Recent Developments in Anesthesia Malpractice*

JACK B. RUSSELL, LL.B.

Lecturer in Legal Medicine, Medical College of Virginia, Richmond, Virginia; Member of the firm of Browder, Russell, Little and Morris, Richmond, Virginia

The very fact that I have been asked to participate in a program of this significance is indicative of an ever increasing problem that is facing all facets of the medical profession—that is, how to stay in the hospital and out of the courtroom. I shall be talking about some of the general considerations all of you, as anesthesiologists, anesthetists, and physicians, should keep in mind in order to understand your legal responsibilities to the patient.

The topic "Recent Developments" is partially a misnomer because what I am going to address myself to is the recent trends or developments in three particular areas of the law as it affects the field of medicine, and then attempt to relate these particularly to the field of anesthesiology. You must also understand that "recent" medically and "recent" legally may in fact be years apart. What are commonly referred to as recent legal theories, frequently find their origin in court decisions several decades old. At the same time, some of what follows is of such recent vintage as to be classified by a vintner as green.

First, I would like to discuss the physician's duty to inform his patient and the recent legal developments in the area of informed consent. Second, I will discuss briefly the area of potential contract liability which is somewhat related to informed consent. And last, some of the more classical legal problems involving a physician and his patient, with special emphasis on the Captain of the Ship Doctrine and respondeat superior.

While the time has not yet arrived, and hopefully never will, when a physician cannot go about his daily tasks without having a copy of *Gray's Anatomy* in one hand plus *Corpus Juris* in the other, education as to the legal aspects of the practice of medicine in recent years has or should become a required course of study in our nation's medical schools and colleges. It is with this thought in mind that I present to you today's discussion.

Informed Consent. The Doctrine of Informed Consent is the child of the Doctrine of the Inviolability of the Individual Body, a concept born of the common law. Thus, it was stated in a recent case that "Anglo-American law starts with the premise of thorough-going self-determination; each man is considered to be master of his own body and he may, if of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment, and while a doctor might well believe that an operation or a form of treatment is desirable or necessary, the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception" (1).

It is because of this deep-rooted concept that, prior to any treatment, a physician must obtain his patient's consent. Valid consent to treatment can be obtained in any of several ways. First, the physician can obtain the *express* consent of the patient. This is done either orally or in writing, and most hospitals now have some type of consent form, though frequently inadequate. Second, consent may be *implied in fact. Implied in fact* consent occurs when a patient knowingly accepts treatment, as in rolling up his sleeve for an injection or agrees to an examination by lying on the examining table. Third, consent may be *implied in law.* Such consent occurs when the patient comes to a hospital unconscious or an emergency condition arises whereby he is unable to acknowledge his consent to treatment. Finally, consent may be given by a parent or guardian in the case of a child or incompetent.

For various reasons, the consent given may be a nullity. For instance, the consent may have been

* Presented at the 25th Annual Stoneburner Lecture Series, February 25, 1972, at the Medical College of Virginia, Richmond.

given by one who had no authority to give it, or it may have been obtained by fraud or misrepresentation on the part of the physician. While most physicians are aware of these traditional reasons for invalidating a consent, a relatively new reason for such has developed in recent years. Thus, courts have held with increasing frequency that a patient's consent must be informed and intelligent in order to be valid. The patient must have a clear understanding of what procedure is to be performed on him and the risks and possible complications involved. A disclosure that falls short of this test can invalidate the consent given just as thoroughly as if it had been obtained through fraud.

While actions at law have always been available to patients against their physicians for fraudulently induced consent or for operations performed without consent, only recently have actions at law been maintained by patients who allege that although their consent was given, it was invalid due to the physician's falling short of his duty to inform. This new right of action appears to have its genesis in the dictum† of a Virginia case, *Hunter v. Burroughs* (2), decided in 1918. In this case, the plaintiff was suffering from eczema and the defendant/physician recommended x-ray treatment as a cure. Back in 1914 such a treatment was revolutionary, and the defendant failed to warn the plaintiff of the risk of possible burn involved in its use. The patient suffered severe burns and sued his physician on two theories. First, he alleged that the treatment had been administered negligently; and second, he alleged that the physician failed to warn him of the possible dangers of x-ray treatment. The court affirmed a judgment for the plaintiff on his negligence theory and thus did not have to reach the issue of informed consent. However, in a dictum, the court laid the ground work for later court decisions on informed consent (3).

The basis of such an action is that a patient cannot give a valid consent to a treatment which he knows little or nothing about. The inviolability of the individual body necessitates that any consent given must be based on information necessary to make the consent intelligent and freely given. This includes the duty of the physician to disclose to his patient all relevant information concerning a proposed treatment, including the collateral risks and complications attendant to the treatment, so that the patient's consent would be an intelligent one based on complete information. The modern action based on a lack of informed consent did not fully develop until 1960 in the case of *Natanson v. Kline* (4), a case very similar factually to the *Hunter* case.

In the *Natanson* case, Mrs. Natanson had undergone surgery for the removal of a cancerous lesion in her left breast. As a precautionary measure, her physician, Dr. Kline, advised that she undergo radiation therapy to prevent further spread of the cancer. Mrs. Natanson consented to such treatment, but as a result of it, suffered severe burns. Subsequently, Mrs. Natanson brought an action against her physician on the theory that the consent to treatment was not informed. The Supreme Court of Kansas held that Dr. Kline was under the affirmative duty to make reasonable disclosure to Mrs. Natanson, allowing her to make an intelligent decision whether or not to take cobalt treatment. This duty included disclosing the risk inherent in the proposed course of treatment, but was limited to the disclosure only of facts necessary to form the basis of an intelligent consent.

In defining this basis, the court held that the degree of disclosure is to be measured by the standard of what a reasonable medical practitioner would disclose to his patient under the same or similar circumstances. Thus, the patient must introduce expert medical testimony in order to establish the community standard as to disclosure. Once such testimony is produced, it becomes a jury question as to whether the defendant/physician falls short of this standard.

Acknowledging the liability of a physician to his patient for failure to provide sufficient information necessary for an informed consent, the question arises as to what type of action is to be maintained by the patient. The courts themselves are somewhat confused in this regard but generally the action is brought on one of two theories: that of assault‡ or that of negligence. It is important to understand the difference between an action for assault and an action for negligence. In the former, the essence of the action being the unauthorized touching of the patient's body, the consent given, if there is any,

† Dictum—a statement of a principle of law in a decision by a court which was suggested by the case but was not necessary for a decision of the case as decided.

‡ The term technically should be "battery" which is an unauthorized touching of another's person; however, the courts have not been consistent in the use of this term, frequently using "assault" in place of it. The word "assault" is used generically to include both.

must be a complete nullity due to some misrepresentation or omission by the physician. On the other hand, negligence connotes the breach of some duty or standard of care imposed upon the physician. An example of an action for assault or unauthorized operation is the case of *Bang v. Charles T. Miller Hospital* (5), in which the patient was suffering from a urinary problem and, after consultation with the attending physician, consented to a transuretheral prostatic resection. The physician, however, failed to inform the patient that in doing the operation the spermatic cords would be cut and that the operation would render him sterile. The court held that the failure of the physician to disclose this essential fact rendered the plaintiff's consent invalid and hence, supported an action for assault. One of the key factors in an action based on assault is that lack of skill in performance of the operation or procedure is of no concern. The operation or treatment may have been performed in the most skillful manner but if there was no consent—informed consent—the plaintiff is entitled to recover damages from the physician. No expert testimony is needed in such a case.

A case closer to home is that of *Woodson v. Huey* (6), where prior to an operation the patient informed his physician that under no circumstances did he want a spinal anesthetic administered to him and was assured by the physician that he would receive a general anesthetic. The patient's wish was entered in his record by the physician. However, the anesthetist administered a spinal anesthetic following which the patient suffered paralysis. The court held the anesthetist liable for assault but not the surgeon. The fact that the spinal was given in a perfectly proper manner was of no consequence in an action for assault (7).

A negligence action, on the other hand, requires the plaintiff to show that (a) the risk was recognizable and the physician's duty of care required the disclosure of that risk; (b) had the patient known of the risk, he would not have consented; and (c) no justification existed for the physician's failure to disclose the risk (8). The plaintiff must prove the first element by expert testimony establishing the community standard and showing that the physician's actions fell short of that standard. The second element necessarily involves the subjective intent of the patient and can be established by his simply testifying that had he known of the risk, he would not have agreed. The third element comes into play only if the plaintiff can establish the first and even then would require expert testimony to establish the requirement of disclosure. (A few courts have placed the burden of proving this third element on the physician rather than on the patient, the effect of which is to create a jury issue in such cases.)

If these three elements are shown by the plaintiff, he has made out a prima facie case, and the defendant must counter by showing that he in fact did make adequate disclosure or that under the accepted standards, disclosure was not required.

Although a few courts still treat informed consent cases as an action for assault, the great majority of jurisdictions are getting away from this theory and are treating such as actions sounding in negligence; thus putting them in the same category as an action for mistreatment (9). Thus, in the case where the community standard is to secure consent to the administration of a spinal anesthetic during childbirth, it may be malpractice, that is, an action for negligence, where such consent is not procured prior to the actual giving of the spinal anesthetic (10).

Exactly what the courts require to make consent effectual is at the present time in a state of confusion. The Arizona Supreme Court has set down a good rule in defining consent:

> Consent . . . is effectual if the consentor understands substantially the nature of the surgical procedure attempted and the probable results of the operation. This, as a matter of law, constitutes an informed consent. . . . Given an informed consent, liability if any must be predicated in malpractice (11).

Coupled with the foregoing rule is the corollary being adopted by more and more courts that the primary duty of a physician is to do what is best for his patient, and that a physician may withhold disclosure of information regarding any risks or complications of the operation or treatment where a full disclosure would be detrimental to the patient's total care and best interest (12). Thus, when in the physician's professional opinion, informing the patient of certain of the risks or complications would make the patient unduly apprehensive and increase the risk of complications during surgery, information may be withheld. However, let me emphasize the importance of making a notation of such action on the patient's chart and, if appropriate, informing the patient as soon as possible after the surgery has been completed.

What then, as anesthesiologists, should you do, and tell your patients prior to the administration of anesthesia? Unfortunately, there is no hard and fast rule which can be stated as to the circumstances under which you can withhold making a full disclosure and as to the kind of information which can be withheld. Each case must of necessity depend on its own particular facts.

However, there are some basic guides that should be kept in mind:

1. Examine the patient prior to administering anesthesia, preferably the night before and this should be more than a cursory examination. Make a notation in the chart of the date and time of your examination, the findings, and any appropriate orders. Any doubt as to the patient's condition should be clarified because you will be held responsible for what could have been discovered by a proper physical examination. In the case of *Butler v. Layton* (13) negligence was found in the administration of ether to a patient suffering from a bad cold when the patient developed acute bronchitis which was caused by the anesthetic. However, where evidence is produced by the physician that a proper physical examination was given to the patient prior to administering the anesthetic, liability on this ground is usually avoided (14).
2. Explain generally the type of anesthetic to be administered, what will happen, and that there are risks and complications attendant to any medical procedure. Depending upon the patient's condition and emotional stability, make your decision as to how full a disclosure should be made. A fairly detailed explanation of what will take place may be of invaluable help since fear of the unknown is always much worse than fear of the known.
3. Have the consent form executed by the patient with any restrictions imposed by the patient noted thereon. If there are any restrictions these should also be noted in the chart. Incidentally, if there is any subsequent change as to any limitations on the previously given consent, this should be thoroughly and completely documented in the chart.

Contract Liability. As an adjunct to informed consent, let me give you a word of caution with respect to the assurances given to a patient. Courts have been severe in judging physicians who mislead, inadvertently or otherwise, their patients in regard to the potential seriousness or relative simplicity of a proposed procedure or operation. Thus, the physician who makes such statements as, "No danger can result" or "It's a perfectly safe treatment," may be held liable even though the operation he performs is done with all due care and competency. Illustrative of this is a recent case from Michigan (15), decided in 1971, in which the plaintiff was suffering from a peptic ulcer and contacted the defendant physicians regarding a possible operation. The patient was never told that he *must* have the operation, but the gist of what the defendant physicians told him is the following:

> Once you have an operation it takes care of all your troubles. You can eat as you want to, you can drink as you want to, you can go as you please. Dr. [X] and I are specialists, there is nothing to it at all—it's a very simple operation. You'll be out of work three to four weeks at the most. There is no danger at all in this operation. After the operation you can throw away your pill box. In twenty years if you figure out what you spent for Maalox pills and doctor calls, you could buy an awful lot. Weigh it against an operation.

The court held that such words amounted to an offer of a contract to achieve by the operation the condition described; that in reliance on the description, the plaintiff accepted the offer; and that when these results in fact were not achieved, the contract condition described was breached. A substantial jury verdict for the plaintiff based on breach of contract was affirmed.

The majority opinion held that the question of whether a contract exists is a question of fact for a jury in every instance. Obviously, if this decision were to be followed by other courts, the effect could be disastrous because it would severely limit physicians in their efforts to assure patients and calm their normal fears. There was a very strong and well-reasoned dissent, and I would hope and expect that the attitude of the majority of the courts would not extend this holding to the normal practice of encouraging the patient with reasonable assurances which although they may at times be somewhat exaggerated, are made with a therapeutic intent.

Captain-of-the-Ship or Respondeat Superior.

This now brings us to our next area of discussion. It involves a straight malpractice case with special emphasis on the Captain-of-the-Ship Doctrine or respondeat superior. The Captain-of-the-Ship Doctrine is based upon the long-accepted premise that the surgeon is in charge of all that takes place in the operating room and is, therefore, liable for it all. Respondeat superior simply means let the master respond for anything that his servants or employees may do.

By way of illustration, let me refer to a case that occurred in California which clearly illustrates the broad umbrella of responsibility that is frequently applied. The anesthesia was being administered by a first-year resident who was under the immediate supervision of an anesthesiologist who was responsible for supervising other operations at the same time. The anesthesiologist was a salaried member of a private group of anesthesiologists, which group through its chief was responsible for the anesthesiology training program. The residency program was under the joint sponsorship of the local hospital, the county hospital, and the state university. The chief of the anesthesiology group was out of the country at the time the incident occurred, but was ultimately responsible for the program and all that went on in connection with it. When suit was filed, the defendants included the resident, the supervising anesthesiologist, another anesthesiologist who came to their assistance, the chief of the group, the group itself, the local hospital, the county hospital, the state university, and the surgeons performing the operation. The case was ultimately settled prior to trial with all parties contributing with the exception of the surgeons. Anoxia and cardiac arrest developed during surgery apparently due to several factors, all of which were the responsibility of those administering the anesthesia. Recognizing the distinct areas of separate responsibility which is gaining wider acceptance by the courts, the surgeons did not contribute to the ultimate settlement of the case. The right to control is the basis for liability in situations of this type, and it can be traced from the resident all the way through the various people or organizations participating in the training program.

In spite of the broad implications of the Captain-of-the-Ship Doctrine, the courts pretty uniformly recognize the expertise of anesthesiologists and except in very unusual situations, do not impose liability upon surgeons for anesthesia malpractice nor upon anesthesiologists for surgical malpractice.

When the anesthesia is being administered by an anesthetist, we find less uniformity in the decisions and a greater willingness on the part of some courts to impose liability upon the surgeon for the negligent administration of the anesthetic. There are two cases in point. One, *Jackson v. Joyner* (16), is a North Carolina case in which a nurse who was an employee of the hospital negligently administered the anesthetic. The court held that while the operation was in progress, the surgeon had full power and control over all assisting nurses and that hence, the nurse administering the anesthetic stood in the position of a borrowed servant to the surgeon for the purpose and duration of the operation. In the case of *McKenney v. Tromly* (17) the court held that it was an admitted fact that the surgeon had the absolute right of control of all personnel in the operating room during the operation and hence, was liable for the negligence of any of these persons. These cases represent the extreme position and find their origin in the ready willingness of surgeons to testify that they are in absolute control of all that goes on in the operating room during the performance of the operation. This certainly is no longer true, and they are doing themselves a disservice by failing to recognize the distinct areas of responsibility that exist in present day medicine.

Certified Registered Nurse Anesthetists (CRNA) are highly trained specialists with more training and experience in the field of anesthesiology than the vast majority of the surgeons. Thus, even in situations where CRNAs have administered the anesthetic, courts are recognizing their expertise and the separateness of their function. They follow the principle that where several doctors or nurses have distinct and separate parts to take which require the undivided attention of each, only the one who failed to use due care in the performance of the part assigned to him should be held responsible. This is true unless it can be shown that one exercises or has the right to control the other (18).

In Virginia, the question of whether a hospital-employed nurse/anesthetist is an agent of the operating physician or the hospital is a question of fact to be determined by the jury and the main test, as in all agency situations, is who has the right to control (19).

As you can see, all of the illustrations that have been given were not necessarily anesthesia cases. However, the legal principles involved would apply equally to you as anesthesiologists, and they do illus-

trate some of the more troublesome areas from a medical legal point of view.

I hope you will all become keenly aware of the problem of informed consent, and when you return to your respective hospitals, check and see what type consent forms are now being used; see that they are updated, and do as some groups of anesthesiologists are doing and use your own consent form. Litigation in the area of informed consent has only been going on for approximately 20 years, and each year there has been an increase in the number of suits filed involving this problem. A good consent form and an appropriate discussion between anesthesiologist and patient would go a long way in reducing the amount of litigation on this point.

With respect to respondeat superior and vicarious liability, it is difficult to predict how the courts will treat this in the future. However, I am certain there will be more and more judicial recognition of the "area of expertise" principle, thus limiting liability to those actually performing a specific task. At the same time, you should not overlook the fact that one negligent act by a first-year resident can start a domino theory of liability, and this is particularly true in the teaching institutions. In such situations, there is no substitute for active and closer supervision by the teaching staff.

Finally, let me remind you that it is an integral part of your responsibility to keep your patients assured and their fears to a minimum. However, don't let your exuberance and self-confidence get the best of you to the point that you find yourself as the defendant in a breach of contract action as did the physicians in the Michigan case referred to.

Thank you for your kind attention and I trust that you can continue to avoid the legal pitfalls some of my colleagues are constantly putting in your paths.

CASES CITED

(1) *Natanson v. Kline,* 186 Kan. 393, 350 P. 2d 1093 (1960), *Reh. Den.,* 187 Kan. 186 354 P. 2d 670.

(2) 123 Va. 113, 96 S.E. 360 (1918).

(3) *Id.* at 133 96 S.E. at 366.

(4) *Natanson, supra.*

(5) 251 Minn. 427, 88 N.W. 2d 186 (1958).

(6) 261 P. 2d 199 (Okla. 1953).

(7) *Pedesky v. Bleiburg,* 251 Cal. App. 119, 59 Cal. Reptr. 294.

(8) 1970 Wisc. L. Rev. 879, 855 (1970).

(9) *Diflippo v. Preston,* 173 A. 2d 333 (Del. 1961).

(10) *Mager v. Dowsett,* 400 P. 2d 234 (Ore. 1965).

(11) *Shelter v. Rochelle,* 2 Ariz. App. 358, 370 409 P. 2d 74 86 (1965).

(12) *Nishi v. Hartwell,* 473 P. 2d 116 (Hawaii 1970); *Natanson, supra.*

(13) 226 Mass. 117, 164 N.E. 920 (1929).

(14) *Updegraft v. Gage-Hall Clinic,* 125 Kan. 518, 264 P. 1078 (1928).

(15) *Guilmet v. Campbell,* 358 Mich. 57, 188 N.W. 2d 661 (1965).

(16) 236 N.C. 259, 72 S.E. 2d 589 (1952).

(17) 386 S.W. 2d 564 (Tex. 1964).

(18) *Hover v. Protestant Deaconess Hospital Association,* 127 Ind. App. 565, 133 N.E. 2d 864 (1956); *Wiley v. Wharton,* 68 Ohio App. 345, 41 N.E. 2d 255 (1945); *Woodson v. Huey, supra.*

(19) *Whitfield v. Whittaker Memorial Hospital,* 210 Va. 176, 169 S.E. 2d 563 (1969).