Legal Briefs

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The importance of following procedures in anesthesia

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One of the things that I notice about the practice of anesthesia is the extensive use of protocols and procedures. As I learn more about anesthesia I realize how important protocols and procedures are to ensure patients' safety. When an emergency arises in anesthesia the anesthetist's reaction must be swift and accurate. There is no time to begin searching the literature for a discussion about how to handle this crisis. I am impressed with the positive and careful manner in which procedures have been developed to deal with many aspects of anesthesia. As a lawyer I also see that these procedures can protect the anesthetist. Should the anesthetist be required to defend himself or herself, it may be difficult to remember the exact details of an anesthetic given years before. Sometimes, it is helpful to be able to testify that certain matters are always done by following established procedures, even if you cannot remember what happened in a particular case.

While the anesthetist must always be aware and able to use professional judgment, established procedures or protocols are found in a variety of areas. There are procedures for checking out equipment, procedures to be followed when conditions such as malignant hypothermia are encountered, and procedures in many other areas of anesthesia. Giving an anesthetic clearly requires thought and judgment, but the importance of having and following procedures can not be minimized.

Groller v Methodist Medical Center of Oak Ridge

When I tried to find an anesthesia case that would illustrate the value of establishing procedures, the cases that best illustrated the principle had little to do with anesthesia. In *Groller v Methodist Medical Center of Oak Ridge,* (Tenn. 1989) 1989 W.L. 151498), a patient named Mr. Kuykendall was admitted to a hospital for a myelogram, contracted bacterial spinal meningitis, and died as a result of a cerebral hemorrhage. The patient's estate claimed that the surgeon, the hospital, and their agents were negligent and committed malpractice by failing to observe and

maintain sterile conditions and later by failing to properly diagnose and treat the meningitis.

The lengthy record of the case set forth in the appellate decision demonstrates a disturbing lack of communication between an absent physician and the hospital's floor nursing staff. One nurse testified that she had called the surgeon because the patient was complaining of pain and had a high temperature. The surgeon denied having talked to the nurse and asserted that he received a message over the intercom in the midst of an operation to tell him that he had a patient in pain. He claimed that he was not told and did not know that the patient had an elevated temperature. He prescribed pain medication and nothing else. He further testified that if he had been aware of an increase in temperature he would have wanted to see the patient immediately after finishing the surgery. At change of shift, the patient's care was transferred to another nurse, and his medical care was transferred to the on-call doctor when the primary care physician signed out. Although the on-call doctor ordered a complete blood count, the order was not given any priority and no blood was drawn until almost midnight. By the time the blood work was performed, the patient's condition was much worse. He had become disoriented and uncooperative, and his pupils did not react to light. When the medical staff realized how serious the situation was, it was too late. The patient went into a coma and died shortly thereafter.

Established procedures as evidence

There were 2 examples in the subsequent malpractice case of the court's acceptance of established procedures as evidence. The first was the surgeon's testimony that he was unaware that the patient had developed a fever. The surgeon's testimony used the plaintiff's charge of negligence in reverse. If the surgeon had been aware that the patient had developed a fever, he testified, his custom would have been to see the patient immediately after he finished his surgery. Because he did not see the patient, then, obviously, he could not have been told that the patient had a fever.

The second example related to testimony as to how the patient became infected in the first place. The patient's attorney was questioning one of the surgical nurses who had the primary responsibility of preparing the myelogram tray for use by the surgeon. The plaintiff's attorney was trying to show that the presterilized myelogram tray had been improperly opened and prepared, breaching the sterile field of the tray, and that this breach might have caused the meningitis. The nurse testified that she had opened the tray just before the doctor arrived. The attorney clearly was disappointed with the answer and confronted the nurse with her testimony from a deposition that she had given earlier in the case. The attorney read from her deposition:

"*Question: Did you tell me that you placed something over the tray itself?*

Answer: No, we never do."

Later in the deposition, the following exchange occurred.

"Question: Once you opened this presterilized tray from Pharmaseal and pulled back the paper covering, as you have showed me, the tray remained sitting there exposed to the atmosphere for the period of time you have told me about all these other activities take place?

Answer: Yes, it's sitting there."

At trial, the nurse replied that while she may have said that during her deposition, "normally we don't do that; we wait until the doctor gets in and then we open up the tray."

What is interesting about this exchange is the distinction between testimony as to what actually happened during the patient's operation and testimony as to the procedures that are normally followed. If you look carefully at the testimony, what the nurse is testifying to is not what she did on the day the plaintiff was operated on but what she *normally* does. This point was made even clearer on the subsequent exchange when the nurse was asked,

"Question: Do you recall that is what took place the morning of Mr. Kuykendall's myelogram?

Answer: That's probably true, I'm not real sure."

The judge tried to make this clearer.

"The court: ...I would assume even at the time you were taking that deposition, that is the morning he was asking you those questions in the deposition, that you were talking about what you routinely do rather than independent recollection of what you did in Mr. Kuykendall's case. Am I right or wrong?

The witness: You are right.

The court: And do you specifically recall what you did in the case involving Mr. Kuykendall?

The witness: As much as I can remember, that is the way it went."

The rules of evidence are complicated and try to exclude evidence that experience tells us is unreliable. Evidence of a defendant's actions other than in the particular case is normally not permitted because the fact that the person has engaged in a certain kind of conduct on one or more occasions is no proof that he engaged in it in

this one. However, there are exceptions in the rules of evidence, and one of the most important is that a witness is allowed to testify as to habit or custom. We believe that testimony as to what is done habitually is as likely to tell us what was actually done as a direct recollection. If the nurse routinely opened a package in a certain way, then that is most likely the way she opened it in this case. Thus, it is appropriate to ask the nurse how she "normally" or "routinely" opened a sterilized myelogram package because that is, most likely, the way she opened it for Mr. Kuykendall's operation. The judge not only *permitted* the nurse to testify as to what she habitually did, but *encouraged* her to do so.

Hall v Arthur

The application of this rule of evidence to medical malpractice can also be seen in the case of *Hall v Arthur*, 141 F.3d 844 (US Court of Appeals, 8th Circuit, 1998). In this case the patient was admitted into a hospital for an anterior cervical diskectomy and fusion surgery. In this operation, a damaged disk is removed from the spine and replaced with another object. Usually, it is replaced with bone from the patient or a donor. In the early 1990s, a ceramic material known as "Orthoblock" was used experimentally by some surgeons. Mr. Hall's surgery was done with Orthoblock, but the pain did not subside and Mr. Hall saw another neurosurgeon. In the second surgery, the Orthoblock was replaced with bone taken from Mr. Hall's hip. Mr. Hall then sued his first neurosurgeon claiming, among other things, that using Orthoblock in spinal surgery was negligence. By 1992, it was known that Orthoblock was not an appropriate material for spinal surgery, and the accompanying package insert stated that Orthoblock was not designed for use in spinal applications.

The court permitted 2 examples of testimony regarding custom and routine procedures. The first was when it became relevant whether the neurosurgeon had advised other patients that Orthoblock was experimental. The surgeon testified in his deposition that all of his patients knew that Orthoblock was not designed for use in spinal surgery or approved by the US Food and Drug Administration (FDA). He testified that he told all of his patients that Orthoblock could fracture and migrate after it was in place. As we noted, being able to testify that you *always* followed a procedure is helpful because even if you cannot prove what was said in a particular instance (such as what the surgeon, in fact, said to Mr. Hall), you can introduce evidence of what you routinely and customarily tell *all* of your patients.

Mr. Hall, however, found other patients of the neurosurgeon who had not been told that Orthoblock was experimental. Normally, they would not have been allowed to testify, because whether or not the surgeon told them Orthoblock was experimental was not relevant to what he may have told Mr. Hall. However, the failure to tell other patients is relevant to whether it was the surgeon's custom and habit to tell something to all of his patients. If the surgeon told all of his patients Orthoblock was experimental, why are these patients testifying that the surgeon did not tell them? The neurosurgeon's strategy backfired. Once the neurosurgeon introduced evidence of custom and habit, testimony that he failed to tell some of his patients has a bearing on his credibility. Moreover, whether they are supposed to or not, some jurors must have wondered: "If the neurosurgeon did not tell these patients, how can I believe that he told Mr. Hall?"

The second example is that a nurse practitioner was prepared to testify that it was her customary and routine practice to talk with each patient who had seen the surgeon, and she would have asked them if they understood the risks. If the patient indicated that the risks had not been explained, she would refer them to the surgeon for a discussion. The trial court had excluded this testimony thinking that it bore only on the credibility of the witnesses. The appellate court disagreed. It was evidence of routine practice and should have been admitted. While the appellate court agreed that it should have been admitted, based on the totality of the evidence, the appellate court did not feel that its exclusion had had an adverse effect on the trial's outcome.

Conclusion

Thus, we see the benefit of using protocols. During situations that are so routine that they seem to blend together, or during a crisis so intense that each minute seems like an hour and when it is over, you can no longer remember exactly what happened for what seems like whole days, consider protocols. If a protocol is *always* used and always followed, then no matter how boring or intense the operation, you can be sure that what needs to be done, gets done. Even if you cannot remember exactly what you did in a particular case, you can testify as to your routine and customary practice because this is, in fact, what you do when faced with a particular situation. For

example, if you begin your day or each operation checking out your anesthesia machine according to FDA guidelines, then even if you cannot remember what you did on February 1, 1995, you will know you checked the anesthesia machine because that is what you *always* do.

On the other hand, do not claim you have adopted routine practices if you do not always do them. When you testify that something is your routine practice you are suggesting that it is the standard of care. (If it is not, why do you always do it?) If patients or coworkers are going to testify that you did not always follow these protocols, you are practically admitting negligence and malpractice, and you are creating a situation where people are going to be able to testify that they saw you fail to observe the standard of care.

Anesthesia is so safe that the public believes that nothing can go wrong. If something does go wrong, the public wants to believe it could only result from malpractice. Clearly, this is not the case. Despite the best efforts of anesthetists, occasionally things can go wrong. Even though the anesthetist may not have been at fault, any lapse in vigilance or failure to follow rigorously the standard of care, even if the lapse or failure had nothing to do with the incident, exposes the anesthetist to the possibility of being found liable. A jury will want to believe that the problem could have been avoided had the standard of care been adhered to. Protocols and procedures can be very helpful in permitting the anesthetist to follow the standard of care even in difficult moments, whether in moments of boredom or of crisis. Taking preplanned and preconceived steps improves patient care. As an added benefit, the fact that these procedures are always followed can allow the anesthetist to testify as to the anesthetist's custom and routine practice, even if the anesthetist cannot remember what occurred in a specific case.