
Legal Briefs

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Malpractice: The gathering storm

On October 16, 1846, a dramatic event occurred at Massachusetts General Hospital in Boston, Massachusetts, which would thereafter significantly affect the future of medicine throughout the world. At the urging of a Boston dentist, William Morton, the renowned surgeon, John Collins Warren, performed surgery on an anesthetized patient for the first time in history. The patient was anesthetized with the use of the vapors of a substance which the world came to know as ether. The event was so significant that the amphitheater in which the operation was performed, called the "etherdome," is now preserved as a National Historic Landmark. In addition, the hospital has commemorated "Ether Day" each October 16 since 1903 in various ceremonies and speeches.¹

If Dr. Warren were alive today to see the progress that has been made in the field of anesthesia, he would recognize that his pioneering efforts had led to enormous advances in the field of anesthesia, though not without its problems. Among the most difficult of these problems are the increasing threat of malpractice claims and large malpractice judgments.

This article will explore the nature of malpractice claims, their common causes in the anesthesia field and what the individual practitioner can do to prevent them.

Malpractice defined

At the outset it is important to understand what is really meant by the term "malpractice." It is not, as many people seem to believe, an independent field of the law with its own rules and practices. It is no more and no less than an extension to a particular field of the doctrine of negligence, with which we are all reasonably familiar in our daily lives.

Although the subject matter is obviously more complex, the general theory of the law relating to

malpractice actions does not differ significantly from the law relating to accidents between motor vehicles. Drivers of automobiles owe each other a duty of reasonable care, and when they fail to exercise that reasonable care, by failing to stop at a stop sign or speeding for example, and that breach of duty causes harm to someone else—that is, an accident occurs—the driver who has breached his duty is liable for the damage caused.

Once a professional relationship is established between a CRNA and a patient, the patient has a right to expect that the CRNA will have and use the level of care and skill commonly possessed and used by similar professionals in like circumstances. Thus, the CRNA is not responsible for unfortunate medical results no matter how much harm may be caused to the patient, but the CRNA is *liable* to the patient for damages when he or she breaches the duty owed to the patient either by failing to possess the requisite skill and training which competent professionals in the field should have or by failing to use that skill and training in a way consistent with sound practice in the field. If such a breach of duty causes harm, the patient is entitled to recover damages for that harm in a legal action which we call a *malpractice* action.

Malpractice in anesthesia

What then have been the areas which have led to frequent claims in the anesthesia field, and how can these claims be prevented?

First, it is clear that the failure to obtain an adequate medical history in advance of a surgical procedure, and the failure to make that medical history available to all of the participants in the procedure, can and does frequently lead to claims in the anesthesia field. Take, for example, the case of Helen Weinstein who died following childbirth.²

This 33-year-old woman was in the ninth month of pregnancy when the unfortunate events which led to her death occurred. She and her husband had breakfast together in the morning, and, after he left for work, she began to experience labor pains. When she reached the hospital, the examining physician determined that the unborn child was suffering from fetal distress, and Mrs. Weinstein was immediately prepared for delivery. She was taken to the delivery room, at which time a nurse anesthetist was summoned. Under instructions from the attending physician, the nurse anesthetist administered 100% oxygen utilizing an inhalator mask. Thereafter, the nurse anesthetist never again put her hands on or near the mask. Approximately two minutes after the baby was

born, the patient gave several gasps and died. When the mask was removed from the patient's face, it was clear that she had vomited during anesthesia and died when she had inhaled gastric material into her lungs.

We will come back to this case later, because it illustrates another problem common to malpractice actions against CRNA's, that is, the improper monitoring of patients and equipment during the administration of anesthesia. However, the case is significant at this juncture for another reason. None of the medical personnel involved, perhaps because of the perceived emergency with regard to the condition of the baby, made any effort to take the patient's history in advance of administering anesthesia. Thus, they were all ignorant of the fact that Mrs. Weinstein had eaten breakfast two hours or less before the administration of anesthesia. The failure to make any such inquiry formed in part the basis for the entry of an order directing a new trial against the nurse anesthetist who had prevailed in the first jury trial.

The lesson of the *Weinstein* case, and others like it, is to get a history which includes data pertinent to the administration of anesthesia before the procedure begins.

Furthermore, it is not enough to simply obtain the data, it must be transmitted to the people who can make use of it. Take the case of Donna Marie Carlsen who died on January 17, 1982, as a result of liver dysfunction.³ The admitting hospital record disclosed that Mrs. Carlsen had suffered from hepatitis in 1956 during her childhood. As a result, the surgeon made a medical decision not to use Penthrane® for anesthesia in elective gallbladder surgery because he believed that the use of a halogenated anesthetic could cause complications in a patient with a history of liver problems.

The nurse anesthetist in charge of administering the anesthesia administered Penthrane®, and Mrs. Carlsen died 12 days after the surgery. In this situation, the requisite data was clearly available. However, the nurse anesthetist testified that no one had told her to refrain from using Penthrane®. The regrettable circumstances surrounding Mrs. Carlsen's death may be attributed simply to a failure of communication relative to data pertinent to anesthesia. Again, the lesson is clear: *Make sure that the appropriate data is obtained and make sure that the people who need it have it.*

Another common problem is the failure to monitor patients during the administration of anesthesia. The previously discussed *Weinstein* case serves as a good example of this problem as well.

Expert testimony at the trial revealed that the nurse anesthetist should have kept her hands on or near the mask, or at least in the vicinity of the patient's head, so as to be able to detect vomiting if it occurred. The failure of the nurse anesthetist to follow this procedure was one of the bases on which the appellate court relied to establish liability.

Similarly, the case of Laura Lee Slayton is also instructive.⁴ On April 14, 1978, Miss Slayton underwent surgery to repair a ventral hernia and remove marlex mesh from her abdominal wall which had been inserted in a previous operation to aid healing of a large abdominal wound. Almost immediately after surgery was completed, Miss Slayton suffered a cardiac arrest with resulting brain damage. She died on April 24, 1978. The nurse anesthetist moved for summary judgment in her favor, contending that on the facts of this case, she could not be found liable to the patient. Among the bases on which the appellate court relied in upholding the denial of her motion was the fact that neither she nor the surgeon had adequately monitored the progress of Ms. Slayton prior to transferring her to the recovery room.

Again, the lesson from these cases is clear. The nurse anesthetist cannot escape responsibility for the monitoring of a patient under anesthesia simply because an experienced surgeon is present in the operating room. All of the professional personnel who endeavor to treat the patient owe the patient a duty of reasonable care, and that duty requires a nurse anesthetist to carefully monitor the progress of a patient under anesthesia. If that does not occur, liability follows.

Overdoses of anesthesia have also given rise to their share of problems in the anesthesia field. Take for example the case of Alice Webb who died 13 minutes after a nurse anesthetist commenced the administration of anesthesia in preparation for a surgical procedure.⁵ Among the claims asserted by the plaintiffs was that the nurse anesthetist administered an improper mixture of halothane with oxygen and nitrous oxide. In the view of plaintiff's expert, the nurse anesthetist should have set the anesthesia machine so that there would be a flow rate of the gas mixture of at least 4 L./min. Instead, the flow rate was only 2 L./min which served to magnify the vaporization of halothane, intensifying its strength, resulting in death by an overdose of halothane.

It is obvious that the dosage and correct mixture of anesthesia, and the proper use of the anesthesia machine are the responsibility of the nurse anesthetist who administers the anesthesia. Many

professionals believe that the use of a checklist during the course of each anesthesia procedure is the best antidote for the inevitable mistakes which human beings make in the operation of mechanical equipment and in the preparation of patients for anesthesia. Many times an experienced professional believes that he or she needs no such aid to repeat a process performed so often that it can be done almost by rote, but experience teaches us that seasoned professionals are as likely to err in this area as the rawest rookie. In short, the development of an anesthesia checklist and the careful following of it thereafter can go a long way towards the avoidance of problems caused by simple carelessness or oversight.

Such a checklist can also provide the basis for an effective defense when the question of whether or not a particular procedure was followed is raised at a later time. Checklists, however, are not enough. It is worth noting that among the claims cited against the nurse anesthetist in the *Slayton* case discussed earlier was the failure of the nurse anesthetist to properly record the dosage of medication on the anesthesia record. That record, of course, serves two purposes. The information is important not only as part of the record of medical treatment of the patient, but from the viewpoint of this discussion, it serves as a contemporaneous record of what anesthetic agents/drugs the patient was given which can later be used to help in the defense of overdose claims or claims that the wrong anesthetic was utilized. Without such a full, complete and accurate contemporaneous record, the nurse anesthetist is left with no way to demonstrate, independent of personal recollection, the actual facts concerning the type of medication and the dosage which were administered.

The final area which emerges as a common cause of malpractice claims against nurse anesthetists is the use of improper emergency procedures or the failure to undertake emergency action. Perhaps the most shocking case in this area involves Lois Elaine Laptad.⁶ Mrs. Laptad had a medical history of stomach pains and digestion difficulties which had resulted in several hospitalizations. As a result she was admitted to the hospital for a celiac access study to be carried out by a board-certified radiologist. The anesthesia team, which was to administer anesthesia, consisted of a board-certified anesthesiologist, a CRNA and a registered nurse who was studying to be a CRNA.

The anesthesiologist left the room to go to his office after the administration of anesthesia began, leaving the CRNA and the registered nurse to continue observing the patient, although they

monitored neither her breathing nor her pulse. The radiologist was busy with preparations for the procedure, and thus the CRNA and the registered nurse were the only ones observing the patient. The CRNA became disturbed at the rapidity with which Mrs. Daptad had "gone under" and then left the room to talk with the anesthesiologist, leaving the registered nurse to manage the anesthesia.

Neither the CRNA nor the registered nurse advised the radiologist of their alarm since they had been instructed not to disturb physicians about problems pertaining to anesthesia. Once the procedure began, the radiologist became concerned with the patient's pulse which had diminished to a degree where he could no longer detect it. By the time the patient was resuscitated, the absence of blood pressure rendered her semi-comatose for the remainder of her life.

The lessons from this case are self evident. A life-threatening situation is not merely a problem pertaining to anesthesia. It is a problem which must be confronted and handled by the professional personnel in the operating room. When it becomes apparent to any of the professional personnel present, the physician in charge of the procedure must be immediately alerted and appropriate steps to handle the crisis must be taken by all professional individuals present. This is one of those instances in life where it is better to "cry wolf," even though the object sighted on most occasions may be no more harmful than the family dog.

REFERENCES

- (1) The foregoing information is taken from an article in the October-November 1984 issue of *American Heritage Magazine*, Volume 35, No. 6 entitled "The Genealogy of Mass. General" by William Bennet.
- (2) *Weinsten, Administrator v. Prustkuff, et al.* 23. Misc. 2d 376 (NY-1959).
- (3) *Carlsen v. Javurek M.D., et al.* 526 F2d 202 8th Cir. 1975).
- (4) *Slayton v. Brunner, et al.* 276 Ark. 143, 633 S.W. 2d 29 (1982).
- (5) *Webb v. Jorns*, 488 S.W. 2d 407 (Tex. 1973).
- (6) *Laptad, Administrator v. Torvey*, 548 F. 2d 316 (10th Cir. 1977).

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ACKNOWLEDGEMENT

The author gratefully acknowledges the assistance of Attorney Treazure R. Johnson, an Associate at Fine & Ambrogne, whose research and advice contributed significantly to this article.