



# LEGAL BRIEFS

**Gene A. Blumenreich, JD**

*Nutter, McClennen & Fish, LLP  
Boston, Massachusetts*

## STANDARDS OF CARE AND THE ASA MEDICAL DIRECTION STATEMENT

**Key words:** Negligence, role of professional association, standard of care.

It should come as no surprise that malpractice attorneys are among the many people who do not understand what nurse anesthetists do or what their capabilities are. Recently, a newsletter directed to both anesthesia providers and lawyers, quoted several malpractice attorneys who were under the impression that the American Society of Anesthesiologists (ASA) Statement on the Anesthesia Care Team was a standard of care and that hospitals employed CRNAs only to save money.<sup>1</sup> When the makers of one brand of a soft drink say it tastes better than the others (or it opens the door to a fuller life or whatever), the public judges the statement with some skepticism and feels no hesitation in buying the other brands. But in healthcare, the public has been conditioned to believe that medicine is based on scientific principles. It assumes that when physicians make statements, they are based on scientific principles. Of course, there is no science behind the ASA Statement on the Anesthesia Care Team. Nonetheless, the Statement does not get the same scrutiny because of the respect the public gives to physicians.

Where did the ASA Statement on the Anesthesia Care Team originate? In the late 1970s the ASA decided to develop a statement on the anesthesia care team, nurse anesthetists and anesthesiologists working together. ASA established a committee to

develop the statement. Nurse anesthetists serving on the committee were surprised in 1982 to read a newly issued ASA Statement on the Anesthesia Care Team that had not been discussed with them.

The statement is offensive to many nurse anesthetists because it requires that the Anesthesia Care Team has to be directed by an anesthesiologist. Even more difficult was that it sets forth a number of requirements that have to be fulfilled by the anesthesiologist directing the team. These requirements include:

1. Preanesthetic evaluation of the patient
2. Prescription of the anesthesia plan
3. Personal participation in the most demanding procedures in this plan, especially those of induction and emergence
4. Following the course of anesthesia administration at frequent intervals
5. Remaining physically available for the immediate diagnosis and treatment of emergencies
6. Providing indicated postanesthesia care

Is the ASA Statement on the Anesthesia Care Team a standard of care? The ASA Statement is not required by law, has not been shown to have any impact on the quality of anesthesia care, and is not customarily followed. It is not a standard of care. Although there are some states that require that nurse anesthetists be supervised or directed by a physician, every state permits nurse anesthetists to work directly with physicians other than anesthesiologists. A

requirement of anesthesiologist supervision or direction would substantially change the ground rules under which anesthesia is administered in this country. Even in states that require direction or supervision, substantial leeway is given to health-care personnel to develop their own standards and the terms “supervision” and “direction” are undefined. No state restricts the performance of the elements contained in the ASA Statement to physicians.

Most lawyers (including most judges and malpractice attorneys) do not have expertise in the health-care area. To avoid interfering with what they do not understand, the courts put healthcare in a special category, a profession. Unlike other areas where people are expected to conduct themselves the way that courts and juries determine that a reasonable person should conduct himself or herself, a professional is required to conduct himself or herself with the same degree of skill, care, and diligence exercised by other members of the same profession. When something goes wrong and the courts require knowledge as to the standard of care, an expert is required to testify, or explain to the court or jury, the practices that other members of the profession would have followed in the same circumstances.

### Standard of care

There are several things to notice about the standard of care. First, standards of care are not issued by professional associations. The standard of care is what others in the

profession would do under similar circumstances. What a professional association says about the standard of care is irrelevant unless an expert says it is what the members of the profession do. While experts may sometimes refer to statements by a professional association, only the members of the profession can establish the standard of care and they do it by their conduct. Second, you have to consider the real world circumstances of why and when the court is determining the standard of care. As a rule, courts do not care about standards of care when everything goes well. If we are concerned about a standard of care, then something has gone wrong and a patient and lawyer are looking for someone to blame. Both the patient and the practitioner will offer expert testimony as to the standard of care. Usually, their experts differ either on the “standard” or on how it should be applied to the facts of the particular case. Under our system of jurisprudence, the trier of fact, sometimes a court, but often a jury, has the ultimate responsibility of determining the standard of care. No one really knows the extent to which juries are influenced by their sympathy for an injured plaintiff. Finally, it is at least theoretically possible for the standard of care followed by the members of a profession to be below a reasonable standard. Were that to occur, the courts would apply a standard of care that was reasonable and not necessarily the practices followed by the profession.

In healthcare, defining the standard of care is complicated. It is not just the things that everybody does or that most people do that constitutes the standard of care. It is the things that practitioners do that relate to quality outcomes that define the standard of care. Which brings me to Tiger Woods, the very successful professional golfer.

When Tiger Woods plays a golf tournament, he wears a red shirt on the last day of the tournament. He does this every time. Does this make the wearing of a red shirt on the last day of the tournament a standard of care for professional golfers? Obviously not. First, even Tiger Woods does not win every golf tournament in which he wears a red shirt on the last day of the tournament. While Tiger Woods has been very successful, he does not win every time. In fact, he does not even win most of the time. Moreover, golfers who do not wear red shirts win golf tournaments as well. There is no scientific evidence that wearing red shirts on the last day of a golf tournament has any bearing on winning or losing golf tournaments.

What about anesthesia procedures? Closed claims studies demonstrate that pulse oximeters, end-tidal CO<sub>2</sub> monitors, temperature monitoring, and other “standards” save lives and improve the “quality of care.” It would be difficult to find an expert willing to testify that these monitoring devices were not necessary during surgery, and it would be difficult to find a jury willing to agree that administering anesthesia without these devices met the standard of care. On the other hand, while wearing striped scrubs in the operating room may be unusual, it is not contrary to the standard of care because there is no scientific research that it has any affect on quality outcomes.

Some assume the ASA Statement on the Anesthesia Care Team is a standard of care, but that is usually limited to the uninformed and to anesthesiologists who resent competing with nurse anesthetists. However, there is no scientific evidence that following the Statement will improve the quality of care. Those who are familiar with the healthcare system and are aware

that 2 qualified groups of professionals share the field of anesthesia, see the ASA Statement as what ASA wanted or hoped the standard would be. There is no evidence to support it, but it is good for anesthesiologists.

### **Why it's not a standard of care**

But what do we tell those people who assume that the ASA Statement on the Anesthesia Care Team is a standard of care? It cannot be a standard of care because it is not customarily followed. How do we know that? Certainly, anesthesiologist supervision of nurse anesthetists cannot be followed in 65% of rural hospitals in the United States where CRNAs are the sole anesthesia provider. They have no anesthesiologists to carry out the duties imposed by the Statement. Even in hospitals that use both CRNAs and anesthesiologists, anesthesiologist supervision of nurse anesthetists in the manner wished for in the ASA Statement on the Anesthesia Care Team is not the standard of care. AANA conducts surveys of its members, specifically asking them about the nature of anesthesiologist involvement in various aspects of care. In 2001, respondents were asked about the frequency with which anesthesiologists engaged in certain functions. According to the respondents, anesthesiologists supervising nurse anesthetists who complied with ASA's elements of supervision even as frequently as “most of the time” ranged from 31.3% to 66.2%. A “standard” that half of the practitioners follow less frequently than “most of the time” is not a standard.

Complicating the question of measuring how widespread the ASA's conception of anesthesiologist supervision is, is the fact that Medicare's Tax Equity and Fiscal Responsibility Act (TEFRA)

requirements incorporate significant elements of the ASA Statement on the Anesthesia Care Team. Medicare does not require these as a standard of care. Medicare has no requirement of anesthesiologist supervision and will reimburse CRNAs who are not supervised by any physician if they meet the appropriate requirements. Medicare uses the TEFRA conditions merely to determine if an anesthesiologist has been sufficiently involved in the administration of an anesthetic to justify paying the anesthesiologist. Remarkably, even when paid to perform these elements, anesthesiologists do not always perform the tasks. We are aware of cases in which anesthesiologists have had to make huge payments because of their failure to comply with the TEFRA requirements even when they were billing as if they had. This is further indication that the ASA Statement on the Anesthesia Care Team is simply not the standard of care.

Does this mean we are providing substandard anesthesia in half of all operations? In healthcare, drugs, devices, and procedures that save lives or make a difference rapidly become the standard of care. After 21 years, the ASA Statement has not become the standard of care because hospitals and surgeons are comfortable working with nurse anesthetists, and there is no credible evidence that there is any difference in the quality of care provided by CRNAs or anesthesiologists or CRNAs supervised by anesthesiologists. While all anesthesia providers are human and sometimes make horrific mistakes, anesthesia's safety record has greatly improved. Improvements in technology and monitoring devices have made all of anesthesia safer, whether administered by CRNAs or anesthesiologists.

Because the ASA Statement is

not the standard of care, it does the healthcare community a disservice. Since so much anesthesia is administered without complying with ASA's Statement on the Anesthesia Care Team, healthcare practitioners run the risk that if something goes wrong plaintiff's attorneys will claim that there should be liability because the ASA Statement was not complied with. Unfortunately, some hospitals seem to have done everything possible to make it easy for plaintiffs to make this claim. Some hospitals have permitted anesthesiologists to incorporate the ASA Standard into their operating practices even though no one ever complied with them. When something goes wrong, with or without negligence, the plaintiff's attorney can claim that the unfortunate event related to the failure to comply with the ASA Statement, if the jury can be convinced it is a standard of care. It makes no difference that compliance is not required by law, nor best practices, nor that no one at the hospital ever complied with it. In these cases, liability depends not on the standard of care but how sympathetic juries feel to the injured plaintiff.

### **Harris v Miller**

*Harris v Miller* (335 N.C. 379, 438 S.E. 2d 731, 1994) is an example of the liability that can stem from unnecessary hospital policies. *Harris v Miller* came before the North Carolina Supreme Court as a challenge to a ruling of a trial court that a surgeon could not have vicarious liability for the negligence of a nurse anesthetist. The trial court had held that there was insufficient evidence to establish a "master-servant" relationship between the surgeon and a nurse anesthetist who had been negligent. Because this was an appeal of a directed verdict, the only question before

the North Carolina Supreme Court was whether a surgeon could ever have liability for the negligent acts of a nurse anesthetist. The court pointed out that under North Carolina law, vicarious liability depended primarily on control. The court reconciled North Carolina cases by holding that while surgeons were not automatically liable for everything that went on in the operating room, there certainly existed the possibility that a surgeon could be liable for the negligence of an anesthetist (and that conclusion is hard to disagree with—there are cases where surgeons have been found liable for negligence of anesthesiologists as well as nurse anesthetists). The case actually has the same applicability to anesthesiologists as it does to nurse anesthetists.

The test of whether a defendant is vicariously liable for the negligence of another party under rules of agency is whether the defendant has the ability to control the details and means by which the person accomplishes the task (335 N.C. at p. 387). At best, a surgeon may retain control over the anesthetic result ("Keep him relaxed, keep him quiet!"). Even in states that require that nurse anesthetists be supervised by a physician, rarely would a supervising physician be able to exercise control over the details and means ("Administer 100 mg of succinylcholine!"). CRNAs are highly skilled and know a great deal more about anesthetic agents and their administration than do surgeons. Whether a surgeon has the right of control is a factual inquiry. In *Harris v Miller* there was no evidence that the surgeon controlled either results or means. The only evidence bearing on liability was the hospital's anesthesia manual that required that a nurse anesthetist work under the "responsibility and supervision" of a surgeon. The North Carolina

Supreme Court did not rule that this was or was not sufficient to hold the surgeon liable; however, it reinstated the case so that a jury could decide whether the phrase in the anesthesia manual was sufficient evidence that the surgeon had control over the details and means of anesthesia.

For surgeons concerned about their liability for anesthesia (whether administered by an anesthesiologist or a nurse anesthetist), *Harris v Miller* should be a wake-up call. Eliminate gratuitous anesthesiologist-sponsored or hospital-imposed requirements that a surgeon be responsible for the delivery of anesthesia.

### **Denton v LaCroix**

Another case in which an unnecessary hospital policy created liability even though no one was negligent was *Denton v LaCroix* (947 SW 2d 941, Tex App, 1997). In that case, the wife of a local football coach had a seizure that prevented the CRNA from intubating the patient. The nurse anesthetist had to paralyze the patient with Anectine to establish an airway. While the first attempt to intubate the patient ended up as an esophageal intubation, the nurse anesthetist recognized it immediately and properly reintubated the patient. Even though there was no evidence of negligence, the plaintiff's attorney succeeded in establishing liability because the anesthesia department had adopted a policy remarkably similar to the ASA Statement on the Anesthesia Care Team. The hospital's anesthesia department required that an anesthesiologist perform the preanesthetic evaluation, that an anesthesiologist discuss with the patient the anesthesia plan, and that an anesthesiologist supervise the CRNA by being "physically present or immediately available in the operating suite." Of course, since the policy had nothing to do with improving care, it was not uni-

formly followed. Given the absence of negligence, did it really make a difference that the hospital's policy had not been followed? Obviously not! Yet this was sufficient for a jury to find the hospital liable because anesthesia was not being administered in accordance with hospital policies. The anesthesia policy had nothing to do with malpractice or its prevention, but it turned out to have everything to do with liability.

### **Herrington v Hiller**

In case fear of unnecessary liability is not a sufficient reason for hospitals to avoid the ASA's Statement on the Anesthesia Care Team, there is the case of *Herrington v Hiller*, (883 F2d 411, 5th Cir. 1989). In 1989, the United States Court of Appeals for the Fifth Circuit sent a case back for a new trial, holding that a hospital may be liable to patients for damages when the hospital refuses to provide around-the-clock anesthesia services because of "political" reasons. The court found that a jury should have been allowed to determine whether a hospital's refusal to provide 24-hour anesthesia coverage because it would have meant that CRNAs would give regional anesthesia was medically sound practice or was motivated by "political" purposes. The hospital was following the ASA's October 1983 "Statement on Regional Anesthesia" recommending that CRNAs should not be allowed to administer regional anesthetics. ASA's Statement on Regional Anesthesia was yet another ASA anti-CRNA policy that was widely ignored because there was no scientific evidence to support it.

In *Herrington v Hiller*, a 448-bed facility had the only obstetrical unit available within a 60-mile radius containing approximately 400,000 people. Two thousand babies a year were delivered in the hospital, or an average of five a day. According to testimony, which the trial court excluded, various staff physicians

were in favor of instituting 24-hour anesthesia services but were unable to convince the hospital. According to the excluded testimony, the provider of anesthesia services in the hospital was willing to provide 24-hour services if the hospital would permit CRNAs to place epidural catheters. According to the excluded evidence, the only reason why CRNAs were unable to place epidural catheters was because of "politics." The plaintiff went to the hospital to give birth at 3:00 A.M. While in labor, she suffered a catastrophic rupture of her uterus. The attending physician ordered an immediate cesarean section. Because the hospital did not have 24-hour anesthesia coverage, an anesthetist had to be called from home. Delivery was accomplished within minutes of the anesthetist's arrival; however, because of the delay in commencing the operation the child was deprived of oxygen and born severely crippled and retarded. The United States Court of Appeals determined that the district court was wrong to keep evidence that the hospital had refused to provide 24-hour coverage because of anesthesia politics from the jury. If the jury believed the evidence, the court felt that the jury could have found in favor of the Herringtons and against the hospital.

### **Conclusion**

Hospitals should develop policies based on evidence, not politics and not based on the self-serving statements of professional associations. The ASA Statement on the Anesthesia Care Team does not improve patient care and has no business in facilities that are supposed to be dedicated to science and to protecting patients.

### **REFERENCE**

1. Haddad A. Expect Plaintiff to Hold Up ASA Medical Direction Statement as the Standard of Care—for MDs and CRNAs. *Anesthesia Malpractice Prevention*. October 2003; 8:73-78.