LEGAL BRIEFS

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

THE DANGER OF USING A NURSE WHO IS NOT A CRNA TO ADMINISTER ANESTHESIA

Key words: **Attorneys, negligence, standard of care.**

Many Certified Registered Nurse Anesthetists (CRNAs) have expressed concern about hospitals and other institutions requiring nurses who do not have anesthesia education to administer and monitor conscious sedation. There are several issues. Individual reaction to many of the drugs that are used for conscious sedation varies widely, and levels of agents that are thought to be standard dosages may create a fully anesthetized state for some patients while in others, the same dosage can be insufficient to permit a patient to tolerate the procedure. Will someone without anesthesia education be able to safely adjust the amount of agent to meet a patient's response? Second, if the patient becomes anesthetized, is the administrator capable of caring for a patient who lacks involuntary responses? It is one thing to care for a patient capable of communication and another to take care of a patient who cannot communicate and may not have normal bodily responses. What level of education should be required?

The official AANA pronouncement on this subject is the Considerations for Policy Guidelines for Registered Nurses Engaged in the Administration of Conscious Sedation,[1] adopted by the AANA Board of Directions in June 1996. These guidelines do not engage in turf battles but merely set forth guidelines to be followed and areas of expertise that should be required to administer and monitor "conscious sedation." The guidelines point out that:

> Conscious sedation may easily be converted to deep sedation and the loss of consciousness because of the agents used and the physical status and drug sensitivities of the individual patient. The administration of conscious sedation requires constant monitoring of the patient and the ability of the administrator to respond immediately to any adverse reaction or complication.

The guidelines suggest qualifications for registered nurses to engage in conscious sedation and requirements that should be followed in managing and monitoring conscious sedation. The concerns expressed by nurse anesthetists relating to nurses using anesthetic agents who are not properly educated was, unfortunately, realized in the facts underlying the case of *Howell v Baptist Hospital* (2003 W.L. 112762, (Tenn. Ct. App.)).

While the *Howell* case is the usual complicated appeal of a medical malpractice, this time dealing with the qualifications of experts, the facts of the case and the heart of the claimed malpractice was that the plaintiff was having an esophagogastroduodenoscopy, an examination of the esophagus, stomach, and duodenum to look for ulcers, tumors, inflammation, and areas of bleeding. A registered nurse who was not a CRNA was sedating the patient with "a titration of Sublimaze and Versed." The plaintiff's expert would have testified that performing this type of procedure without using an anesthesiologist or a nurse anesthetist was negligence. His testimony was excluded for technical reasons; the trial court did not believe that the expert's affidavit sufficiently identified the correct geographic area to qualify him as an expert. Thus, the court did not examine the details of the negligence. However, the court's discussion states that the patient developed multiple air emboli in the brain resulting in continuing neurological difficulties. It is my understanding (although I learned this from a friendly CRNA rather than from the court's opinion) that the positioning of the patient when performing an esophagogastroduodenoscopy can affect the possibility that air emboli will form. The complaint alleged that there was a failure to diagnose air emboli and to recognize the patient's physical distress. Personnel with an anesthesia education would have known how to place the patient, would have looked for signs of air emboli, and would have been equipped to handle them if diagnosed.

During the procedure, the patient's blood pressure dropped from 102/55 to 72/36 in less than 3 minutes. When the procedure was completed, she could not be aroused. The surgeon gave her Romazicon, Narcan, and then more Versed, but she remained unresponsive. Computed tomography scans of the brain subsequently showed multiple air emboli. The patient was transferred to a neurological intensive care unit but had a continuing neurological deficit due to brain damage as a result of the air emboli. Suit was brought on behalf of the patient against the hospital as well as the physician, the nurse who administered the sedation, and 2 other nurses (who

were subsequently dismissed from the litigation but whose role was never described). Suit was based on *res ipsa loquitor*; the patient was in the exclusive control of the defendants and this type of damage does not occur in the absence of negligence. The complaint alleged that the defendants failed to conduct adequate tests that would have allowed the surgeon to make a correct diagnosis of the air emboli, that it was negligence not to ensure that an anesthesiologist or a nurse anesthetist was present during the procedure, that the patient's informed consent should have been obtained to undergo the procedure without the aid of an anesthesiologist or a nurse anesthetist, that the defendants failed to inform the patient of the risks involved with the administration of the procedure, and that it was negligence to fail to recognize the patient's physical distress during the procedure.

Expert testimony

The bulk of the legal decision is a battle of expert testimony. The surgeon acted as his own expert witness and submitted his own expert testimony affidavit. He stated that he was familiar with the standard of care regarding the performance of an esophagogastroduodenoscopy and that, in his expert opinion, he had complied with the standard of care. His affidavit stated that he had discussed with the patient the risks, benefits, and potential complications associated with the procedure and that while he did not discuss the potential risk of cerebral air emboli, he claimed that this was because air emboli occurs so infrequently that disclosure of the risk was not required. Finally, he asserted that injuries of the type suffered by the plaintiff may occur in the absence of negligence, attempting to negate the plaintiff's *res ipsa loquitor* theory.

The plaintiff then submitted an affidavit from her medical expert, an anesthesiologist who was chief of Anesthesiology at Southern Tennessee Medical Center and an associate professor of Anesthesiology at Vanderbilt University. In the anesthesiologist's expert opinion, the surgeon had violated the standard of care by not having an anesthesiologist or a nurse anesthetist administer the anesthesia. The anesthesiologist also thought that the surgeon had failed to conduct a proper postoperative medical examination that led to his failure to diagnose the air embolism. Finally, it was the anesthesiologist's opinion that the administration of Versed following the dose of Romazicon was improper and delayed the diagnosis and treatment of the patient.

The trial court held that the affidavit from the anesthesiologist was insufficient because the anesthesiologist did not specifically state that he had knowledge of the standard of care in Nashville, Tenn, in January 1999, nor that he had knowledge of the standard of care specifically for gastroenterologists. The anesthesiologist had stated he was an associate professor of anesthesiology at Vanderbilt University (which, of course, is located in Nashville, Tenn), but the trial court was not satisfied because the affidavit did not state when the anesthesiologist held the position. Having eliminated the patient's expert testimony, the trial court had only the defendant's affidavit that in the opinion of the defendant, everything was done properly. Whether the defendant's affidavit was believable or not and whether it was self-serving or not, it was the only expert testimony and the case was dismissed. Thus, the failure to state that the anesthesiologist was knowledgeable about practice in Nashville was looking like a big mistake, especially in light of the anesthesiologist's teaching position in Nashville.

Comments from the Appellate Court

The Appellate Court made a very interesting comment in its decision that was not raised by the plaintiff's attorneys and would be easy to miss. The surgeon's affidavit of his own expert opinion (on which the trial court relied to dismiss the case) contradicted the patient's case in all respects except that it did not address the charge that the surgeon's failure to have an anesthesiologist or a nurse anesthetist present during the procedure was negligence. The Appellate Court wrote (but only in a footnote): "Consequently, it is unclear why partial summary judgment was granted as to those claims [the failure to have an anesthesiologist or a nurse anesthetist was negligence] in the Howell's complaint." Thus, the case reinforces the concern that under these circumstances, failure to have anesthesia provided by an anesthesiologist or a nurse anesthetist is negligence.

The patient needed to find a way to convince the court that her expert was, indeed, qualified to testify on practice in Nashville. The patient filed a motion to alter or amend the trial court's order. The patient also asked the trial court to permit her to supplement the record by including her expert's curriculum vitae (which showed that the anesthesiologist had been an associate professor at Vanderbilt University from 1988 to the time of the dismissal). The anesthesiologist also offered to amend his affi-

davit to state that he was familiar with the recognized standard of acceptable professional care for gastroenterologists in Nashville, Tenn, as it existed in January 1999 (which is what the affidavit should have said in the first place). The trial court refused to permit any of these corrections to be made, and the plaintiffs appealed to the Tennessee Court of Appeals.

The law governing expert testimony in Tennessee is that the plaintiff has the burden of proving what is the recognized standard of acceptable professional practice in the profession and any specialty in the community in which the defendant practices or in a similar community at the time of the alleged injury or wrongful action occurred (Tenn. Code Annotated, Section 29-26-115(a)(1)). The Appellate Court agreed with the trial court that the original affidavit (which stated only that the expert was familiar with the standard of practice in "middle Tennessee") was insufficient to satisfy the requirement of the statute that the expert be familiar with the standard of practice in the community in which the accident occurred. However, whether or not "middle Tennessee" could have included Nashville was not clear. When the patient offered to supplement the affidavit with additional proof that the reference to "middle Tennessee" was intended to include Nashville, the Appellate Court ruled in the patient's favor. The Appellate Court felt that the defendant could not claim that it was prejudiced and that the trial court abused its discretion when it refused to allow the clarification to be made.

Howell is a very confusing case because of its brutal devotion to the requirements of the statute and the trial court's willingness to let the case be dismissed when the expert anesthesiologist who taught in Nashville wrote "middle Tennessee" instead of Nashville. What is interesting about the case is almost an afterthought: a patient was badly hurt because she was monitored by someone who was neither an anesthesiologist nor a nurse anesthetist.

North Carolina State Bar v Dumont

The *Howell* case has similar facts to an operation discussed in the case of *North Carolina State Bar v Dumont* (52 N.C. App. 1, 277 S.E. 2d 827, 1981). Unlike the *Howell* case, in the facts of the *Dumont* case, a nurse who was not a CRNA gave an anesthetic in connection with an operation, not merely a procedure. The operation (a "tonsil operation") had been performed in 1971. Because of problems with the administration of anesthesia, brain damage occurred. After the incident, the head of the anesthesia department asked an anesthesiologist at a well-known medical center to review procedures at the hospital to make sure the anesthesia department was not doing things that were harmful to patients. The anesthesiologist issued a report and followed up with a very frank letter to the administrator of the hospital. The anesthesiologist was critical of the hospital's lack of monitoring equipment and was especially concerned because 1 "of these cardiac arrests occurred when a nurse who was not specifically trained in anesthesia was administering the anesthetic raised rather perplexing questions" (52 N.C. App., page 5). The *Dumont* case was not, however, a malpractice suit against the hospitals. Perhaps some of our more observant readers have noted that the title of this case, *North Carolina State Bar v Dumont* is a rather peculiar title for a medical malpractice case. What does anesthesia have to do with a case brought by the board responsible for disciplining attorneys?

The reported case actually concerned a lawyer's appeal of a 6-month suspension of his right to practice law. The attorney appealing the suspension had been appointed by an insurance company to represent the hospital in the malpractice case following the tonsil operation. During preparations for the case, the attorney had provided a copy of the consulting anesthesiologist's report to the plaintiff's lawyer but had not provided a copy of the anesthesiologist's letter. The plaintiff had requested a copy of the letter but used the wrong first name for the anesthesiologist. The plaintiff also assumed that the letter had been written to the head of the anesthesia department when, in fact, it had been written to the hospital administrator. During the preparation for the case, not only had the hospital not provided a copy of the letter, but also the attorney had told the hospital's witnesses to deny the existence of the letter. The attorney justified his position on the grounds that since the first name of the expert in the request was incorrect, there was no letter from such a person. Worse, he told the witnesses that if the subject of the letter came up, they were to deny that they had seen it since the letter was addressed to another individual in the hospital. Finally, if pressed further, they were to simply state that they could not remember the letter at all.

Those of you who may have been involved in legal proceedings will undoubtedly recall every trial lawyer's first guideline: Listen carefully to the question and answer only the question asked. Lawyers might differ on whether a

request for a letter from *Frank* Smith required production of a letter from *John* Smith. Some lawyers might say that the letter was not properly identified. Others would say that the request was close enough, the letter is likely to come out anyway and why make it look like you are hiding something. However, it is never appropriate for an attorney to suggest to a witness that the witness testify that he or she has forgotten the very thing that they are discussing or that the witness has not seen something that the witness has seen. (This is especially inadvisable when the witness has not only seen the letter but also has a copy of it in his or her possession.)

The case was ultimately settled but several years later, in 1977, the attorney for the patient found out what the attorney for the hospital had advised. He turned the matter over to the North Carolina State Bar Association for disciplinary proceedings, and the attorney representing the hospital was suspended from practicing law for 6 months. The attorney appealed to the Court of Appeals and ultimately to the Supreme Court of North Carolina but none of the judges had any sympathy for his actions.

It took many years for hospitals to become convinced that anesthesia during operations should only be given by people educated in anesthesia. As the *Dumont* case demonstrates, it is rare today to find an anesthetic administered during an operation by anyone who is not an anesthesiologist or a Certified Registered Nurse Anesthetist. Anyone who is familiar with statistics on anesthesia-related incidents has seen the dramatic improvement in quality when hospitals turned exclusively to personnel educated in and devoting their practice to anesthesia. The standard of care for anesthesia for more minor procedures is developing. But as the *Howell* case shows, the American Association of Nurse Anesthetists was quite correct to point out that there are quality issues involved in who provides anesthesia, even for "minor" procedures, and what kinds of qualifications they must have.

REFERENCE

1. Considerations for Policy Guidelines for Registered Nurses Engaged in the Administration of Conscious Sedation. In: *Professional Practice Manual for the Certified Registered Nurse Anesthetist.* Park Ridge, Ill: American Association of Nurse Anesthetists. June 1996:No. 4.2.