Expert testimony

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Courts do not understand what CRNAs do and rather than impose standards and requirements which apply to everyone, the courts classify them as “professionals.” More is expected of nurse anesthetists than merely to act the way a reasonable person would act. Nurse anesthetists must show the same skill and care as a reasonable nurse anesthetist would show in similar circumstances. Thus, professionals set their own standard of care, and when the courts need evidence as to what the professional's standard of care is, it is provided by expert witnesses. An expert witness, in general, is one who helps the judge or jury understand the evidence in a case, provides testimony which is based on scientific knowledge, and finally, is “qualified” as an expert (that is, convinces the court that he or she knows enough about the subject to help the judge or jury understand the evidence).

Anesthesia is primarily administered by anesthesiologists and nurse anesthetists. The public, and consequently judges and juries, expect the same high quality of care no matter who is administering the anesthetic. With respect to anesthesiologists and nurse anesthetists, no study has ever shown that the quality of care differs between the two groups. Similarly, legal cases involving anesthesia show that both nurse anesthetists and anesthesiologists are held to the same high standard of care. That is, in malpractice cases all anesthesia providers, both nurse anesthetists and anesthesiologists, are expected to deliver anesthesia in the same skilled manner. The law does not say that an anesthesiologist is permitted to make this mistake but a nurse anesthetist is not. Therefore, since nurse anesthetists and anesthesiologists are held to the same high standard of care, one could reasonably expect that either could testify as experts on the standard of care in anesthesia without regard to whether the administrator was actually a nurse anesthetist or an anesthesiologist.

Carolan v Hill

There are, undoubtedly, many trial court cases where either profession has testified as to the standard of care in anesthesia, but appellate cases have been more rare. There have been numerous appellate cases where anesthesiologists have been permitted to testify as to the standard of care for nurse anesthetists. Logically, one could also expect appellate cases where nurse anesthetists should have been allowed to testify as to what was the standard of care for an anesthesiologist. There is probably one reason why there are fewer cases of nurse anesthetists testifying on the standard of care for anesthesiologists than those where anesthesiologists have testified on the standard of care of nurse an-
esthetists. Some antiquated state statutes were drafted by persons who were largely unaware that nurse anesthetists and anesthesiologists not only perform the same procedures but also perform them with equal skill. Recently, the Supreme Court of Iowa faced this issue and in Carolan v Hill (553 N.W. 2d 882, Iowa, 1996) overturned a case in which a jury had rendered a verdict in favor of the defendant anesthesiologist and hospital where the trial court had not permitted a nurse anesthetist to testify that the anesthesiologist was negligent.

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 which 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 standard of care concerning the proper positioning and padding of arms during administration of anesthesia; however, the trial court refused to permit the nurse anesthetist from testifying.

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 nonphysician medical personnel 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 came to the appellate court, the appellate court pointed out that it is first required to give effect to the legislature's intent. It must look to the language of the statute and then, if the language is ambiguous, try to determine the intent of the legislature. Although the statute refers to a person's "medical qualifications," the statute uses both "physician" and "person." If the legislature intended to restrict expert testimony to physicians, the statute would, more properly, 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. . . ."

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 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 was not the only qualification. The court stated that learning and experience may also provide essential elements of qualification. The Iowa court determined that the criteria for qualification as an expert witness should be based on knowledge, skill, experience, training, or education; and it would not allow distinctions to be based on whether or not a proposed expert belongs to a particular profession or has a particular degree. With regard to the Carolan case, it noted that the nurse anesthetist 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.

In an earlier column we had commented on the ability of nurse anesthetists to testify as expert witnesses, but those cases dealt with their ability to testify as to the profession of nurse anesthesia. The Carolan case is an interesting case because it recognizes the ability of a nurse anesthetist to testify not only about nurse anesthesia but also about anesthesia in general, including anesthesia as practiced by an anesthesiologist.

**Lundgren v Eustermann**

Although the subject of expert testimony seems straightforward, it developed significance, perhaps because at one time there was a supposed reluctance of physicians to testify against another
member of their profession. One would expect that if there were someone who could testify as to the standard of care, the courts would be happy to listen, no matter what the expert's degree or license. That however, has not been the history of expert testimony in the courts. For example, in *Lundgren v Eustermann* (370 N.W. 2d 877, Minnesota, 1985), a consulting psychologist could not offer an opinion on the standard of care required of a family physician. The psychologist was going to testify that it was inappropriate to keep a patient on Thorazine® over a 6-year period. Although the psychologist had "admirable qualifications and extensive training and experience in the areas of psychology and pharmacology," had performed consultant work for drug companies, and "may well have the requisite scientific knowledge to testify about the nature of Thorazine, its dangers and uses," he still could not testify.

Why would the court not allow the expert to testify? After all, this was exactly the expert testimony required! The answer goes back to the nature of a profession. The courts do not expect perfection. In fact, the courts do not even require practitioners to be correct. All the courts expect is that the practitioner will exercise the same degree of care that other members of the profession would exercise. In the *Lundgren* case, the psychologist may have known a great deal about Thorazine and may have known that side effects made it unwise to keep patients on it for long periods of time. However, the psychologist, not being a physician, did not know how physicians prescribed it and what monitoring physicians followed when they did prescribe it. Thus, the psychologist could not testify as to what physicians would do when placed in the position of the defendant, and despite the psychologist's expertise regarding Thorazine, the psychologist lacked expertise in what physicians would do, the area where expertise was needed.

**Goodman v Phythyon**

In *Goodman v Phythyon* (803 SW 2d 697, Tenn. 1990), an anesthesiologist was permitted to testify in a case where a nurse anesthetist had difficulty keeping a patient still during an ophthalmologic procedure. The anesthesiologist testified that both the nurse anesthetist and the ophthalmologist were negligent in not recognizing that the patient needed to be more still. The ophthalmologist testified that he had relied on the nurse anesthetist who told him the patient was under control. The anesthesiologist testified that the ophthalmologist should not have relied on the nurse anesthetist. However, the anesthesiologist was not familiar with and was not an expert on the standard of care of an ophthalmologist. The defendant ophthalmologist had testified that he was following the standard of care and that he was justified in relying on the nurse anesthetist. Because the anesthesiologist admitted he was not an expert on ophthalmologic surgery, his testimony regarding the ophthalmologist was disregarded and the case against the ophthalmologist was dismissed.

**Cornfeldt v Tongen**

In *Cornfeldt v Tongen* (262 N.W. 2d 684, Minnesota, 1977), the Minnesota Supreme Court came close to permitting a CRNA to testify against an anesthesiologist. 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 so the incision was closed. 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 which 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 then had been sent to a professor of pathology who determined that cancer was present. A gastrectomy was the only effective treatment to prevent the risk that the cancer might spread, and to be effective it had to be done with reasonable dispatch. Mrs. Cornfeldt's laboratory work was normal except that her alkaline phosphatase reading was very high (145 compared to a normal range of 30 to 85) and her serum glutamate oxaloacetate transaminase (SGOT) reading was over 250 (10 to 50 is normal). 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, he decided to proceed with the operation without ordering further tests. Mrs. Cornfeldt's recovery appeared to be going well, but after a few days, jaundice was evident. Ultimately, she was transferred to another hospital where despite measures, including a liver transplant, she died from her hepatitis. Had the surgery been postponed, the court reported that there was an 85% to 90% probability she would have recovered from hepatitis in a month or 6 weeks. 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 give an expert opinion. 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 about the matter. Therefore, the trial court erred in excluding the nurse anesthetist's testimony. However, the plaintiff 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 what was at issue is 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 same standard of care

Despite the fact that anesthesia is administered by two 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. Since both groups share this uniform standard of care in anesthesia, it is to be expected that either group should be allowed to testify as to what this high standard is. The Carolan and Cornfeldt cases are evidence that the courts accept both professions as following this high standard.