a duly licensed physician with training or experience in anesthesia." (In 1990, the Georgia statute was amended to require supervision by only a duly licensed physician). In *Worthy*, because the nurse anesthesia student had not been supervised by a physician, the Georgia statute had not been followed. In general, failure to follow a statute adopted for public safety is negligence per se. That is, courts will not require proof that the conduct was negligent nor even that the conduct, in fact, led to the injury.

In *Bonner*, rather than bother with proof of the standard of care and whether the negligence led to the injury, the court apparently thought it would save a lot of time if it turned out that the statute was not complied with. Then, as in *Worthy*, everyone involved would be guilty and liable as well, and the court could go on to another case!

But, in *Bonner* there was a supervising physician, and he was even an anesthesiologist. What possible argument could be made that the statute was not complied with? The court recognizes that the statute does not provide a definitive standard of supervision. The court said, however, that a jury could find that the statute had not been complied with because the nurse anesthetist had no written guidelines of when to call the anesthesiologist. Instead of seeking expert evidence on whether the defendants met the standard of care, the court says the testimony of the experts (two anesthesiologists) that the supervising physician should have been called earlier can be used as evidence that the Georgia statute was not complied with. Therefore, with just a little ingenuity, the court can make the *Bonner* case look like the *Worthy* case, and it does not have to find out how physicians actually supervise CRNAs (which is what the Court should really have considered) or whether a CRNA really needs an anesthesiologist in the room to reintubate a patient (not the CRNAs I know).

CRNAs should be aware of *Bonner* case

Even though the *Bonner* case is a poor decision, CRNAs should be aware of it, and they should be

aware that the case is not interpreting any legal requirement of supervision. The level of supervision is a factual question. Conclusions concerning factual matters vary from case to case and do not influence decisions in subsequent cases. In the discussion of the case by the Appeals Court, the only testimony that was reviewed by the court was the testimony of the two anesthesiologists, both of whom testified that the supervising physician should have been called earlier. Because the issue of the level of supervision is a factual one, CRNA testimony would have been appropriate and would undoubtedly have been sharply different than the testimony of the two anesthesiologists. While in those states which require supervision, the relationship between a nurse anesthetist and the supervising physician should depend on the circumstances of the individuals involved, the relationship in the *Bonner* case does not sound different than countless other supervisory relationships. The AANA Position Statement on Relationships Between Health Care Professionals would have undoubtedly been helpful to the court for its explanation that in the reality of practice, the level of supervision takes into account a number of factors including the relative experience of the nurse anesthetist and the supervisor and that there is not a single supervision model to be followed.

Bonner is an attempt to force the facts of an anesthesia mishap case involving a nurse anesthetist into the most convenient mold that could be found without effort. Nurse anesthetists should be aware of it and be prepared to point out its unusual and faulty reasoning. Most importantly, the finding of inadequate supervision is a factual and not a legal finding. Proper evidence would have gone a long way in eliminating the problem.

Another interesting aspect of the *Bonner* case is its recording of the efforts of the defendant anesthesiology group and hospital to escape liability through legal forms. Most have heard of the legal principle that an employer is liable for the negligence of its employees. Consequently, the hospital did not employ the anesthesiologists. They were independent contractors providing full-time anesthesia services to the hospital. The hospital did not employ the nurse anesthetists either. As a matter of fact, neither did the anesthesiologists. The nurse anesthetists were independent contractors who had agreements with the anesthesiology group. The court said that despite these efforts, the jury was justified in finding liability because the nurse anesthetists identified themselves as being part of the hospital's anesthesia service and the anesthesiologist testified that despite the contracts, he could still control the actions of the CRNA.

Leiker

In *Leiker v Gafford*, 245 Kansas 325 (1989), a surgeon worked directly with a CRNA. The surgeon was held liable for the CRNA's alleged negligence. The surgeon appealed based on the fact that the surgeon was not in control but was only supervising the CRNA. The Supreme Court of Kansas refused to overturn a jury verdict. The court commented that "There was conflicting testimony from expert witnesses as to whether . . . [the surgeon] . . . appropriately supervised . . . [the CRNA]." (p. 353)

Although the surgeon's position that he was "supervising" and not "controlling" indicates a good understanding of the issues, there were a number of factors in *Leiker* which drove the court to uphold the jury's verdict. Among other things, the surgeon had admitted that his professional corporation had vicarious liability for the negligence of the CRNA. This admission was inconsistent with a position that the surgeon was not liable. The surgeon also appeared to have engaged in negligent acts of his own. Because the surgeon and his attorney failed to ask the jury what specific acts of the CRNA the surgeon was vicariously liable for, the area which could be reviewed on appeal was severely limited. The jury found only that the surgeon was liable for the negligence of the CRNA. The surgeon's attorney did not ask the jury to indicate the specific acts for which the surgeon was responsible, and, consequently, there was very little for the Appeals Court to consider on appeal.

There is a prior case in Kansas saying mere supervision of another professional is insufficient to hold a physician liable— *McCullough v Bethany Medical Center*, (235 Kan. 732, 1984). To hold a physician liable, there must be a finding of control or the right to control. The principles which govern a surgeon's liability when working with a nurse anesthetist also govern the surgeon's liability when working with an anesthesiologist. Because of its unique factors, *Leiker* does not shed any light on the issues of supervision.

Other cases

Bonner is inconsistent with other cases examin-

ing the liability of physicians working with nurse anesthetists. For example, in *Parker v Vanderbilt*, 767 SW2d 416 (Tenn., 1988), the court recognized a CRNA as "a highly trained specialist acquiring skills in the course of his or her training that a surgeon does not possess." In that case, neither the surgeons nor the absent anesthesiologist were held liable for the nurse anesthetist's negligence. There have been similar findings in numerous other states.

Conclusion

Why is "supervision" difficult for the courts to understand? Part of the problem arises from cultural stereotypes which some judges have permitted to influence their decisions. In the *Bonner* case, the court wrongly assumed that nurses could not be responsible for anesthesia without the immediate oversight of an anesthesiologist. The Appeals Court in *Bonner* was so uninformed that it viewed nurse anesthesia as an exception to the requirement that only physicians could practice medicine.

One can certainly be "supervised" by someone who knows less than the person supervised. Once nurses began to specialize in anesthesia, it was obvious that in very little time they would become more knowledgeable and adept at anesthesia than the physicians supervising them. This was the case at the time statutes recognizing nurse anesthetists were adopted in many states. If nurse anesthetists were not giving exceptional care, the profession would have died long ago, especially because it competes with a physician group which also specializes in anesthesia. Those states requiring supervision permit supervision by *any* physician, not just those specializing in anesthesia.

It is important that courts considering "supervision" understand the reality of practice. In those cases where the court only gets to hear testimony from anesthesiologists on *when* an anesthesiologist should be called and not *if* an anesthesiologist should be called, is it any wonder that the court makes uninformed statements on supervision?