Legal Briefs

GENE A. BLUMENREICH, JD
AANA General Counsel
Powers & Hall
Boston, Massachusetts

Franklin v. Gupta

A recent Maryland case (*Franklin v. Gupta*, 81 Md. App. 345, 567 A 2d 524, 1990 Md. App. Lexis 2, (January 3, 1990) *cert den* 319 Md. 303, 572 A 2d 182), illustrates a number of principles which we have previously discussed in this column. The plaintiff had a history of temporary blackouts, asthma, emphysema, bronchitis, hyperthyroidism, chronic depression and a nervous condition. The plaintiff, 5 feet, 5 inches tall, also weighed 295 pounds., Prior to the operation, he was evaluated as being ASA Class III, although one of the expert witnesses estimated his condition as ASA Class IV.

The day before the surgery, the plaintiff was evaluated by an anesthesiologist. However, the anesthesiologist never discussed his findings with the nurse anesthetist who was actually to administer the anesthetic. Although both the anesthesiologist and the nurse anesthetist came to the same general conclusions about the anesthesia, they did so independently.

The conclusion which they came to was that a general anesthetic was inappropriate and that the patient should be given a brachial block. The nurse anesthetist administered the block while the patient was in the holding room. Just before administering the block, he gave the patient one cubic centimeter of Sublimaze®. As the patient was wheeled into the operating room, he received a second cc of Sublimaze®, and about 10 minutes later he received a third cc of Sublimaze®. Because the block was not working, the nurse anesthetist wanted to give the patient another block but the surgeon insisted that the patient be given a general. Believing that general anesthesia was inappropriate, the nurse anesthetist summoned another nurse anesthetist, reviewed the plaintiff's vital signs and then left to consult with the anesthesiologist. The anesthesiologist, handling another case and unable to leave, agreed with the nurse anesthetist that the patient should be given another block and not given a general anesthetic.

Unfortunately, while the nurse anesthetist was consulting with the anesthesiologist, the patient became cyanotic. The patient was resuscitated and the surgery was cancelled. The patient sued the surgeon, the anesthesiologist, the nurse anesthetist and the hospital. The jury brought in a verdict in favor of the surgeon but against the anesthesiologist, the nurse anesthetist and the hospital.

Judgment notwithstanding the jury's verdict

The jury's verdict against the anesthesiologist, the nurse anesthetist and the hospital was in the amount of $375,000. The anesthesiologist, the nurse anesthetist and the hospital asked the court for a "judgment NOV" or a judgment notwithstanding the jury's verdict. A "judgment NOV" is granted when, as a matter of law, there is insufficient evidence on which a reasonable jury could render a verdict in favor of the plaintiff. "Judgments NOV" are granted by a judge when, after the introduction of all evidence at trial, the judge believes that there

is insufficient evidence to support a verdict in favor of the plaintiff but to avoid extensive after-trial procedures or the potential of a new trial, the judge allows the jury to consider the case.

To grant a "judgment NOV," the judge must decide that there was no evidence which would support the plaintiff's claim. A case of medical malpractice consists of evidence which:

1. Establishes an applicable standard of care.
2. Demonstrates that the standard has been violated.
3. Develops a causal relationship between the violation and the harm which was done (1990 Md. App. Lexis, Page 9).

In determining whether or not to grant a "judgment NOV" the court must look for *any* legally relevant and competent evidence, however slight, from which the jury could have found the required evidence.

What was the evidence from which a jury could have determined that there was evidence of negligence? In this context, the court considers the evidence backing the patient's claim consisting of the expert testimony of an anesthesiologist who noted five separate areas of negligence. Before discussing these alleged areas of negligence, it is necessary to understand that these are not the holdings of the court. The court is *not* saying that any of these areas were, in fact, negligent conduct. The court is merely looking to see if there was *any* evidence on which a jury could have based the determination that there was negligence.

The anesthesiologist, testifying as an expert witness, mentioned five specific areas of negligence:

1. The preoperative evaluation conducted by the anesthesiologist was incomplete. A pulmonary consultation should have been used. As a result, the expert witness testified that the CRNA underestimated the actual risk and difficulty of the patient's status.
2. There was no communication between the anesthesiologist who had conducted the preoperative evaluation and the nurse anesthetist. Moreover, the anesthesiologist was supposedly supervising the nurse anesthetist and yet there was no communication between the two.
3. The anesthesiologist was unavailable.
4. Too much Sublimaze® was used.
5. The CRNA should not have left the patient to seek consultation with the anesthesiologist.

The expert witness testified that these five factors resulted in a lack of planning and contributed to the damage to the patient.

Consequently, whether the court agreed or disagreed with this testimony, it was obligated, for the purposes of determining whether a "judgment NOV" could have been granted, to give absolute credibility to this testimony. If the jury believed the expert witness, there was evidence on which the jury could have found negligence, and a "judgment NOV" was inappropriate.

Remittitur

The jury awarded the patient $375,000. The trial court felt that this amount was "grossly excessive" and unless the plaintiff agreed to a remittitur, that is, unless the patient agreed to accept only $50,000, the trial court was going to grant a new trial. A decision as to a remittitur is one given to the trial court and can be reversed by an appellate court only if there is an abuse of discretion. In reviewing the grant of a new trial the appellate court applied a wholly different standard than the standard governing the review of "judgments NOV." In reviewing whether there has been an abuse of discretion, the appellate court must look at all of the evidence, not just that favoring the plaintiff. Here the principal injury claimed by the patient was his subsequent emotional reaction to what had occurred. The court said, "Considering his delicate physical and mental condition before the occurrence, along with the fact that the nature, extent and proximate cause of the appellant's post-traumatic complaints were seriously contested by the defendants, we decline to hold that the trial judge abused his discretion in finding the jury's verdict unreasonable in amount" (1990 Md. App. Lexis, Page 24).

Captain of the Ship

The court discussed "Captain of the Ship" in reviewing the jury instructions. The patient had claimed that the court had been in error by failing to give various instructions relating to Captain of the Ship. The jury found that the surgeon was not liable for the anesthesia mishaps. The patient claimed that the jury made this determination because the court failed to properly instruct the jury as to the surgeon's responsibility. The patient had asked for various instructions, asking the jury to recognize the surgeon's "exclusive responsibility and control." The patient also asked for instruction that, "Additionally, any nurse anesthetist who commits a negligent act in the presence of a physician would render the physician liable for their acts should you find that acts directly caused or contributed to cause the injuries or damages complained of. In such case, your verdict should also be against the defendant physician [the surgeon]" (1990 Md. App. Lexis, Page 26).

In what is becoming a familiar pattern, the court reviewed the history of the development of Captain of the Ship and concludes "to the extent

that the doctrine is regarded as an expansion of the traditional borrowed servant rule, most courts have either expressly rejected it or have declared it inapplicable when the negligent actor is an anesthesiologist or nurse anesthetist" (1990, Md. App. Lexis, Page 38). The court notes that the operating room environment is changing to a point where the surgeon can no longer have actual control over technical equipment and the persons who operate it. Moreover, since hospitals are increasingly paying for the negligence of hospital employees, "there is no socioeconomic need to extend the vicarious liability of the surgeon for the negligence of the hospital's employees, simply to create a fund for victims of malpractice" (1990, Md. App. Lexis, Page 44).

One of the interesting features of *Franklin v Gupta* is that both the jury and the court agreed that the surgeon should not be held liable. The patient repeated arguments that had been accepted as evidence of the surgeon's control when Captain of the Ship was accepted by the courts. This included the so-called right of the surgeon to cancel or postpone the surgery. Courts are recognizing that anesthesia providers are not controlled by surgeons. In this case, when the brachial block did not work, the surgeon asked that general anesthesia be given. The fact that general anesthesia was not given should be evidence that surgeons do not control nurse anesthetists.

Conclusion

Franklin v Gupta is an interesting case describing the relationship of surgeons, anesthesiologists and nurse anesthetists. Because of the particular way in which the case came before the court, it may be referred to for the wrong reasons. The court's discussions of negligence in the actual case are not the court's findings but merely a repetition of evidence by an expert witness. While an anesthesiologist was involved, there are indications in the case that the surgeon would not have been held liable even if there had not been an anesthesiologist.