Legal Briefs

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The standard of care

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In the February 1988 issue of the *AANA Journal,* this column examined the introduction of pulse oximeters and concluded that we were witnessing the creation of a new practice standard in anesthesia. My conclusion was based on articles appearing in the *AANA Journal* (Monitoring in Anesthesia: Clinical application of monitoring oxygenation and ventilation, *AANA Journal* Course, 53:513-525, authored by Lorraine Jordan, CRNA, MS, and Linda Huffman, CRNA, BA), the remarks of the St. Paul Fire & Marine insurance company that the number of anesthesia claims were declining (*AANA News-Bulletin,* May 1990), and the fact that knowledgeable CRNAs attributed this decline to better monitoring.

This column reported that *"As yet no appellate case has mentioned the use of pulse oximeters as part of the standard of care."* There has now been an appellate case affirming a decision that a hospital failed to meet the standard of care when it failed to supply a carbon dioxide endtital monitor (*Washington u Washington hospital Center,* et al., 579 A.2d 177, District of Columbia Court of Appeals, 1990, hereafter referred to as the *Washington* case). The *Washington* case illustrates several principles regarding the standard of care.

As we have seen, nurse anesthetists are professionals, they set their own standard of practice and when the court needs to know what this standard is, the court seeks expert testimony. When dealing with nonprofessionals, the law of negligence is that a person is liable for injuries caused when the person fails to act as a "reasonable man" would act. How a "reasonable man" would act is a question which a jury decides based on the jury's own understanding and reactions. A Louisiana court described the standard of care as follows: *"... required of every health care provider in rendering professional services or health care to a patient shall be to exercise that degree of skill ordinarily employed under similar circumstances by the members of his profession licensed to practice in the State of Louisiana who is in good standing in a similar community or locale and to use reasonable care and diligence, along with his best judgment in the application of his skill; provided, however, that in the case of a health care provider practicing in a recognized field of specialty, the standard of care in rendering professional services or health care to a patient shall be to exercise that degree of skill ordinarily employed, under similar circumstances by the members of that specialty in good standing, and to use reasonable care and diligence, along with his best judgment, in the application of his skill."* (*Mohr u Jenkins* 393 So. 2d 245, Louisiana, 1980).

Frequently, anesthesia is recognized as a specialty, and anesthesia providers are required to meet a national standard of care rather than a local standard of care. There are, however, some states where the standard of care even for specialties is limited to the standard of care in the locality.

How does a court find out what the standard of care is?

The standard of care is determined by a jury or court from the testimony of expert witnesses. There have been some interesting decisions on the nature of that expert testimony. First, the testimony cannot be based on mere speculation or conjecture but should have an adequate factual basis. *"While absolute certainty is not required, opinion evidence that is conjectural or speculative is not permitted."* (*Washington u Washington Hospital Center* quoting from *Sponaugle u Pre-term, Inc.,* 411 A. 2d 366, District of Columbia,

1980). The testimony must show what the standard is as practiced by the profession. What a single practitioner would do does not establish the standard of care. Similarly, the testimony should not be what the expert would have done under similar circumstances but what members of the profession would do.

In the *Washington* case, the plaintiff was a healthy 36-year-old woman who underwent elective surgery at the Washington Hospital Center on November 7, 1987. An endotracheal tube was inserted into the esophagus rather than the trachea. It was not noticed until it was too late, and the plaintiff suffered catastrophic brain injury. The nurse anesthetist and anesthesiologist settled, and the case proceeded only against the hospital. It was claimed that the hospital was negligent in failing to provide an end-tidal carbon dioxide monitor which would have allowed early detection of insufficient oxygen, arguably in time to prevent the brain injury. After a jury verdict in favor of the plaintiff, the hospital asked the trial court to rule that the expert testimony offered was insufficient and the judgment should have been entered in the hospital's favor, notwithstanding the jury verdict. The trial court refused, and the hospital appealed the decision to the District of Columbia Court of Appeals.

The plaintiff's expert had testified that the hospital deviated from the standard of care by failing to supply a carbon dioxide monitoring device. Among other things, the hospital claimed that the plaintiff's expert lacked an adequate factual basis for his testimony. The court noted that the standard of care was *"The course of action that a reasonably prudent* [professional] *with the defendant's specialty would have taken under the same or similar circumstances." "Thus the question for decision is whether the evidence as a whole and reasonable inferences therefrom, would allow a reasonable juror to find that a reasonably prudent tertiary care hospital... at the time of* [plaintiff's] *injury in November 1987 and according to national standards, would have supplied a carbon dioxide monitor to a patient undergoing general anesthesia for elective surgery."*

It was claimed that the plaintiff's expert opinion that the standard of care in November 1987 required a hospital to provide an end-tidal carbon dioxide monitor was based on inadequate facts. Even though the expert gave no testimony on the number of hospitals having end-tidal carbon dioxide monitors in place in 1987 and never referred to any written standards or authority as the basis of his opinion, the court concluded that his opinion, combined with other evidence concerning the standard of care, was sufficient to create an issue for the jury.

The plaintiff's expert had based his testimony on his practice at the Los Angeles County Hospital and from *"What I have read where* [the monitors were] *available in other hospitals."* The expert's testimony was also based on standards for basic intraoperative monitoring approved by the American Society of Anesthesiologists (ASA) House of Delegates on October 21, 1986, which encouraged the use of monitors. (The *Washington* opinion identifies the ASA as "the American Association of Anesthesiologists" and refers to them as "the AAA.") The expert also mentioned an article entitled "Standards for Patient Monitoring During Anesthesia at Harvard Medical School," published in the *Journal of the American Medical Association,* August 1986.

What would a reasonably prudent hospital do?

The hospital argued that these statements were indications that end-tidal monitors were not the standard of care. The ASA policy was only a recommendation and the Harvard standards referred to carbon dioxide monitors as an "emerging" standard. The court indicated nonetheless that the expert's testimony should be allowed to stand based on other testimony introduced at trial. The question is what a reasonably prudent hospital would do and, *"Hence, care and foresight exceeding the minimum required by law or mandatory professional regulation may be necessary to meet that standard."* Thus, the fact that neither the ASA nor Harvard Medical School recognize carbon dioxide monitors as a standard of care was irrelevant if a reasonably prudent hospital would have followed them.

Other testimony which was introduced in this case included a 1986 alumni newsletter from the Department of Anesthesia at the University of Pennsylvania which indicated that carbon dioxide monitors were then in use at that institution's hospital and the defendant's own expert who had testified that not only had his hospital installed carbon dioxide monitors by early 1986, but by 1987 many hospitals were in the process of converting to carbon dioxide monitors.

Finally the court was clearly impressed by evidence from the defendant hospital's own chairman of Anesthesiology. In December 1986 or January 1987, the chairman had submitted a requisition to the hospital to acquire end-tidal carbon dioxide units stating that if the monitors were not provided, the hospital would "fail to meet the national standard of care." If the request had gone through, the monitors would have been fully operational in July 1987, four months before the unfortunate incident which gave rise to the case. The court concluded that the jury had sufficient evidence from which it could determine that the standard of care required an end-tidal carbon dioxide monitor.

It is interesting to note the limited role which

the court permitted a professional organization to play in setting standards of care. While the organization's determinations are evidence of the standard, what both the jury and the court really want to know is not what the professional organization says but what is customarily followed by members of the profession. An indication of ASA's limited influence is the fact that the court could not even get its name right.

Standard of care set by practitioner

The role of the practitioner in setting the standard of care is also reflected in the Louisiana case of *Mohr u Jenkins,* 393 S. 2d 245 (Court of Appeals of Louisiana, First Circuit, 1980). A patient sued a nurse anesthetist for complications allegedly caused by the nurse anesthetist's improper administration of injectable Valium®. The patient claimed that the entire procedure occurred in less than one minute while the nurse anesthetist testified that she administered Valium slowly in order to judge its effect. While the nurse anesthetist did not use a watch to time the injection, expert testimony revealed that the standard practice was not necessarily to use a watch, and that specialists did not follow manufacturers' inserts concerning the administration of Valium or any other medicine strictly or literally.

The trial judge, although holding that the nurse anesthetist had not violated the standard of care, had determined that the drug was administered in less than the time prescribed by the manufacturer. The appellate court found there was no evidence that the nurse anesthetist did not administer the drug in accordance with the way in which other nurse anesthetists would have administered the drug. What is interesting is the emphasis which the court places on actual practice. Even the drug manufacturer could not determine the standard of care. The standard of care is determined by practitioners, and these practitioners may engage in activities which do not comply with the instructions of the drug manufacturer.

The hospital in the *Washington* case also claimed that the standard followed at a teaching hospital would not necessarily have been followed at a general hospital. The court did not discuss this issue but dismissed it on the grounds that the hospital's lawyer had not fully identified the differences between Washington Hospital Center and the hospitals which were supposedly establishing the standard of care. The significant issue in the case was not whether carbon dioxide monitors were part of the standard of care, which the court clearly accepted as true, but only if having monitors was part of the standard of care in 1987 when the accident occurred.

Once more, to someone not familiar with anesthesia, the principles underlying the *Washington* case seem straightforward. Why then did the hospital incur the expense of an appeal to lose once more in the appellate court? Perhaps the hospital believed that in November 1987, carbon dioxide monitors really were not the standard of care and that the plaintiff had not proved they were. Writing at approximately the same time, I only cautiously concluded that pulse oximeters had become the standard of care. I had not concluded that carbon dioxide monitors were. While many hospitals acquiring pulse oximeters also acquired carbon dioxide monitors, not all did. The proof that was offered in the *Washington* case to the court and jury that carbon dioxide monitors were the standard of care seems pretty thin. The only real evidence was that the University of Pennsylvania hospitals, Los Angeles County Hospital, the hospital of the defendant's expert, and *some* Harvard Hospitals had carbon dioxide monitors.

In a legal "Catch 22," the most compelling evidence came from the defendant and even it was not convincing. In order to find an expert to support the hospital's case who would be credible to the jury, the hospital was almost forced to use a practitioner from a hospital that was likely to have more advanced technology than hospitals in general. The expert had to admit his hospital's use of carbon dioxide monitors in his testimony, and the court said the admission could be used as evidence. Finally, the statements of the hospital's head of anesthesia, made to convince the hospital to purchase these monitors, was accepted as evidence against the hospital. A reader of the case remains unconvinced, however, that there was a factual basis for the conclusion that carbon dioxide monitors were the standard of care in November 1987. The *Washington* case glosses over a serious issue and seems to stretch to support the jury's verdict.

While this case is binding only in the jurisdiction in which it was decided (the District of Columbia) and the determination of the standard of care is a factual matter which must be established for each case, to the extent that any hospital or nurse anesthetist continues to operate today without pulse oximeters and carbon dioxide monitors, the concerns we expressed in February 1988 have emerged as predicted. Hospitals and nurse anesthetists who continue to function without monitoring equipment will find it difficult, if not impossible, to justify their practice. Moreover, the *Washington* case illustrates, and practitioners must keep in mind, that while the law is that standards are set by practitioners, the reality is that they are established by juries and courts who have the benefit of hindsight.