The standard of care

Key words: Absence of anesthetist, role of the courts, standard of care.

Each of us owes a duty of care to others to act the way a reasonable person would act. For example, careless operation of an automobile can injure or kill other people. We are expected to exercise a standard of care in driving our automobiles as reasonably prudent men and women would use in driving their vehicles.

Juries, based on their own experience and judgment, determine the standard of care. Because ordinary juries and the courts do not understand what nurse anesthetists do, they designate nurse anesthesia as a profession. In the professional area, the standard of care becomes more complicated. The professional must render care with the same degree of care as a reasonable member of that profession in similar circumstances would render. A nurse anesthetist has expertise and education which ordinary members of society do not have. A nurse anesthetist has an obligation to render care that is not merely the same level of care that a reasonably prudent member of society would render but a level of care which other nurse anesthetists, persons with the same expertise and education, would render. This lets members of individual professions determine the quality of care to be rendered by their own profession.

When a court questions whether the nurse anesthetist has rendered appropriate care, the court obtains expert testimony as to the standard of care applicable to the nurse anesthetist. Normally, only members of the profession are competent to testify as to the standard of care for their profession. In the area of anesthesia, the courts have not distinguished between the level of care rendered by nurse anesthetists and the level of care rendered by anesthesiologists. Consequently, there are cases where courts have permitted anesthesiologists to testify as to the standard of care to be followed by nurse anesthetists and cases where nurse anesthetists have been allowed to testify as to the standard of care of anesthesiologists.

Standard of care is closely related to the quality of care. A profession that renders care at a lower standard than another will, necessarily, have a different quality of care. In the anesthesia field there is a uniform quality of care between nurse anesthetists and anesthesiologists, and that is further evidence that the “standard of care” for the two professions is the same. In some healthcare areas, the quality of healthcare may vary from community to community and area to area. In those cases, practitioners are only held to the standard of care within their community. This is referred to as the “locality rule.” In specialty areas such as anesthesia, however, there is a nationwide standard of care that does not vary from community to community.

Modified locality rule

Some recent cases provide some light on the standard of care and how it is used by the courts. On June 8, 1992, the Supreme Court of Indiana changed its description of the standard of care for healthcare practitioners. In medical malpractice cases, Indiana used to apply a principle known as the “modified locality rule.” The modified locality rule states that “The standard of care . . . is that degree of care, skill and proficiency which is commonly experienced by ordinarily careful, skillful and prudent [physicians], at the time of the operation and in similar localities.” In the case of Vergara v Doan, 593 N.E. 2d 185 (Indiana, 1992), the court determined that in Indiana “a physician must exercise that degree of care, skill, and proficiency exercised by reasonably careful, skillful, and prudent practitioners in the same class to which he belongs, acting under the same or similar circumstances.” In other words, the
court eliminated the condition in the prior rule that the physician need only comply with the standard of care that was common to similar localities.

As we have seen, members of society are expected to act as reasonably prudent persons would act under similar circumstances. In the area of healthcare because of the greater skill and education of practitioners, the court holds them to a higher degree of care than that which would be provided by ordinary prudent persons. Practitioners are expected to act as other practitioners would act in similar circumstances. In the late 19th century, there was a great difference between medical opportunities, equipment, facilities, and training between rural and urban communities. Consequently, the courts recognized a variation in the standard of care of professionals based on the locality in which the professional practiced. Rural doctors were not held to the same standards as doctors in large cities.

On the basis of advances in communication, travel, and education, the difference between rural and urban healthcare lessened and justification for two standards of care began to disappear. In addition, the courts became concerned about the practical problems of having a separate standard of care for each community. First, for a patient to establish that a practitioner was negligent, the patient had to present expert testimony that the practitioner's care had fallen below the standard. Since each community, theoretically, could have its own standard of care, the patient had to find a person familiar with the standard of care in the particular community. It was hard to find local doctors to serve as expert witnesses against other local doctors. Patients hurt by negligent care were unable to recover because they could not find local doctors who would testify that the operating surgeon had not followed the standard of care. Second, in some localities, a small number of local doctors could establish the standard of care at a very low level.

Given the drawbacks to the "locality" rule and the fact that with advances in communication and education there was less need for it, the courts modified it. Indiana and a number of other states no longer restricted evidence of the standard of care to the precise locality. Practitioners were held to a modified locality rule: they must follow the standard of care of "similar localities" to the one in which they practiced.

Obviously, having a standard of care determined by the care that is accepted in "similar localities" still leaves the standard of care subject to the criticism that rural communities would have a lower standard of care. Moreover, there were practical concerns about what was a "similar locality." The modified locality rule was intended to make it easier for patients to bring suit against negligent healthcare workers by allowing greater ease in establishing the standard of care. The modified locality rule still left unclear what was a "similar locality." As a result, the "modified locality rule" simply added another element of uncertainty that could be disputed to avoid liability. Practitioners could dispute whether the standard of care to which the expert testified was applicable to their community. In addition, because of advances in communication and transportation, local practitioners had the opportunity to be as expert as practitioners in urban communities. The reasons to hold practitioners in rural communities to a lesser standard than practitioners in urban communities were less and less. In reaching its decision, the Indiana Supreme Court also pointed out that widespread insurance coverage provided patients with more choice of doctors and hospitals. How this bears on the standard of care in rural institutions, however, is not clear.

**Locality as one of several factors**

As a result, in its decision announced on June 8, 1992, Indiana departed from its tradition and adopted a standard of care that was no longer determined by reference to the local community. "The physician must exercise that degree of care, skill and proficiency exercised by reasonably careful, skillful and prudent practitioners in the same class to which he belongs, acting under the same or similar circumstances." The Indiana Supreme Court explained that rather than focusing on different standards for different communities, the new principle would use locality as only one of several factors to be considered in determining whether the doctor acted reasonably. Other factors would include advances in the profession, availability of facilities, and whether the doctor is a specialist or general practitioner.

What was the practical effect of the court's ruling? Interestingly, the case involved a cesarean section and the standard of care that the surgeon allegedly failed to meet was "the failure to have either an anesthesiologist or a qualified nurse anesthetist present at the delivery." An expert witness had testified that the surgeon failed to meet the standard of care. The jury disagreed and found in favor of the surgeon. The trial court had instructed the jury that the standard of care was the modified locality rule, "that degree of skill and knowledge which ordinarily was possessed by general practice physicians who devote attention to obstetrics and its treatment in Decatur [Indiana] and similar localities of similar size in 1979." This led the plaintiff to appeal the case to the Supreme Court of Indiana and to succeed in changing the formulation of the standard of care.

530 Journal of the American Association of Nurse Anesthetists
Once the Supreme Court of Indiana changed the standard of care deleting the reference to localities, the court was obligated to determine if the outcome of the case would have been different if the trial court had instructed the jury to follow the new standard of care. The court points out that although the modified “locality” rule no longer applies, the instruction given by the court was not clearly erroneous because the considerations of locality can be considered under the “similar circumstances” test of the new standard the court adopted. Therefore, whatever error may have resulted from the application of the old standard was harmless and the jury verdict vindicating the physician was allowed to stand.

The decision of the Indiana Supreme Court, changing the formulation of the standard of care but leaving the jury’s verdict intact, was not unanimous. One of the judges concurred in the result (leaving the jury verdict intact) but not the reasoning (changing the formulation of the standard of care). In his words, the opinion has “articulated a distinction without a difference.” While it was true that the new formulation of the standard of care did not specifically refer to locality, it referred to “acting in the same of similar circumstances.” Consequently, what the Supreme Court shut out through the front door (variations based on localities), they let in through the back door (while some rural hospitals are well equipped, others might lack the equipment and facilities that would be found in a metropolitan hospital and therefore justify a lesser standard). Thus, the concurring judge said there had been no change in the standard of care. Instead of permitting a different level of care because of locality, the rule now permitted a different level of care based on the type of facility. If the description of the standard does not affect the outcome of this case, what case could it affect? Why did the court bother restating the formulation of the standard of care?

The case is more puzzling when you consider the traditional role of the courts. Unlike legislatures, courts are not supposed to make law. The courts merely find what the law is (and always has been). In the Indiana case, the Indiana Supreme Court is frankly acknowledging that they are changing the law by changing the description of the standard of care. Why did the Indiana Supreme Court change the law if the change does not affect their decisions?

**Doctor-patient relationship**

In *Meena v Wilburn*, 603 So. 2nd 866 (Mississippi, 1992), Ms. Wilburn’s leg was operated on. After the operation, the surgeon installed staples to keep the wound closed. What happened next is one of those situations which is everyone’s worst nightmare: patient, physician and nurse. The day after the operation, a doctor doing a colleague a favor came to remove the staples of Ms. Wilburn’s roommate. The doctor and his nurse approached Ms. Wilburn, the wrong patient. The doctor received an emergency call and had to leave. He instructed his nurse to remove the staples. She removed the staples from Ms. Wilburn without checking Ms. Wilburn’s wristband. Ms. Wilburn brought suit against the doctor and nurse for malpractice. The case is interesting because the defense was that Ms. Wilburn was not the patient of the doctor or the nurse and, therefore, no malpractice action could be brought. The physician argued that for there to be medical malpractice, there must first be a doctor-patient relationship. Because the staples were removed from someone who was not his patient, there was no doctor-patient relationship.

The case raises the kind of issue (similar to whether a tree falling in a deserted forest makes a sound) that only amateur philosophers can worry about: Can injuring someone who is not a patient be malpractice? The court answered that whether or not there was a doctor-patient relationship, healthcare professionals still owe a duty of care not to be negligent. Therefore, yes, you can have a professional obligation to persons who are not your patients. The most basic duty is to make sure that the person you practice on is the right one.

An interesting aspect of the case is that the jury found in favor of the nurse but against the physician. The doctor asked the court to order the jury to reconsider its holding because the doctor viewed the verdict as irrationally inconsistent. The court’s reasoning on the nurse’s role is not satisfactory. The court stated that the jury could have determined, as a factual matter, that the nurse was justified in carrying out a procedure on someone whom the physician identified as the patient even though the doctor’s selection of the patient was negligent. Given the fact that the nurse was at the doctor’s side and should have observed that the doctor had not adequately determined that he had found the right patient, the court’s conclusion seems to be surprisingly theoretical, especially in view of the patient’s testimony that she told the nurse several times that she did not think it was right to be removing the staples because her surgery had been so recent. The court’s response was that the doctor “should have been thrilled that the jury exonerated his nurse.”

These cases illustrate the difficulty courts and juries have in dealing with the activities of professionals, which is the reason the courts created their special treatment of professionals in the first place.