LEGAL BRIEFS

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Key words: **Dead man's statute, informed consent, vicarious liability.**

VICARIOUS LIABILITY FOR ANESTHESIOLOGISTS

In the recent effort to convince the Health Care Financing Administration (now known as Centers for Medicare and Medicaid Services) to let state legislators rather than a federal bureaucracy determine whether nurse anesthetists had to be supervised, anesthesiologists tried to obscure the fact that any administrator of anesthesia can sometimes have an untoward result, with or without negligence. No matter how hard we try and no matter how many systems we put into effect, at some point anesthesia is administered by humans and all humans, even anesthesiologists, make mistakes. When mistakes happen in anesthesia they can happen with tragic results no matter who the administrator is.

In all the recent flurry of activity over supervision, the policy makers often seem unaware that anesthesiologists make mistakes, too. How can anesthesiologists suggest supervision of nurse anesthetists as a cure-all when anesthesiologists make the same mistakes? If they promote the anesthesia care team as preferable to nurse anesthetists working directly with surgeons, why aren't they promoting it over anesthesiologists working directly with surgeons?

Toogood v Rogal

Consider *Toogood v Rogal*, 764 A. 2d 552 (2000, Penn.). Kevin Toogood was involved in automobile accidents in 1989 and 1992, which left him in intense pain with migraine headaches and a ringing in his ears. To treat his jaw pain, he saw Dr Rogal, a dentist at The Pain Center, a multidisciplinary medical center providing various forms of pain management. In December 1993 he received a paravertebral nerve block injection from an anesthesiologist at The Pain Center. After receiving the injection Mr Toogood felt pain in his chest. He drove himself home, but he later checked into a hospital complaining of breathing difficulties. There, he was diagnosed with a collapsed lung. He recovered fully and because he did not suffer any damages from missing work (he had been out of work due to the injury, anyway), his lawsuit claimed no economic loss. He nonetheless filed suit against the dentist who had treated him and the anesthesiologist who had given him the nerve block, which he alleged caused the collapsed lung.

What, you may ask, is the connection between this case and nurse anesthesia? Well, basically, none. (Except that the anesthesiologist's son happened to be a nurse anesthetist.) This case became interesting when the anesthesiologist died before the case could come to trial.

The courts have developed a number of restrictions on evidence they will allow a party to present. These rules are intended to assure that evidence introduced at trial is reliable and truthful. What problems arise when a key party has died? One of the basics of the Anglo-American jury system is the assumption that 12 members of the jury will be able to determine whether someone is telling the truth by judging the person's conduct on the witness stand. Is the witness sincere as the witness tells his or her story? How well does the witness react to challenges by a hostile attorney? When a person is deceased, obviously, the jury cannot judge the manner, the ease, or unease with which the witness gives testimony. Normally, the death of a witness does not have a major impact on a trial. However, if the deceased is one of the parties to the litigation, the deceased's testimony cannot be easily replaced.

States have developed a variety of methods for dealing with this problem of unfairness. In Massachusetts, for example, when a party has died, statements made by the party may be introduced in evidence even though they would normally be excluded as "hearsay" (233 Mass. Gen. Laws §65). In Pennsylvania where the *Toogood* case arose, the "dead man's statute" takes an entirely different approach. The Pennsylvania dead man's statute provides that if a person who is party to a "thing or contract in action" has died, the other party to the thing or contract in action may not testify unless the deceased was one of several parties and the action is continuing against all of the parties.

Mr Toogood had brought suit against the anesthesiologist, The

Pain Center that employed the anesthesiologist, and the dentist who was the owner of The Pain Center. When the anesthesiologist died, the court had no choice but to dismiss the claim against the anesthesiologist. Under the Pennsylvania dead man's statute, the plaintiff was prohibited from testifying against the deceased anesthesiologist and there would not be any testimony to establish the anesthesiologist's liability. However, the dead man's statute did not apply in the plaintiff's suit against The Pain Center or the dentist. For those who know surgeons who are afraid to work with nurse anesthetists for fear that the negligence of the nurse anesthetists could be imputed to the surgeon, the *Toogood* case is just another case where an injured plaintiff is suing someone (in the *Toogood* case it happens to be a dentist, but it could just as easily have been a plastic surgeon or other physician) because of the negligence of an anesthesiologist. The trial court awarded $465,000 in favor of the patient against The Pain Center and its owner. A claim by The Pain Center against the anesthesiologist's estate seeking indemnification for his negligence remained unresolved.

In addition to its single-handed refutation of the fallacy that surgeons can feel comfortable working with anesthesiologists because they do not get sued for the anesthesiologist's negligence, the *Toogood* case raised some interesting issues. The owner argued that if the court dismissed the action against the anesthesiologist then, necessarily, the court had to dismiss the action against the owner of the clinic. The owner of the clinic had said that in a similar situation, when the plaintiff dismisses a lawsuit against an agent, the plaintiff necessarily dismisses the lawsuit against the principal. The appellate court did not agree with the analogy. The anesthesiologist had been eliminated from the case not on the basis of a release but because of immunity conferred by statute. The immunity conferred by statute does not extend to other parties who may be liable and, in specific, the fact that the plaintiff, Mr Toogood, could not testify against the anesthesiologist as to what happened, would not keep him from testifying as to what happened in a case against the owner of The Pain Center.

Res ipsa loquitor

The court also addressed the sufficiency of Mr Toogood's proof of negligence. There is a presumption in the law that medical or surgical services are presumed to have been performed in a skillful manner. What testimony was there to overcome this presumption? The plaintiff had relied on the theory of *res ipsa loquitor,* which requires a showing of 3 elements: "*(a) the event is of a kind which usually does not occur in the absence of negligence; (b) other responsible causes, including the conduct of a plaintiff and third persons, are sufficiently eliminated by the evidence; and (c) the indicated negligence is within the scope of the defendant's duty to the plaintiff*" (764 A. 2d 552, at 556).

Because of the nature of anesthesia, the usual question in the application of *res ipsa loquitor* to anesthesia malpractice cases is whether this is the kind of an event that does not occur in the absence of negligence. In the *Toogood* case, the court referred to a case decided in Georgia in which almost the identical fact pattern had occurred. The Georgia Court of Appeals had ruled that *res ipsa loquitor* was applicable in *Killingsworth v Poone* (167 Ga. App. 653, 307 S.E. 2d 123, 1983). The court held that a puncture to the lung was not a possible and known risk of a procedure because a puncture of the lung was not one of the risks mentioned when informed consent was obtained. The Georgia appellate court favorably referred to the case of *Lindsey v Central Anesthesia Associates* (161 Ga. App. 214, 288 S.E. 2d 292, 1982) where a suit over a broken tooth was dismissed because the patient had been told that "this is a risk that one must accept when undergoing general anesthesia." Thus, a test for whether this is the kind of event that usually does not occur without negligence is whether it is mentioned as a known risk when informed consent was obtained.

The *Toogood* case is valuable because it demonstrates once more that surgeons can be every bit as vicariously liable for the actions of anesthesiologists as they might be for nurse anesthetists. It also reminds us of the process and nature of medical malpractice claims. To establish a case, the plaintiff is either going to introduce expert testimony that the acts of the anesthetist constituted negligence or the plaintiff will rely on *res ipsa loquitor*. If the plaintiff relies on *res ipsa loquitor*, there are 3 things that must be proved: (1) that the event does not ordinarily occur in the absence of negligence, (2) that it is caused by an agency within the exclusive control of the defendant, and (3) that it is not due to any voluntary action of the plaintiff. None of this need ever surprise a nurse anesthetist or the nurse anesthetist's attorney.

The nurse anesthetist can defend these charges either by introducing the nurse anesthetist's own expert to testify that the action

did not represent negligence or that the result was one of those unfortunate incidences that can occur without negligence. In this context, we can see the value of well-thought-out informed consent. If an anesthetist is to defend himself or herself against charges of negligence on the grounds that what occurred was a possible and known risk, which can occur without negligence, the plaintiff will closely examine the risks that were actually disclosed to the patient. If what went wrong was not disclosed, how can one claim it was a known risk that could occur without negligence if the anesthetist never mentioned it. Properly prepared informed consent, in many ways, can be like an insurance policy.