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# Legal Briefs

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## Being smart about malpractice

*Key words:* Captain of the ship doctrine, malpractice, standard of care.

In *Lauro v Knowles*, 739 A 2nd 1183 (R.I., 1999), the Rhode Island Supreme Court had an opportunity to consider some of the issues that appear frequently in this column. The case clarifies the type of control necessary to hold a surgeon liable, and it illustrates the way attorneys approach cases. The mindset of attorneys, unfortunately, must be considered when evaluating anesthesia practice, because the appearance of less-than-optimal practice sometimes can be as detrimental to the anesthesia provider as actual negligence.

In *Lauro v Knowles*, a patient underwent surgery to alleviate carpal tunnel syndrome. An anesthesia care team consisting of an anesthesiologist and a student nurse anesthetist administered the anesthesia. When the patient awoke from surgery, she had suffered an abrasion to the cornea of her eye that the parties agreed was sustained in connection with her anesthesia. The operation was performed in 1988, and the patient brought suit against the surgeon and hospital in 1989. In 1992, the patient tried to add the anesthesia team to the lawsuit but the statute of limitations had already

expired, and the anesthesia team was successful in getting the case against them dismissed.

Rather than drop the suit, the patient continued the suit against the surgeon. The surgeon requested summary judgment on the grounds that he had no direct involvement in the anesthesia. Summary judgment was granted, and the patient appealed to the Supreme Court of Rhode Island. Summary judgment often becomes crucial in medical malpractice cases because defense attorneys are reluctant to go to trial and take the chance that a jury will be swayed by emotion and sympathy for someone injured during a procedure, even without clear evidence of negligence. The patient argued that the trial court should not have granted summary judgment, first, because the surgeon was the “captain of the ship”; second, because the surgeon was in control of the operation; and third, because the surgeon had failed to obtain a proper informed consent.

### Is the “captain of the ship” liable?

“Captain of the ship” is a doctrine that courts used to hold surgeons liable for any negligence that occurred while they had “taken command” of the operating room. The surgeon’s legal responsi-

bility was supposed to be like the responsibility of the captain of a ship for anything that occurs. Some anesthesiologists continue to refer to the doctrine to frighten surgeons away from working with nurse anesthetists. Often left unsaid is that not only has it been widely discredited as a legal doctrine, but also that its strict application made surgeons liable for the negligence of anesthesiologists as well as nurse anesthetists. The Rhode Island Supreme Court said that the captain of the ship doctrine had never been applied in the state of Rhode Island and dismissed it as a basis to overturn the trial court.

### **Agency principles and control of the operating room**

The plaintiff next argued that whether or not captain of the ship doctrine applied, the surgeon's right to control what goes on in an operating room was sufficient to create liability under traditional "agency" principles. Thus, the case becomes important to nurse anesthetists because one of the arguments sometimes made in states that require that nurse anesthetists work under the direction or supervision of a physician is that liability depends not only on control but also on the *right* of control, a supposedly lesser standard. The Rhode Island Supreme Court carefully approached the subject by noting that with or without the captain of the ship doctrine, the surgeon could be liable for anesthesia only if the anesthesia personnel were his agents. The court set forth the basic elements that must be shown in order to show agency:

1. The surgeon "manifests" that the anesthetist acts for him or her,
2. The anesthetist must accept the undertaking to act as agent, and
3. The parties must agree that the surgeon will be in control of the undertaking.

The essence of the agency relationship, noted the court, is the right to control the work of the agent. The type of control required is the ability to control "in detail" what the agent actually does.

Normally, a surgeon would not have the right or the ability to control the work of an anesthetist. Anesthesia is its own specialty with its own specialized education and knowledge. Laws requiring physician supervision or direction of nurse anesthetists arose from an effort to make clear that nurse anesthetist practice was acceptable and did not constitute the illegal practice of medicine. In this context, supervision and direction meant only that the physician provide any "medical" input

that was required. Even in states that require that a physician supervise or direct a nurse anesthetist, supervision or direction does not require control.

While there is not a great deal of authority on what a physician is supposed to do when directing or supervising a nurse anesthetist, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is the only healthcare body to set forth any guidelines on what is expected of a physician supervising a nurse anesthetist. The JCAHO requires only that the supervising physician determine that the patient is a suitable candidate for the planned anesthesia. There is no requirement that the surgeon have any expertise or training in anesthesia. The nurse anesthetist is the expert on anesthesia.

In the Rhode Island case, the surgeon testified in his deposition that whenever a patient presented a "terrible" risk for anesthesia, it was his practice that an anesthesiologist or a nurse anesthetist had to be in the room. The patient tried to extend the surgeon's requirement into evidence that the surgeon had the right to control the anesthesiology team in the operating room. In fact, the surgeon's admission is far from an admission of control; it is a confession that he lacked specific knowledge of anesthesia.

The Rhode Island Supreme Court understood that the surgeon's admission lacked significance. They pointed out that this requirement did not show that the surgeon was able to control "in detail" what the anesthesia personnel actually did. Therefore, the court held that the proof failed to create a genuine issue of material fact because the plaintiff did not introduce evidence from which a fact finder could conclude that the operating room surgeon controlled the work of the anesthesia personnel. The court found no evidence that the surgeon controlled anesthesia or that he had any role in causing the plaintiff's eye injury.

The plaintiff's second argument was that it was improper for the trial court to grant summary judgment because the surgeon could be liable under the doctrine of *res ipsa loquitur*. *Res ipsa loquitur*, or "the thing speaks for itself," holds that when an event occurs that would not happen without negligence, negligence is assumed, and it is not necessary to introduce specific evidence of the negligence—often an expensive and uncertain process. The Rhode Island court points out that the doctrine of *res ipsa loquitur* could not be used against the surgeon unless the anesthesia team were his agents, and, as the court had already pointed out, the plaintiff had failed to prove agency.

## **Informed consent and expert testimony**

Finally, the patient claimed that the trial judge erroneously granted summary judgment in favor of the surgeon on the patient's claim that the doctor had not obtained her informed consent to the surgical procedures. Here, the Supreme Court of Rhode Island agreed that the plaintiff was entitled to a trial on whether the surgeon had properly obtained the patient's informed consent. The lower court will have to determine if the surgeon had a legal duty to obtain the plaintiff's informed consent to an anesthesia-related aspect of her care and whether there are any issues of material fact concerning the doctor's breach of care. One issue that arose was whether the court was justified in throwing out the charge of lack of informed consent because no expert testimony had been offered. The court pointed out that with informed consent, it is not the customary practice of the profession that matters (to which an expert witness could have testified), but what a patient in the position of the plaintiff needs to hear in order to make an informed decision. Therefore, expert testimony was not necessary. The jury is to decide whether the plaintiff was made aware of sufficient facts to have given informed consent, and the jury is to use its own good sense in making this determination.

This case not only clarifies the type of control necessary to hold a surgeon liable, it also illustrates the way attorneys approach cases. When a lawsuit against the anesthesia team had been eliminated because of the expiration of the statute of limitations, the plaintiff's attorneys did not throw up their hands and quit. They were resourceful and attempted to use what they had to recover damages. Lacking better evidence of the surgeon's control, they tried to interpret whatever statement the surgeon made as evidence of control. It is important to be aware not only of legal arguments that can be used but of legal tactics and approaches as well. Let us be clear about the implications of tenacious malpractice attorneys and anesthesia mishaps, with or without negligence.

Today, anesthesia has become so safe that when there is an anesthesia incident one can almost expect the patient to make a claim against the anesthetist or anesthesiologist with or without any clear evidence of negligence. Studies show that the incidence of anesthesia mishap is extremely low, perhaps 1 event in every 250,000 anesthetics. The public's reaction to this remarkable accomplishment is to assume that if something goes wrong in anesthesia, someone is at fault and

should pay for it. Although anesthesia risk is extremely low, it is not zero. Given what we understand to be the current volume of cases in the United States, more than 100 patients will suffer some form of anesthesia mishap each year. In addition, these statistics do not predict the number of persons who will suffer an anesthesia mishap in the absence of negligence.

## **Appearances count**

Given the ease with which malpractice claims can be brought under our legal system and jury sympathy for those who are injured in the health-care system, it is not surprising that the expense and ultimate cost of defending oneself in an anesthesia mishap may be unaffected by whether any negligence was involved. Substandard or nonstandard anesthesia practice can be as helpful to a plaintiff's attorney, in these circumstances, as actual negligence.

Anesthetists should review their practices to avoid situations or circumstances that give the impression that their practice is less than optimal. Anesthetists should not take shortcuts or put themselves in positions where it appears that they are giving less-than-optimal care. One of the things that has impressed me about anesthesia and healthcare in general is the extent to which personnel are willing to look at mistakes, their own and others, to learn from them, and to improve their practice. Applying this approach to malpractice claims, it is clearly inadvisable to engage in what even appears to be suboptimal care, relying on the fact that you know that you are very careful and would not be negligent or make a mistake. The fact is that things can go wrong in anesthesia for which no one is to blame. An anesthetist who even gives the impression of suboptimal care leaves himself or herself open to challenge by malpractice attorneys, criticism by other anesthesia practitioners, and the very real possibility that a jury will be overly sympathetic to an injured patient and emboldened to impose punishment on an anesthetist who appears to give less-than-optimal care.

To the extent that anesthetists had thought that they could afford to take shortcuts in the belief that their superior care would be all that mattered, they should consider the possibility that a patient could suffer damage, which although not their fault, would be blamed on them and offer an opportunity for a jury to find against them. Each nurse anesthetist should, with this critical viewpoint, reassess his or her own practice. Would an

expert agree that your procedures, your machinery, and your processes are “state of the art?” Are aspects of your practice unusual or at odds with those followed by most anesthesia personnel?

Imagine that someone has suffered an unavoidable incident. Could anything about your practice be held up for criticism? Are you sure that your practice conforms with AANA standards, hospital requirements, and bylaws? Have you read these documents recently? Finally, is there anything about your practice that you would not like to see on a television exposé or in a series published on the front page of your newspaper? Consider this column your opportunity to change it.

#### **Correction**

In the April 2000 *AANA Journal*, on page 107 of the “Legal Briefs” column, in the second sentence of the second paragraph, the term “malignant hypothermia” was used (April 2000; 68:107-110). The correct term is “malignant hyperthermia,” and the sentence should read as follows: “There are procedures for checking out equipment, procedures to be followed when conditions such as malignant hyperthermia are encountered, and procedures in many other areas of anesthesia.”