



LEGAL BRIEFS

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EXPERT TESTIMONY*

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In the past few months there has been a lot of interest in a case decided by the Illinois Supreme Court in February (*Sullivan v Edward Hospital*, 2004 WL 228956, February 5, 2004) in which the court held that a physician could not testify to the standard of care for a registered nurse. The American Association of Nurse Attorneys filed an amicus brief in this case and is very proud (and rightfully so) of the major influence its brief had on the case. While the case is beneficial to nursing because of its recognition that nursing is a profession, its impact on nurse anesthetists is not clear. The reasons that made The American Association of Nurse Attorneys proud of its work on the case—the recognition of nursing as a profession distinct from medicine and the recognition that nurses treat people and patients differently than a doctor—are problematic in an anesthesia context. Do nurse anesthetists and anesthesiologists handle the same matters differently? Are there 2 standards of care in anesthesia? Will the public understand that nurse anesthesia is as safe and has the same high quality as anesthesia administered by anesthesiologists? What impact will the *Sullivan* case have on the profession of nurse anesthesia?

The context

As we have said on numerous occasions, courts do not understand healthcare, so the courts make healthcare practitioners professionals. Professionals set their own standard of care and when courts and juries need to know what the standard is, members of the profession offer expert testimony.

There is no question but that nursing was held back as a profession by the prejudice now referred to as “gender politics.” Until relatively recently, medical doctors were assumed to be male, while nurses were assumed to be female (and, maybe, these assumptions can still be found). Society, in general, discriminated in favor of male workers. The discrimination was found in compensation and in the respect that society afforded to “female” professions. As in other “female” professions, such as teaching, nursing was underpaid and undervalued. In the healthcare field, physicians were the dominant figures setting policies and standards for themselves and for others who worked in the field, including nursing.

For nursing, the discrimination was doubly unfair. Although modern nursing may have begun with Clara Barton, caregivers had been performing services that bear a strong resemblance to nursing care for centuries. During the same period, physicians treated patients by bleeding them and other medical procedures with no scientific basis, sometimes doing more harm

than good. Nursing, independent of medicine, is a well-established profession. As I said in my first speech to an AANA audience, “Nursing is not the ladies auxiliary of the practice of medicine” (1984 AANA Annual Meeting, Chicago, Ill). But, only as a result of changes in the 1960s and 1970s, did society begin to understand the extent of its stereotyping.

If nursing is a profession, then nurses should be able to testify as to the standard of care in their own profession. While this seems obvious, the case of *Sullivan v Edward Hospital* shows that some people still have questions about who should testify about nursing standards. Even as recently as 1981, testimony by nurse anesthetists as to their own acceptable standards of care was challenged. It was argued that nurse anesthetists were not “experts,” even in the field of nurse anesthesia, because they did not hold the highest degree available in the field. Arguably the highest degree available in the field was an MD degree. But times were changing and the appellate court in Louisiana held that nurse anesthetists could testify as to the standard of care in their profession (*Young v Department of Health and Human Resources*, 405 So. 2nd 1209). This was also confirmed by the North Carolina Supreme Court. A trial court had held that a nurse anesthetist could not testify on the need for supervision, whether there was a medical emergency and

* This article incorporates material from articles on the same subject printed in this column: “The CRNA as expert witness” (1995;63:85-87) and “Expert testimony” (1996;64:408-410).

whether the surgeon had a duty to provide supervision. The North Carolina Supreme Court reversed the trial court, ruling that a nurse anesthetist who had participated in thousands of operations was competent to testify as to standards of practice of nurse anesthetists as well as the manner in which surgeons ordinarily supervised nurse anesthetists (*Harris v Miller*, 335 NC 379, 438 SE2d 731, 1994).

Sullivan v Edward Hospital joined this proud tradition in holding that nurses set standards for nurses. In *Sullivan v Edward Hospital*, a patient had fallen 3 times and was becoming agitated. The floor nurse called the patient's primary care physician to ask for an order for a physical restraint to keep the patient from climbing out of bed. Rather than authorize a physical restraint, the physician ordered the administration of a drug to calm the patient and help him sleep. Despite the drug, the patient attempted to get up from his bed and walk. He fell, struck his head on the floor, and developed a subdural hematoma.

The patient's family sued the primary care physician and the hospital that employed the floor nurse. At trial, the patient offered testimony from a board-certified physician specializing in internal medicine who claimed he had substantial experience in observing and working with physicians and nurses in the area of patient fall protection. The physician was expected to testify that the floor nurse was negligent in failing to properly communicate the patient's condition to the primary care physician. He was also supposed to testify that when the primary care physician failed to order a physical restraint, the floor nurse should have realized that a physical restraint was necessary and should have pursued her concerns up the nursing chain of command.

The trial court struck the physician's expert testimony on the grounds that a physician could not testify to the standard of care to be followed by a licensed nurse. On appeal, the Illinois Trial Lawyers Association submitted an amicus curiae brief supporting the plaintiff while The American Association of Nurse Attorneys submitted an amicus curiae brief in favor of the hospital. The Illinois Trial Lawyers Association wanted to reduce barriers to suits by patients while The American Association of Nurse Attorneys wanted to establish that nursing was a profession that sets its own standards.

The law on who can testify as an expert witness has attempted to recognize that in healthcare there are sometimes competing schools on what is proper treatment. There are many areas where there is no uniform agreement among healthcare practitioners on what is the most appropriate and effective care. One group may believe that a certain cancer should be surgically removed, while another may believe it should be treated with radiation. The law will not judge members of one group by the standards of the other, as long as both approaches are reasonable and have their adherents. In *Sullivan v Edward Hospital*, the Illinois Supreme Court held that for purposes of the law on expert testimony, nursing was a separate "school." Illinois has a statute that says that a healthcare practitioner's conduct should only be judged by the school of which the practitioner is a member. The court cited the following statement from the brief of The American Association of Nurse Attorneys:

A physician who is not a nurse, is no more qualified to offer expert, opinion testimony as to the standard of care for nurses than a nurse would be to offer an opinion as to the physician standard of care. ...Certainly, nurses are not permitted to offer expert testimony

against a physician based on their observations of physicians or their familiarity with the procedures involved. An operating room nurse who stands shoulder to shoulder with surgeons every day, would not be permitted to testify as to the standard of care of the surgeon. An endoscopy nurse would not be permitted to testify as to the standard of care of a gastroenterologist performing a Colonoscopy. A labor and delivery nurse would not be permitted to offer expert, opinion testimony as to the standard of care for an obstetrician or even a midwife. Nor would a nurse be permitted to testify that, in her experience, when she calls a physician, he/she usually responds in a certain manner. Such testimony would be, essentially, expert testimony as to the standard of medical care.

Note that the list of examples of nurse specialists who cannot testify as to the standard of care for physician specialists includes only those who become experts by watching. Neither The American Association of Nurse Attorneys nor the court is referring to nursing specialists (such as nurse anesthetists) who do the same thing as physician specialists.

Although it is dangerous to speculate why something was not said, it may be that nurse anesthetists were not listed because they are very unusual in healthcare. In most areas of healthcare, where care is given by both physicians and nurses, there are clear demarcations between the types of care given by the 2 groups. Anesthesia is unique in that nurses compete with physicians in all aspects of anesthesia care. The reason for this competition probably has something to do with the fact that nurse anesthetists were giving anesthesia before physicians began to specialize in the field. In anesthesia, physicians began to do what the nursing specialty was already doing. Thus, there is no distinction in the type of care given by nurse anesthetists and the type of care given by anesthesiologists.

The same standard of care

Despite the fact that anesthesia is

administered by 2 professions, both nurse anesthetists and anesthesiologists administer anesthesia with the same high standard of care. If something goes wrong with an anesthetic, neither the public nor the courts expect one of the professional groups to be more careful than the other or to adhere to different standards. We expect both nurse anesthetists and anesthesiologists to use the same techniques and follow the same guidelines, applying the same knowledge. We expect administrators of anesthesia to be vigilant, organized, and even more vigilant. The standard of care in anesthesia is not a matter of style or emphasis. It is doing it right or doing it wrong. Because both groups share a uniform standard of care in anesthesia, in a perfect world, and contrary to *Sullivan v Edward Hospital*, either group should be allowed to offer expert testimony as to what this high standard is. If *Sullivan v Edward Hospital* was to mean that anesthesiologists could not testify against nurse anesthetists because nurse anesthesia was different than physician anesthesia, would people choose nurse anesthesia or physician anesthesia? For specialties like anesthesia where nurses and physicians compete in the same area, it would be logical that both physician anesthetists and nurse anesthetists be able to testify as to the standard of care they jointly follow.

Cornfeldt v Tongen

Although the issue has not been decided by the Illinois courts, courts in jurisdictions other than Illinois have considered expert testimony in anesthesia and have not made distinctions between anesthesia administered by nurse anesthetists and that administered by physician anesthetists. In *Cornfeldt v Tongen* (262 N.W. 2d 684,

Minnesota, 1977), the Minnesota Supreme Court would have allowed a CRNA to offer expert testimony as to the standard of care to be followed by an anesthesiologist. However, the lawyer for the plaintiff was going to ask the wrong question and the case was dismissed.

Mrs. Cornfeldt, complaining of severe abdominal pain, entered a hospital in St. Paul. A first-year surgical resident examined her, ordered tests and x-rays, and determined that she was suffering from a perforated ulcer requiring emergency surgery. The surgeon discovered a hole in the forward wall of the stomach. Because the cells surrounding the hole looked abnormal, the surgeon called in a pathologist to do a frozen-section analysis of the suspicious tissue, which was excised along with the ulcer. That analysis proved benign.

Mrs. Cornfeldt's recovery was smooth and uncomplicated. Mrs. Cornfeldt returned to the surgeon for a postoperative checkup. The surgeon recommended a second operation, a gastrectomy that would involve removal of a substantial portion of her stomach. An analysis by the pathology department of a paraffin section revealed that the suspicious cells removed during the earlier operation were "atypical." A slide of the tissue had been sent to a professor of pathology who determined that she had cancer. A gastrectomy was the only effective treatment to prevent the risk that the cancer might spread. To be effective, it had to be done with reasonable dispatch. Mrs. Cornfeldt's laboratory work was normal except that her alkaline phosphatase and serum glutamate oxaloacetate transaminase (SGOT) readings were very high. It turned out that she had hepatitis.

Anesthesia was administered by an anesthesiologist who noted the

abnormal readings but presumed that the readings meant that the cancer had already spread to Mrs. Cornfeldt's liver. He interviewed Mrs. Cornfeldt. She told him that she had been happy with the anesthetic used for her first operation, a combination of drugs whose principal agent was halothane, and the anesthesiologist decided to use this same anesthetic for the gastrectomy. This turned out to be a fatal mistake.

The surgeon was also aware of the abnormal test results but thought they were attributable to a spread of the cancer or to a mild postoperative peritonitis from the first operation. In any event, because of Mrs. Cornfeldt's excellent clinical condition and the relative urgency of the operation, the surgeon decided to proceed with the operation without ordering further tests. Mrs. Cornfeldt's recovery appeared to be going well, but after a few days she developed jaundice. Ultimately, she died from her hepatitis. Had the surgery been postponed, the court's opinion reported that there was an 85% to 90% probability she would have recovered from hepatitis. This was all the more tragic because an autopsy failed to reveal evidence of cancer anywhere in her body. Nor was any cancer found in that part of her stomach removed in the gastrectomy.

The trial court would not permit a nurse anesthetist to testify as an expert. Apparently, the basis of the court's ruling was that the nurse anesthetist was not licensed to practice medicine. The Minnesota Supreme Court ruled that the nurse anesthetist was not disqualified from testifying solely because he was not a licensed physician as long as the nurse anesthetist otherwise had sufficient scientific and practical experience. Therefore, the trial court erred in excluding the nurse

anesthetist's testimony. However, before ruling, the trial court had asked about the subject of the testimony. The plaintiff indicated that it intended to ask the nurse anesthetist his opinion as to whether the anesthetic administered to Mrs Cornfeldt was appropriate. The Supreme Court of Minnesota said that the appropriate issue was whether the anesthesiologist conformed to accepted medical practice, not what the nurse anesthetist would have done. Because the nurse anesthetist's testimony would have been irrelevant, its exclusion was not error. The case is important because it shows that the Minnesota Court would have accepted testimony from a nurse anesthetist about the standard of care in anesthesia to be followed by a physician anesthetist.

Carolan v Hill

In 1996, the Supreme Court of Iowa also faced the issue of whether a nurse anesthetist could testify as to whether an anesthesiologist had met the standard of care in anesthesia (*Carolan v Hill* (553 N.W. 2d 882, Iowa, 1996)). *Carolan v Hill* overturned a trial court case in which a jury had rendered a verdict in favor of the defendant anesthesiologist and hospital after the trial judge had refused to permit a nurse anesthetist to testify as to the standard of care in anesthesia.

James Carolan underwent surgery in August 1991. Anesthesia was delivered by a physician anesthetist. Following surgery, Mr Carolan began experiencing pain and numbness in his left arm that continued even after he was discharged from the hospital. Ultimately, he was diagnosed with an ulnar nerve injury to his left arm. He filed suit against the anesthesiologist and the hospital claiming that the injury was caused by the

improper positioning and padding of his arm during the administration of anesthesia during surgery. Carolan planned to have a nurse anesthetist testify as to the proper positioning and padding of arms during the administration of anesthesia; however, the trial court refused to permit the nurse anesthetist to testify.

Iowa Code Section 147.139 provides:

If the standard of care given by a physician and surgeon licensed pursuant to Chapter 148, or osteopathic physician and surgeon licensed pursuant to Chapter 150A or a dentist licensed pursuant to Chapter 153, is at issue, the court shall only allow a person to qualify as an expert witness and to testify on the issue of the appropriate standard of care if the person's medical or dental qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case.

The trial court believed that the statute did not permit anyone but a physician to testify as an expert witness. Although the trial court's argument is not set forth, it is likely that the trial court focused on the requirement that an expert must have "medical or dental qualifications." Since nurse anesthetists do not have "medical qualifications," the trial court may have felt that the nurse anesthetist was not entitled to testify. When the case was appealed to the appellate court, the appellate court saw its role as giving effect to the legislature's intent. The court described its role in interpreting a statute. It must look to the language of the statute and then, if the language is ambiguous, "to determine the intent of the legislature." Although the statute refers to a "person's medical qualifications," the statute uses both "physician" and "person." The court felt that if the legislature had intended to restrict expert testimony to physicians, it would not have referred to "persons." The statute would have read: "the court shall only allow a

physician to qualify as an expert witness...if the physician's medical or dental qualifications relate directly to the medical problem or problems at issue...." But the statute as enacted referred to a "person" not a "physician."

The appellate court held that:

Use of the word 'person' is not ambiguous. In our search for legislative intent, we are to be guided by what the legislature actually said, rather than what it should or might have said... Iowa Code Chapter 4, which addresses the construction of statutes, defines the word 'person'... Unless otherwise provided by law 'person' means individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership or association or any other legal entity. We must presume that the legislature intended this definition of 'person' because it is not defined in Iowa Code Chapter 147. If the legislature wanted to restrict expert testimony to physicians and dentists it easily could have done so.

The Iowa court then ruled that although licensing may carry the presumption of qualification to testify in a given field, it is not the only qualification. The court stated that learning and experience may also provide essential elements of qualification. The criteria for qualification as an expert witness should be based on knowledge, skill, experience, training, or education. Distinctions on whether or not a proposed expert belongs to a particular profession or has a particular degree are only symbols of qualification. The appellate court noted that the nurse anesthetist whose testimony was refused had 27 years of experience and had delivered anesthesia to 17,000 patients. The appellate court determined that the trial court "abused its discretion in prohibiting his [the nurse anesthetist] testimony." Therefore, that portion of the case that related to the anesthesiologist's liability was reversed and returned to the trial court for trial.

All 3 courts were interpreting statutes on expert testimony. While

the courts seemed to take different views, the distinctions are understandable. In *Sullivan*, the issue was the standard of care to be followed by a nurse in a matter that represents a question of nursing care. Nursing staff, not physicians, have the skills and responsibility to prevent patients from falling. In *Cornfeldt*, on the other hand, the question of whether or not to administer halothane to a patient with high alkaline phosphate and SGOT readings has to be answered by an anesthesia provider. In *Carolan*, how to position an arm to avoid ulnar nerve injury also has to be answered by an anesthesia provider. Anesthesiologists and nurse anesthetists have the skills and the responsibility

to make these decisions. Nurse anesthetists and anesthesiologists have to follow the same procedures. There is no room for 2 schools of thought. One path leads to a safe anesthetic; the other leads to terrifying and unacceptable consequences whether the administrator is male or female, nurse or physician. Since both groups must follow the same practices, either should be expert enough to testify in court. What approach will the Illinois courts take in view of *Sullivan v Edward Hospital* if they are faced with an anesthesia case? The *Carolan* and *Cornfeldt* cases are not binding on the Illinois court. Conceivably, Illinois might take the position that *Sullivan v Edward Hospital* requires it to consider nurse anesthesia and

physician anesthesia as separate professions. However, I think it is much more likely that the Illinois courts will recognize, as did the courts in Minnesota and Iowa, that there is only one standard of care in anesthesia and that nurse anesthetists and physician anesthetists must meet, and can testify about, that standard of care.

Sullivan v Edward Hospital is an important case, nonetheless. It shows that nursing continues to win its battle for respect. Hopefully, the days when courts looked at physicians as the only expert in healthcare are ending. As the *Cornfeldt* and *Carolan* cases show, nurse anesthetists have been successfully fighting that battle for years.