Mitchell v Amarillo Hospital District

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Over the summer the Texas Court of Appeals decided *Mitchell v Amarillo Hospital District* (855 S.W.2d 857, Texas 1993). Because the plaintiff asserted such a peculiar legal theory, I had determined that there was no reason to comment on the case. However, the meaning and decision of the case has been misunderstood so it is important that Certified Registered Nurse Anesthetists (CRNAs) understand what the case stands for and, just as importantly, understand what the case does not stand for to prevent its inappropriate use.

The patient, Michael Mitchell, was admitted to a Texas hospital in February 1987. His cardiologist had diagnosed his heart condition as cardiac tamponade. A surgeon was contacted and decided that surgery was needed as quickly as possible. A CRNA employed by the hospital was designated to perform the anesthesia services. The anesthesia caused a cardiac arrest. Mr. Mitchell suffered brain damage and died approximately 3 years later. On his behalf, Mr. Mitchell's wife and father brought suit against the CRNA, the surgeon, the hospital, and the medical director of the department of anesthesia. The Mitchells settled their claims with the CRNA and the surgeon and proceeded against the hospital and the head of the anesthesia department. The peculiar aspect of the case was that the plaintiff did not allege any negligence on the part of the CRNA, the surgeon, or the hospital. Rather, the plaintiffs alleged that the hospital violated Mr. Mitchell's civil rights under the Fifth and Fourteenth Amendments of the United States Constitution.

As we are aware, the public is not familiar with nurse anesthesia. In *Mitchell v Amarillo Hospital District*, this misunderstanding is reflected in the plaintiff's distorted claims that the hospital and its medical director deprived Mr. Mitchell of his civil rights. One of the Civil Rights Statutes (42 USC Section 1983) provides that: *Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State... subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law.*

As a county hospital district receiving public funds, the actions of the hospital were state acts for purposes of the Fourteenth Amendment and Section 1983. But what had the hospital done to deprive Mr. Mitchell of his civil rights? Ridiculous though it seems, the plaintiff claimed that nurse anesthesia practice constituted a denial of Mr. Mitchell's civil rights. The plaintiffs asserted that the hospital denied Mr. Mitchell's civil rights by
permitting a nurse anesthetist to illegally practice medicine; make independent decisions; illegally prescribe, distribute, and administer controlled dangerous drugs, and that the hospital manifested a “deliberate indifference to the lives and safety of patients at the hospital . . . .” The plaintiffs claimed that the hospital’s illegal actions and omissions constituted negligence and negligence *per se* and were the cause of Michael Mitchell’s injuries and death. The hospital pointed out that the plaintiffs were attempting to raise an everyday medical malpractice claim into a constitutional claim under Section 1983.

**Constitutional claim required more than negligence**

As citizens of the United States we have the rights to life, liberty, and the ownership of property. The governments of the United States and the individual states may not deprive us of these rights without due process of law. If a state operates a hospital and an agent of the hospital damages someone though negligence, in a sense, the hospital deprives the patient of the patient’s civil rights because the patient who is injured or deceased cannot live, own property, vote, or enjoy other rights. But surely not every medical malpractice or negligence claim is a constitutional case! The courts have ruled that to rise to the level of a constitutional claim something more besides mere negligence is required. The State action must be “arbitrary, or conscience-shocking . . . .” The Supreme Court has said: *The Due Process Clause of the Fourteenth Amendment does not purport to supplant traditional tort law in laying down rules of conduct to regulate liability for injuries that attend living together in society. It should not be interpreted to impose federal duties that are analogous to those traditionally imposed by state tort law.* (Collins *v* Harker Heights 503 U.S. at ----, 112 S.Ct. at 1070, 117 L.Ed.2d at 275).

The trial court dismissed the Mitchell’s constitutional claims against the hospital and the medical director of the anesthesiology department. In a long and deliberate opinion, the Texas Court of Appeals considered each of nine arguments which the plaintiffs asserted as to why the acts of the CRNA constituted a constitutional deprivation of Mr. Mitchell’s rights and upheld the trial court’s decision. The court held, not remarkably, that none of the arguments was sufficient to support a conclusion that the hospital or the medical director had violated Mr. Mitchell’s civil rights.

Interestingly, there is not one suggestion in the case that the CRNA was negligent or did anything inappropriate. In fact, the case does not even question CRNA practice or suggest any standard of supervision for CRNAs. Rather, the decision discusses whether CRNA practice is, in and of itself, a constitutional denial of a patient’s rights. Not surprisingly, the case concludes that CRNA practice is not such a denial. Even though *Mitchell v Amarillo Hospital District* supports CRNA practice, confusion has arisen because the case was decided on technical legal grounds. The court had to assume that everything in the plaintiff's pleadings was correct but that because of various legal doctrines, the plaintiffs were not entitled to a recovery. Therefore, to be able to make its points and to discuss the case, the court had to assume, as true, a great deal of nonsense about nurse anesthetists and their practice. This resulted in the court making a number of statements such as “Assuming, argiendo, that the practice of allowing nurse anesthetists, or CRNAs, to administer anesthesia violates state or federal law, the Mitchells have alleged a cause of action for negligence *per se*.”

Now, the practice of allowing nurse anesthetists to administer anesthesia does not violate state or federal law, and the court was not saying that it is illegal for CRNAs to administer anesthesia. The court was only making a point that if this were negligence, it was still not a violation of Mr. Mitchell’s civil rights. The sentence appears in a paragraph which begins with the sentence: “Although the Mitchells maintain that their injuries were not the result of negligence, but were the result of the hospital’s deliberate decision to allow nurse anesthetists to prescribe and administer anesthesia in violation of state and federal law, their allegations under these facts and circumstances can not be characterized as arbitrary or conscience shocking, in a constitutional sense.”

The plaintiffs had not alleged negligence. They had alleged a denial of constitutional rights. The court is not saying the CRNA was negligent; it is making the point that mere negligence is not sufficient to be characterized as a denial of someone’s constitutional rights. The court could not say that this was negligence because the plaintiff never alleged that anyone was negligent.

Why did the plaintiff bring what appears to be a simple malpractice case as a claim that the patient’s constitutional rights were violated? *Mitchell v Amarillo Hospital District* does not provide the answer, but two possibilities come to mind. The first is that the plaintiffs may have believed that damages would be greater if the case were brought as a constitutional claim. The second possibility is that the plaintiffs attempted to bring the case as a constitutional claim to avoid preparing and presenting evidence of malpractice. Proving negligence in a trial can be difficult for three reasons.

- **Proving malpractice is expensive.** The ele-
ments of a malpractice case are that the defendant violated the standard of care, and this violation caused damage to the plaintiff. Because the courts do not understand nurse anesthesia, they designate it as a profession. The standard of care for nurse anesthetists is the same degree of skill and care a reasonable member of that profession would render in similar circumstances. The standard of care is created by nurse anesthetists, not the courts. When the courts need to know what the standard is, the standard of care is introduced by obtaining expert testimony, usually from members of the profession. This means that any plaintiff must engage an expert and have the expert review the record. The expert must be made available to testify both at trial and in depositions. Expert testimony can become quite expensive.

- Proving malpractice requires fault. We know that sometimes bad results occur even though no one was negligent. Tort law is not an insurance program. It allocates the cost of loss based on fault. If no one is at fault, the plaintiff cannot recover. Could the Mitchells have proven fault? It is not clear. The case indicates that the surgeon and CRNA settled prior to trial, but we do not know the amount of the settlement nor if it indicated fault. Just because there are damages does not mean that the plaintiff will be able to show fault.

- Proving malpractice is uncertain. Even if a plaintiff goes through the expense of hiring an expert and even if the expert finds evidence of fault, there is no assurance the jury will believe the expert or render a finding in the plaintiff's favor. The expert may not present well under the barrage of cross-examination. The evidence of fault may be ambiguous. The outcome of litigation is always uncertain.

Magic keys

Given these uncertainties, who can blame plaintiffs in medical malpractice cases for looking for a “magic key,” a theory that would remove the uncertainty and provide a clear path to recovery. There are two magic keys a plaintiff can use. Res ipsa loquitur is an often used and well recognized legal doctrine that reduces the burden of proving fault by providing that if the plaintiff can prove that the plaintiff could not have been injured except for negligence, the plaintiff need not actually prove the specific act of negligence which caused the injury. But res ipsa loquitur requires that an expert testify that the injury would not occur without negligence. It is not obvious from the Mitchell case that the injury would not have occurred without negligence.

The second magic key is the theory of "negligence per se." In the Mitchell case, plaintiffs cited Central Anesthesia Associates P.C. v Worthy, 254 Ga. 728, 333 S.E.2d 829 (1985), as being factually identical to their case. Worthy was a case where a student nurse anesthetist was being supervised by a physician assistant. At the time, the Georgia statute on CRNAs required that a nurse anesthetist administer anesthesia “under the direction and responsibility of a duly licensed physician with training or experience in anesthesia.” While the intent of the statute regarding exactly who could supervise a CRNA was not clear (and the statute has since been amended), what is clear is that a physician assistant cannot supervise a CRNA. Thus, in the Worthy case there was a clear violation of the Georgia CRNA statute. Violation of a statute intended to protect public safety is negligence per se. This means that although there was no proof of negligence (in fact there is nothing in the Worthy case to even suggest there was negligence), the law assumes that the bad outcome was a result of negligence. The plaintiffs in the Worthy case did not have to provide proof of negligence.

It is possible that the plaintiffs in the Mitchell case were trying to do the same thing. They alleged that there had been numerous violations of statutes intended to protect public safety. If the court had agreed that the nurse anesthetist’s practice violated the constitutional right of the plaintiff, the defendants would have been liable without any need to introduce proof of negligence. But Texas law does not require that a nurse anesthetist be supervised by an anesthesiologist. The Court of Appeals of Texas did not agree that this case demonstrated a denial of constitutional rights. It stated that “The Mitchells are attempting to turn a medical malpractice tort case into a Section 1983 claim.”

Surely, this finding is not surprising. Can you imagine the injustice if the courts invited plaintiffs to insist their constitutional rights were deprived every time someone had an adverse result from anesthesia? And it would not stop at anesthesia. Every medical malpractice claim would become a constitutional deprivation of rights. Plaintiffs who lost in state courts would have a chance to try their cases all over again in the Federal Courts on the supposed constitutional issues. Mitchell is a strange and unusual case because of the legal theory that was employed, but its dismissal was entirely predictable and expected. In fact, reading the case soon after it was decided, there seemed no point in commenting on it since it was based on such a bizarre theory of law. The case would have remained obscure except that a newsletter circulated in the healthcare industry decided to report the case. The newsletter reviewed the facts and
then somehow concluded that “CRNAs act at their peril when providing anesthesiology services without the direct or indirect supervision of an anesthesiologist.”

The Mitchell case came before the court on summary judgment. No evidence was introduced. The court stated that even if the plaintiffs' charges were true, the plaintiffs were still not entitled to relief. To explain its conclusion the court assumed that the plaintiffs' allegations were correct. The plaintiffs made a lot of untrue allegations in this case, some of which ended up in the article as “findings” of the court. But they were not findings; they were merely accusations which the court had to assume were true to support its grant of summary judgment. The court did not agree with the plaintiff.

Untrue charges

Among the untrue charges made by the plaintiffs in alleging that Mr. Mitchell's constitutional rights were violated, and which the court was forced to assume were true, were the following:

The plaintiff alleged that the hospital had policies and customs which allowed nurse anesthetists to illegally practice medicine. Nurse anesthetists do not practice medicine. The practice of medicine is what physicians do. Nurses practice nursing. Licensing laws do not establish monopolies, they are a legislative recognition of what professions do. There are many functions which are included in both the practice of medicine and the practice of nursing. Even the American Medical Association has recognized this overlap. “There is a marked overlap in the technical areas common to medicine and nursing practice. The act when performed by a physician constitutes the practice of medicine; the same act, when performed by the nurse, constitutes the practice of nursing.”

Anesthesia is one of these overlapping functions. If the court had actually considered whether the hospital had policies and customs which allowed nurse anesthetists to illegally practice medicine, it would not have ruled that nurse anesthetists were illegally practicing medicine.

The plaintiff claimed the nurse anesthetist was not medically supervised and alleged that the hospital neither implemented nor had any actual intention of implementing its written policy with regard to medical supervision of the CRNAs. The Mitchell case does not recite any facts indicating lack of nor improper supervision nor did the case discuss the nature of supervision. Perhaps, the plaintiff's claims were based on the absence of an anesthesiologist. Patients do not enter hospitals just to have anesthesia. They enter hospitals to have an operation or some other surgical procedure which may require anesthesia. Consequently, all anesthesia, whether administered by a physician or by a nurse anesthetist, is given in collaboration with a physician or other practitioner. Under Joint Commission on Accreditation of Healthcare Organizations (JCAHO) policy, which according to the case was being followed by the hospital, the supervising practitioner must be capable only of reviewing the results of the pre-anesthesia evaluation, of determining that the patient is an appropriate candidate to undergo the planned anesthesia and of determining that the patient can be discharged. These functions do not require an anesthesiologist. The American Association of Nurse Anesthetists' policy is that the elements of supervision should be considered on a case by case basis, taking into account the capabilities of the parties and the needs of the patient and procedure. If the court had considered the issue there is no reason to believe it would have determined that the hospital was not implementing its policy.

The plaintiffs alleged that the injuries incurred were not the result of negligence, but were the result of the hospital's decision to allow nurse anesthetists to prescribe and administer anesthesia in violation of state and federal law. The act of the nurse anesthetist in selecting and administering an anesthetic does not constitute “prescribing” under the laws of either the United States or Texas. Again, because this case came before the court of summary judgment, no evidence was introduced. If the court had considered the issue, it would not have agreed with the plaintiffs.

The article states that “Accordingly, the court found that assuming that the practice of allowing CRNAs to administer anesthesia violates state or federal law, the plaintiffs alleged a cause of action for negligence per se.” It is true that, as previously noted, the court wrote “Assuming arguendo that the practice of allowing nurse anesthetists or CRNAs to administer anesthesia violates state or federal law, the Mitchells have alleged a cause of action for negligence per se,” but this was hardly a finding. In fact, it is obvious from a reading of the case, that the court did not agree with this statement.

Finally, the article advises that “CRNAs act at their peril when providing anesthesiology services without the direct or indirect supervision of an anesthesiologist.” This statement is unsupported. Whether there will be a recovery against a nurse anesthetist for an untoward result depends on whether or not the court finds the nurse anesthetist was negligent. If the nurse anesthesia statute requires supervision or direction then, of course, the nurse anesthetist must be supervised or directed. But even
those states requiring supervision or direction permit nurse anesthetists to be supervised or directed by a physician other than an anesthesiologist. The fact that the nurse anesthetist is supervised by an anesthesiologist does not increase or reduce the nurse anesthetist's liability for his or her own negligence. The majority of anesthesia mishaps result from intubation in the esophagus rather than the trachea, undetected disconnection from oxygen, and other errors of observation and attention. Supervision by an anesthesiologist will avoid neither the liability for, not the cause of, negligence.

REFERENCES