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How to Handle an Anesthesia Injury Case

Albert Averbach*

*"The introduction and development of surgical anesthesia has been, next to the printing press, man's greatest contribution to the welfare of man."*¹

*"It is a fact that to anaesthetise a human being, to deprive him of consciousness outright, is to take a considerable step along the road to killing him."*²

THE CRITERIA OF COMPETENCE of the trial lawyer handling a medical malpractice case is, does he have at least as much if not more knowledge of the practice and procedure involved in the case than the defendant physician. In no place is this more true than in the field of anesthesiology. This is not, of course, to suggest that the attorney can compete with the physician in practical experience. But, it is to propose that many valid anesthesia malpractice cases result in nonsuits and that plaintiff's verdicts which are overturned on appeal are almost invariably lost due to insufficient evidence, which is primarily due to ineptness and the lack of thorough preparation by the attorney.

The man on the street is prone to admire the skill of the surgeon. But no one is looked at with more awe than the anesthetist who renders his patient unconscious and then brings him back to life again. The layman does not understand the mechanism by which general anesthesia is produced. An important thing to remember is that neither does the anesthetist. He does not know why—he only knows that he can do it.

Anyone can put a person to sleep by the means available to all anesthetists, and with only a moderate amount of luck he will wake up again in reasonably good condition. The danger is in

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¹ Dillon, *Things as They Are*, 190 J. A. M. A. 997 (1964).

² So said a British High Court Judge in delivering a judgment in a malpractice suit involving a patient who died after an injection of pentothal sodium. Hawkins, *Medicolegal Hazards of Anesthesia*, 163 J. A. M. A. 746 (1957).

the agent used to produce the narcosis and the technique of administration of it, how the patient is handled while unconscious and what is necessary to be done to restore and preserve life in case of complications. This is what separates "the men from the boys" in the field of anesthesiology.

It is frequently said that while there may be minor surgery, there is no minor anesthesia. In 1950, Lahey wrote that the expectancy of death during anesthesia and surgery was roughly one in a thousand.³ In a twelve year study of 56,000 operative procedures done in a community hospital, it was reported that there was one death in every 3,650 cases.⁴ The statistics must be much improved today. In a ten year period at a metropolitan teaching hospital, it was said that there were 26,000 obstetric deliveries without delivery room mortality and only one death in 23,000 tonsillectomies.⁵

It is doubtful that a correct estimate of mortality due to anesthesia can ever be determined, for there is no way to determine the number of poor risk patients who die as a result of anesthesia; the incidence varies dependent upon how the author defines an anesthesia death and what he is trying to prove; such deaths are not reported in the literature. All that can be said with impunity is that there is a significant number of operating room fatalities and serious accidents leading to impairment of bodily functions. How many of such incidents were "due to anesthesia" rather than *under anesthesia* is a matter of conjecture.

The administration of anesthesia is a relatively safe procedure today. Yet, such complications can develop at any stage of it that it has been likened to the exposure of the jugular vein to the fangs of the ferret. In the legally justifiable case of professional negligence, it is the obligation of the plaintiff's lawyer to discover and expose "the jugular vein" in the case and to strike at it with all of the forces of law and medical evidence under his control. To do so he must have knowledge of common practices and principles of anesthesia which will enable him to pinpoint medical facts which might otherwise be ignored.

³ 90 Surg. Gynec. & Obstr. 108 (1950).

⁴ Mannix, *Medico Legal Implications of Operating Room Deaths*, 60 N. Y. St. J. Med. 683 (1960).

⁵ *Id.* at 689.

If malpractice cases are at all justifiable, and it is surprising the number of physicians who hold that they are not, there should probably be more malpractice cases against anesthetists than there are today. Again, there do not seem to be any reliable statistics as to the commencement of suits in this field. According to one survey, only 4 of 447 physicians in reported cases from 1946-1956 were anesthesiologists.⁶ In a four-year survey of 1,000 malpractice cases in one area from 1958-1962, anesthesia was in eighth place in frequency of suits, having been involved in 71 cases.⁷

There is no safe anesthetic agent—only careful anesthetists. The skill of the anesthetist may be unquestionable, his technique apparently faultless, and his selection of drugs and dosages of them apparently proper, yet a person may die under anesthesia or be severely injured without there being any evident surgical or anesthetic error. But complications under anesthesia are not invariably acts of Providence; they are usually the product of cause and effect. Today's patient expects "safe conduct" under anesthesia and a cause of death stated to be "unable to take the anesthetic" is no longer acceptable. In almost every instance there are discernible anatomic, physiologic or pharmacological reasons for morbidity and mortality associated with surgery and it is the lawyer's first duty to ascertain what they are and whether they were the result of negligence.

There are many factors of causal relationship involved in the operating room accident. The physical status of the patient, the magnitude and length of the surgery, the skill of the surgeon, the skill of the anesthetist, the preoperative preparation of the patient, the accuracy of the diagnosis, the facilities available and the nature of the emergency are factors that play important parts in the determination of the success or failure of the procedure. A critical review of most accidents reveals that such might have been prevented if the complication initially responsible had been immediately recognized, if the equipment and materials for correcting all types of complications had been

⁶ Sandor, *The History of Professional Liability Suits in the United States*, 163 J. A. M. A. 459 (1957). It should be observed that there are many anesthesia cases which do not involve anesthesiologists.

⁷ Mills, *Medical Lessons from Malpractice Cases*, 183 J. A. M. A. 1073 (1963). In this survey, the greatest problem encountered was cardiac arrest, which occurred in 19 cases. The fatal result in many cases was not chargeable to the anesthetist but to those thereafter charged with the care of the patient who were unaware of the signs of respiratory acidosis.

readily available, if the physician had used them, and, in the case of cardiac arrest, if resuscitation measures had been promptly instituted. The issue is, how do you prove it?

The legal hazard to the anesthesia malpractice case is that no one, not even the operating surgeon, knows what really goes on behind the screen where the anesthetist sits. Correspondingly, it takes an attorney knowledgeable in that field to appreciate those hazards. It is manifest that the source material of the facts of an anesthesia case are usually meager. Such are generally limited to the hospital chart, the autopsy protocol, if there was one, the death certificate for what it is worth, and the testimonial evidence elicited in discovery and oral depositions of the defendant, and others, in the operating room, in jurisdictions where that procedure is available.

I. Preparation of the Case

The law applicable to the anesthetist is usually no different than the law as applied to physicians generally. One who undertakes to administer anesthesia is required only to exercise ordinary or reasonable care, that is, the skill and diligence of the ordinary anesthetist at the time and place where the defendant undertook to act. He does not insure against harm or guarantee a good result.⁸ The regular rules of malpractice cases as to standard of care, the necessity of expert testimony and the availability of the doctrine of *res ipsa loquitur* are equally applicable in actions against anesthetists, whether physicians or nurses.⁹

Since it is very unlikely that the qualifications of an anesthetist, especially a board certified anesthesiologist,¹⁰ can ever be successfully challenged, it is apparent that the chief difficulty in the anesthesia case is to surmount the problems presented by the case law that a physician is not liable for a mere error in judgment and to causally relate the anesthesia to the injury or death. In most cases it is difficult to attribute a dele-

⁸ 41 Am. Jur., Physicians and Surgeons § 82 (1942).

⁹ Annot., "Malpractice: duty and liability of anesthetist," 53 A. L. R. 2d 142 (1957). See, Wasmuth, Standards of Care in Anesthesiology, 7 Clev-Mar. L. R. 403 (1958).

¹⁰ An anesthetist is anyone who administers anesthesia. An anesthesiologist is a physician whose practice is limited to the administration of anesthesia and the performance of corollary functions. He is a specialist. Sometimes the term is applied only to the anesthetist who is board certified or board qualified.

terious result to the anesthesia alone and to segregate the administration of it from the surgery and physical status of the patient as a proximate cause of the injury or death.¹¹

A. The Death Certificate

Death certificates are notoriously unreliable in describing the cause and manner of death¹² and should be considered only as a lead to the uncovering of the medical facts. For example, the entry on a death certificate of "cardiac arrest" does not describe a specific entity. It is a waste basket term implying a sudden death the cause for which had not been determined. In the great majority of operating room deaths, the anesthesia contributes to the mortality, yet death certificates rarely contain the entry that a cause of death was anesthesia except in the extreme cases where the contribution of it was major and unequivocal.¹³ Death is never ascribed to therapeutic misadventure and anything remotely suggesting malpractice is scrupulously avoided.

B. The Autopsy Report

Neither is an autopsy report to be accorded the sanctity which bench and bar allow it. An autopsy will not reveal a cause of death due to an allergy to the anesthetic agent. In the

¹¹ In *Bishop v. Shurly*, 237 Mich. 76, 211 N. W. 75 (1926), where although the defendant was forewarned of a possible allergy to cocaine, a defendant's verdict was held justified where there was medical testimony that the cause of death was an enlarged thymus gland and that the death would have resulted no matter what anesthetic agent was used. See, for example, *Loudon v. Scott*, 58 Mont. 633, 194 P. 488 (1920), where the defendant admitted that he recognized the danger in giving an anesthetic to a patient who had been drinking heavily, but he also testified that there was danger involved whenever an anesthetic was given and, in view of the patient's generally robust condition, he believed it reasonably safe to proceed with the operation. See also *Yaggle v. Allen*, 24 App. Div. 594, 48 N. Y. S. 827 (1898); *Noe v. Wolf*, 243 App. Div. 542, 275 N. Y. S. 701 (1934).

¹² See Petty, Multiple Causes of Death—The Viewpoint of a Forensic Pathologist, 10 J. Forensic Sci. 167 (1965).

In New York City where an autopsy protocol demonstrates a cause of death different than that of the death certificate, the latter is required to be amended. In a one year study made of such changes, it was noted that approximately 15 per cent of the death certificates had been revised. See Erhardt, Weiner & McAvoy, Pathological Reports for Mortality Statistics, 171 J. A. M. A. 33 (1959).

¹³ See, Medical Certification of Medicolegal Cases, U. S. Dep't. of Health, Education & Welfare Public Health Service Publication No. 810 (1960).

"cardiac arrest" case the problem of establishing the cause of the heart failure may be further complicated for the pathologist by the contusion and trauma of cardiac massage. In a bloody operation, a death can result from multiple transfusions of banked blood which is not fresh, or in which the potassium ion has not been checked, and the real cause of death will not be recorded. The post mortem table does not include the investigative facilities to establish many physiologic mechanisms of death.

C. The Hospital Record

The hospital record can be one of the most revealing factors in determining the cause of anesthesia accidents. Successful management of anesthesia depends to a large degree on the careful investigation of the patient's physiological status before surgery for the purpose of determining deviations from normal. The charts will reveal the history of the ailment for which the surgery is proposed and relevant items to be taken into consideration such as allergies and the patient's personal habits. The results of a complete physical examination will be recorded. It will contain the record of laboratory tests and procedures. In short, the hospital chart will contain much but not all of the information of which the anesthetist should be aware to evaluate the risk and prepare the patient for surgery.

All textbooks bespeak the duty of the anesthetist to visit the patient at least the day before surgery. Although the surgeon will have already evaluated the patient, the careful anesthetist will read all the recorded data, take his own history, and he may do his own physical examination. Since in most instances the anesthetist must make the choice of the anesthetic agent and the technique of administration, and bear the ultimate responsibility for the physiological well being of the patient during anesthesia, he should always make his own evaluation of physical status.¹⁴ He pays special attention to certain disease states which experience indicates are more likely to contribute to operating room mortality. Attention is given to such special hazards as the cardiovascular system, the respiratory system, renal and liver disfunctions and defects in blood coagulation. He inquires as to previous anesthetics and examines for loose

¹⁴ See Artusio & Mazzia, *Practical Anesthesiology*, Ch. 8 (1962). This book is highly recommended for the attorney's medical book shelf.

teeth and dentures.¹⁵ It is particularly necessary to know that such drugs as corticosteroids, tranquilizers, antihypertensive agents, sedations, opiates and alcohol may have been used by the patient.¹⁶

With all of the advances of modern medicine, no substitute has been found for the careful preanesthetic investigation and the surgical preparation of the patient as a means of reducing operative morbidity and mortality. By the same token, where the anesthetist can demonstrate that he followed proper precautions in examining the patient prior to the administration of anesthesia he is a long way to a verdict in his favor in the event of a death or a serious injury during anesthesia.¹⁷ Nevertheless, in a vast number of hospitals, in both smaller communities and metropolitan centers, the anesthesiologist first meets the patient on the cart to the operating suite under the effect of pre-operative medication. These are candidates for successful malpractice cases.¹⁸

D. The Oral Deposition

In every case where local law permits it, the plaintiff's attorney *must* orally examine a defendant doctor before trial. Written interrogatories are wholly insufficient. This may be the most important element in the lawsuit and the preparation for

¹⁵ The number of cases arising from the breaking of teeth during placement of an endotracheal tube is surprising. In *Dohr v. Smith*, 104 S. 2d 29 (Fla. 1958), the anesthetist visited the patient the day before surgery, but she neglected to ask him if he had any false teeth for fear of offending him. After the patient had been put to sleep she placed an airway and lost a bridge consisting of two teeth. She did not tell the surgeon and it was not discovered in the right bronchus until an x-ray was made several weeks later.

See also *Wolfe v. Feldman*, 158 Misc. 656, 286 N. Y. S. 118 (N. Y. City Ct., 1936); *Meyer v. St. Paul-Mercury Indemnity Co.*, 225 La. 618, 73 S. 2d 781 (1953); *Kemalyan v. Henderson*, 45 Wash. 2d 693, 277 P. 2d 372 (1954); *Voss v. Bridwell*, 188 Kan. 643, 364 P. 2d 955 (1961); *Morwin v. Albany Hospital*, 7 A. D. 2d 582, 185 N. Y. S. 2d 85 (1959).

¹⁶ Cf. *Vandam*, *Environmental Factors in Anesthesia*, 7 *Archives of Environmental Health*, 391 (1963).

¹⁷ See *Nemer v. Green*, 316 Mich. 307, 25 N. W. 2d 207 (1946); *Updegraff v. Gage-Hall Clinic*, 125 Kan. 518, 264 P. 1078 (1928); *Mitchell v. Atkins*, 36 Del. 451, 178 A. 593 (1935).

¹⁸ In *Moore v. Bell*, 187 Tenn. 366, 215 S. W. 2d 787 (1948), a complaint was held to state a cause of action where it was alleged in an action for wrongful death that the defendants failed to take a history before operating, failed to examine the heart, take the blood pressure, make a blood count, to make an examination to determine the type of anesthesia to use and to properly observe the condition of the decedent while under anesthesia.

See also *Sanzari v. Rosenfeld*, 34 N. J. 128, 167 A. 2d 625 (1961).

it must be as exhaustive as for the trial itself. Not only is it a prime opportunity to observe how the defendant conducts himself under fire but it should serve as the occasion to survey his general knowledge and preparation. Medical malpractice cases are almost never settled before oral depositions are taken and the defendant's attorney will also be a keen observer. A well prepared examination before trial can lead to an early settlement.

The first inquiries should be directed to the defendant's status. In no other medicolegal field is this more important, for it may determine the standard of care to be applied to the case.

II. The Legal Status of the Defendant

Anesthesiology is a relatively new specialty. The anesthesiologist considers himself as consultant to the surgeon. He is willing to call himself a part of the team of physicians during a surgical procedure and to accept the legal relationship such implies.¹⁹ He should be permitted to assume this status although it is not at all clear that his liability is so extensive. For example, the anesthesiologist insists that it is his prerogative to choose the anesthetic agent which in his judgment is proper for the patient. One text suggests that if the anesthetist administers an improper anesthetic at the surgeon's insistence, it is he who is liable, not the surgeon.²⁰ Another states that if the anesthesiologist is questioned as to agent or technique, he should offer to withdraw from the case.²¹ On the other hand, the leading hospital text states that the choice of anesthesia is "primarily the responsibility of the surgeon."²²

It has been said that there are some hospital staffs which resist the intrusion of the specialty of anesthesiology within the domain of the operating theater on the theory that the surgeon should be "captain of the ship" and control all details of the operation, including anesthesia.²³ It is a general principle that a surgeon is responsible for the anesthesia only if it is administered by a technician under his direction. If it is given by an anes-

¹⁹ Artusio & Mazzia, *op. cit. supra* note 14 at 84-85; Wasmuth, *Anesthesia and the Law*, 41 (1961).

²⁰ Artusio & Mazzia, *op. cit. supra* note 14 at 303.

²¹ Wasmuth, *op. cit. supra* note 19 at 45.

²² MacEachern, *Hospital Organization and Management*, 444 (3rd ed. 1962).

²³ Louisell & Williams, *Trial of Medical Malpractice Cases*, 90 (1960).

thesiologist, it is he who is responsible for the choice of the agent and the care of the anesthetized patient. If the surgeon assumes supervision of the operating room, most courts hold that he becomes responsible for injuries to the patient caused by the negligence of his assistants. The hospital residents, interns, nurses and other personnel become "borrowed servants" while under his supervision and the surgeon, not the hospital, is rendered liable for their acts.²⁴

Correspondingly, most cases held that a surgeon is not liable for the negligence of the anesthetist in the absence of direct supervision, except in those jurisdictions where the captain of the ship doctrine is applied in all cases, or where the surgery is conducted under such circumstances as would impose a duty on the part of the surgeon to correct the anesthetist.²⁵ At least one case has held that, even if it be assumed that the surgeon is in charge of the operation, it does not follow that he is responsible for the negligence of an anesthesiologist exercising his own independent special medical knowledge.²⁶ Each physician is entitled to perform his work independent of the other.

There appear to be relatively fewer competent anesthesiologists today, considering the demands of modern surgery, than there were a decade ago.²⁷ It is a fact of life that there are just not enough board certified anesthesiologists to fill all open positions and to satisfy the needs of some 28,000 board certified surgeons and the thousands of non-board certified physicians who perform an estimated 12 million operations in this country annually, to say nothing of the 3 million obstetrical deliveries accomplished with the aid of anesthesia. It is estimated that there are 8,500 practicing anesthesiologists, and this would average 1,760 anesthetic procedures per physician per year, about three times maximum capacity. Further, only about two-thirds of the residencies in anesthesia are filled each year and many of those filled are by doctors from outside the United States who will return to their home land.²⁸ It is at once apparent that most

²⁴ Jackson v. Joyner, 236 N. C. 259, 72 S. E. 2d 589 (1952).

²⁵ See generally 85 A. L. R. 2d 889, 910: Liability of one physician or surgeon for malpractice of another.

²⁶ Thompson v. Lillehei, 164 F. Supp. 716 (D. Minn. 1958), aff'd 273 F. 2d 376 (8th Cir. 1959).

²⁷ Dillon, *op. cit.* *supra* note 1 at p. 998.

²⁸ Note, Medical Education in the United States, 194 J. A. M. A. 731, 771 (1965).

of the anesthesia for surgery and obstetrics is provided by much less better trained physicians and nurses and that this condition is not likely to be alleviated for some time.

MacEachern says²⁹ that certification by the American Board of Anesthesiology is an indication of competency, but its absence does not indicate a lack of qualifications. He also says that nurse anesthetists are usually competent but that they should have complied with the educational and training requirements of the American Association of Nurse Anesthetists and hold membership in that Association. The differentiation between the nurse and physician anesthetist is that the nurse, not being a physician, is not licensed to administer drugs.³⁰ Reference should be had to the medical licensing or practice act in each State and to the Opinions of the Attorneys General.

Where a nurse had six years of experience and had administered anesthesia to more than 1,200 patients and had made a special study of the administration of anesthesia, it was held that, inasmuch as the surgeon selected the anesthetic and supervised its administration, the nurse was not practicing medicine, but exercising her profession within proper limits.³¹ In the event of an accident occurring during the administration of endotracheal or spinal anesthesia by a nurse anesthetist, special inquiry might well be made to the Attorney General to ascertain if a nurse is authorized to administer that anesthesia.³²

Whether a hospital is to be held liable for the acts of an anesthetist depends upon whether his legal relationship to the patient is that of independent contractor, and that would depend upon the facts and circumstances of each case. It has been held that the only inference that can arise out of the fact that a hospital charges for the use of its facilities and that it furnishes physicians is that it will use care in the selection of competent physicians. Any physician furnished by the hospital, as to the patient, would be an independent contractor, and where the plaintiff had merely charged negligence on the part of the doc-

²⁹ MacEachern, *op. cit. supra* note 22 at pp. 443-444.

³⁰ Sec. 6513 of the N. Y. Education Law provides that the unauthorized administration of drugs is unlawful practice of medicine, a misdemeanor. The Section also provides that in a personal injury or death action, such is *prima facie* evidence of negligence.

³¹ *Frank v. South*, 175 Ky. 416, 194 S. W. 375 (1917). See also *Chalmers-Francis v. Nelson*, 6 Cal. 2d 402, 57 P. 2d 1312 (1936).

³² Cf. Hayt, et al., *Law of Hospital and Nurse*, 168 et seq. (1958).

tor, there could be no basis for recovery.³³ This doctrine was reaffirmed where the negligence charged was that of an anesthetist.³⁴

It has been held that a hospital cannot practice medicine and so cannot be charged with the negligence of a physician on its staff or employed by it as a resident.³⁵ It is submitted that the better view is that where services are rendered by employees of a hospital, then the hospital should be liable under the doctrine of respondeat superior.³⁶

Physicians specializing in anesthesiology, as well as in radiology and pathology, often conduct their practice through the facilities of the hospital. Factors which have been given weight in determining whether an employer-employee relationship exists as between the hospital and physician (anesthetist) are whether the patient is billed directly, whether the physician gives anesthesia at any other hospital, whether the drugs and equipment are supplied by him or the hospital, whether he is "on call,"³⁷ whether he is salaried and lives on the premises,³⁸ whether he has been selected, employed, directed or supervised,³⁹ whether his position is classified,⁴⁰ whether he has an interest in the hospital,⁴¹ and whether he has patients of his own other than hospital patients.⁴²

Financial arrangements between hospitals and anesthetists, such as concessions and monopolies, frequently are of such a nature as to predicate the liability of the hospital.⁴³ For example, where the anesthesia concessionaire operates the "Anesthesia Department," and the hospital furnishes his equipment and supplies, and the monopoly makes it impossible to

³³ *Iterman v. Baker*, 214 Ind. 308, 15 N. E. 2d 365 (1956).

³⁴ *Huber v. Protestant Deaconess Hospital Assoc.*, 127 Ind. App. 565, 133 N. E. 2d 864 (1956).

³⁵ *Moon v. Mercy Hospital*, 150 Colo. 430, 373 P. 2d 944 (1962); See also *Iterman v. Baker*, *supra* note 33.

³⁶ *Bing v. Thunig*, 2 N. Y. 2d 656, 163 N. Y. S. 2d 3 (1957); *Graddy v. New York Medical College*, 19 App. Div. 2d 426, 243 N. Y. S. 2d 940 (1963).

³⁷ *Seneris v. Haas*, 45 Cal. 2d 811, 291 P. 2d 915 (1956).

³⁸ *Gilstrap v. Osteopathic Sanitorium Co.*, 224 Mo. A. 798, 24 S. W. 2d 249 (1929).

³⁹ *Post v. Crown Heights Hospital*, 173 Misc. 250, 17 N. Y. S. 2d 409 (1940).

⁴⁰ *Waynick v. Reardon*, 236 N. C. 116, 72 S. E. 2d 4 (1952).

⁴¹ *Rural Educational Assoc. v. Bush*, 42 Tenn. A. 34, 298 S. W. 2d 761 (1957).

⁴² *Stuart Circle Hospital Corp. v. Curry*, 173 Va. 136, 3 S. E. 2d 153 (1939).

⁴³ *Louisell & Williams*, *op. cit. supra* note 23 at 508.

procure anesthesia from any other source, the mere fact that the financial transactions are kept separate from the hospital should not relieve it from liability.⁴⁴

From the foregoing it will be seen that it is of major importance to fix the legal relationship of the anesthetist to the patient, the surgeon and the hospital. If it is at all possible, a master-servant relationship with the hospital should be established, since experience has proven that juries are much more prone to report verdicts, and more adequate verdicts, against hospitals than against individual physicians whose reputation, it is feared, may be damaged by a charge of professional negligence.

The establishment of the legal status of the defendant is significant also in that the standard of care by which the actions of the defendant are to be measured is settled. Unfair though it may seem, since the same anesthetic is used by all, an anesthesiologist in one operating room is held to the standard of a specialist. The physician who administers the same anesthesia in the next operating room may be held to another, and the nurse anesthetist in the next operating room to yet another.

A. What did he do and why did he do it?

Anesthesiology is the art and science of relieving the body of all modalities of sensation and at the same time maintaining its vital functions. Anesthesia can be given by anyone—and frequently is. We have better medicine in this country than anywhere else—except in this field.⁴⁵

It is probable that most serious accidents in the course of anesthesia occur when the anesthetist attempts a procedure beyond his level of skill and experience and is then unable to handle the emergency which exists. For example, Artusio & Mazzia state⁴⁶ that predictable central nervous system depression is produced solely by diethyl ether. Only a few tenths of a per cent in the inspired concentration of halothane (fluothane) may be the difference between satisfactory anesthetic depth and lethal overdose.⁴⁷ Though halothane does possess certain ad-

⁴⁴ See generally 69 A. L. R. 2d 305, Liability of hospital or sanitorium for negligence of physician or surgeon (1960).

⁴⁵ Dillon, *op. cit. supra* note 1 at 998.

⁴⁶ Practical Anesthesiology, *op. cit. supra* note 14 at p. 123.

⁴⁷ 2 The Medical Letter (Drug and Therapeutic Information, Inc.) 36 (1960).

vantages over other anesthetic agents, these authors refuse to discuss its administration in their text, holding it safe only in expert hands. Yet, it has been estimated that halothane is used in half the surgery performed in this country today.⁴⁸

A great many accidents also occur when it is contemplated that a small amount of anesthesia will be given for a short period of time. An emergency occurs which the anesthetist is unprepared to handle. It is an extremely serious undertaking when a person is rendered unconscious by an anesthetic agent. No induction should be undertaken without revival equipment at hand.

The anesthetist at the head of the table is in a position to take responsibility for the well being of the patient during surgery. Yet, in one study made it was found that 47 per cent of operating room deaths were preventable from the standpoint of anesthesia and that 54 per cent of the people who died were in good physical condition.⁴⁹ The physician holds that a certain number of anesthesia deaths and injuries are inevitable. What he means is that he cannot or does not want to explain them. It is the duty of the attorney to do so if he can.

The first requirement on the examination before trial is to ascertain what the defendant did and, then, why he did it. Specific attention should be given to the pre-operative examination and history. As is noted herein, preparation for anesthesia and surgery is the responsibility of all concerned with the management of the patient. What was the physical status of the patient and how was it determined? Was there apprehension and how was it controlled? What was the anesthetic agent chosen and why was it selected? Did the anesthetist understand the pharmacology of the drug administered, not the manufacturer's literature? Was he aware of complications which might develop and did he have on hand the equipment to handle emergencies?

Were there special considerations given in the selection of the anesthetic agent because of the requirements of the surgical procedure? If the patient had physiological problems which might interfere with the functions of respiration and circulation, what special anesthetic techniques were adopted to overcome them?

Complete recovery from anesthesia is dependent upon re-

⁴⁸ Medical News, 184 J. A. M. A. No. 4 (April 27, 1963) at p. 22.

⁴⁹ Ruth, et al., Anesthesia Study Commission: Findings of Eleven Years' Activity, 135 J. A. M. A. 881 (1947).

versibility of the pharmacological action of the agent. This essential property is possessed by all drugs currently in use; thus, the failure of the patient to regain full consciousness cannot ordinarily be attributed to the anesthetic agent when employed in the usual manner and dosage. The quantity and/or mixture of the agent should be ascertained and inquiry should be directed to the stage of anesthesia attained and the length of time such was maintained. The depth of anesthesia does not modify the pulse, blood pressure or respiration, but the anesthetist must monitor the vital signs continually since they are usually the first warning of an impending mishap.

The immediate post-operative period has been a no-man's land and many hospitals still do not have recovery rooms and intensive care units. The time when the surgeon takes off his gloves and the anesthetist removes his endotracheal tube is of great hazard to the patient. While surgeons generally recognize that the early post-operative period is critical, the management of it has passed by default to the anesthetist. It should be obvious that complications arising in the post-operative period may be the result of anesthesia. Special inquiry should be made specifically directed toward distinguishing the effects of anesthesia from that of the surgery.

The attorney conducting the examination before trial in a medical malpractice case should be the person who is going to try the case in court. He should pinpoint not only what conditions were found in the patient by the anesthetist, but what he did about them, and, in most instances, *why* he did them.

There is an inborn reluctance on the part of most attorneys to ask the question, "why?" Whatever considerations there may be in not propounding such questions in automobile cases, they are not usually valid in taking the oral deposition where the defendant is an expert witness. If a defendant's reasons for the doing of a particular thing are good, then there is no reason why the plaintiff should be deprived of that knowledge, for surely it will come out at trial. Furthermore, it should always be kept in mind that the testimony of the defendant-witness is taken in as much detail as possible for the purpose of review by the plaintiff's medical consultant. As has been suggested, oral depositions are not taken as a rehearsal for trial; they are had to eliminate all booby traps before trial.^{49a}

^{49a} See Frank, *Pretrial Conference and Discovery—Disclosure or Surprise*, 514 Ins. L. J. 661 (1965).

III. Special Considerations

Long before the trial a theory of action should have been developed. In medical malpractice cases, the writer advocates the drawing of the trial brief before the action is commenced. It may have to be modified from time to time, but it will serve as a guide line for the drawing of pleadings, motions, oral depositions and the discovery process, as well as the trial itself.

In the justifiable injury or death case, one should start with the proposition that the ideal anesthetic agent does not exist. Until it is found and the mechanisms by which general anesthesia is produced are discovered, the knowledge of such agents must be gained through experience alone. Secondly, it should be considered that most complications occurring during general anesthesia are preventable and that it is easier to prevent complications than treat them.

In any good text on the subject, many causes for anesthesia deaths and injuries will be enumerated. Some of the most common are: cardiac arrest during induction, an overdose of the agent, failure to secure an airway, hypoxia or anoxia (deficiency of oxygen), pulmonary aspiration of the gastric content, technical mismanagement, negligent administration of intravenous fluids causing an embolism, and explosion and fire.

Many patients have been injured while under the influence of anesthesia due to improper positioning on the operating table, causing nerve palsies. Patients have fallen off the table, or a bed,⁵⁰ while unconscious. The fatigue of the overworked anesthetist has resulted in unexpected complications.

The exposure of the layman to modern medical science should not be underestimated. He has actually seen Dr. DeBakey operate, as well as Casey and Kildare, and he may have all sorts of false notions about mechanical pump oxygenators, electrocardioscopes and the like. Much has been written for popular consumption on cardiac and transplant surgery on the premise of things not so, the most prevalent of which is that the same degree of skill and care and experience in the surgeon and the anesthetist is available everywhere. The average person may well believe that we have reached the age of push button anesthesia. Special attention should be given to these factors in jury selection.

⁵⁰ See the forms for such a case, in, Oleck, *Negligence Forms of Pleading*, Sec. 92 (1957 rev. ed.), based on the Ranelli case.

A. The necessity for expert medical testimony

The gravamen of a malpractice case is the establishment of a standard of care on the part of the anesthetist and a deviation from it. The overwhelming weight of authority is that, ordinarily, expert medical testimony is necessary to make a *prima facie* case.⁵¹ This is said to be because no one other than a physician is competent to appraise the propriety and skill of a physician in his professional treatment of a patient. The exceptions to the general rule follow.

1. Common knowledge

Where the physician's want of skill or lack of care is such as to be within the comprehension of laymen, it has been held that expert medical testimony is not necessary. These cases are usually limited to situations where the evidence presents such a simple, uncomplicated question that a lay jury is deemed to possess sufficient competence to make a decision without the aid of an expert opinion. For example, a court has taken judicial notice of the necessity to sterilize a hypodermic needle before making an injection.⁵² Where a young man in good health died following a tonsillectomy and apparently there was a reaction following the administration of ether but the operation was continued to conclusion, the court held that the jury could infer that if the ether had been stopped at the first sign of danger the life might have been spared.⁵³

Cases of missing sponges, instruments and other foreign objects fall within the same category.

2. Res ipsa loquitur

It is generally agreed that the sole fact that a person is injured or dies while under anesthesia is not enough to apply

⁵¹ See generally 81 A. L. R. 2d 597: Necessity of expert evidence to support an action for malpractice against a physician or surgeon (1962). See also *Ayers v. Parry*, 192 F. 2d 181 (3rd Cir. 1951), cert. den. 343 U. S. 980 (1952), reh. den. 344 U. S. 849 (1952), 345 U. S. 961 (1953).

⁵² *Barham v. Widing*, 210 Cal. 206, 291 P. 173 (1930).

⁵³ *Moehlenbrock v. Parke, Davis & Co.*, 145 Minn. 100, 176 N. W. 169 (1920). Compare, *Terhune v. Margaret Hague Maternity Hospital*, 63 N. J. S. 106, 164 A. 2d 75 (1960), where it was held error to dismiss the case on the opening statement that the plaintiff would try the case without expert medical testimony. A burn on the face had occurred from administration of the anesthetic agent through a mask. The court said that it was not possible to determine at that stage of the case whether or not the negligence was obvious to laymen.

the doctrine of *res ipsa loquitur*. For example, it has been held that the fact that the anesthetic agent exploded in the course of being administered is insufficient evidence to establish that the explosion was caused by the negligence of the anesthetist, the surgeon or the hospital.⁵⁴ So, also, in the case where the patient expires while under anesthesia, the theory is that in the absence of some proof of negligence of the anesthetist it is just as likely that the injury or death resulted from the patient's physical status, or some other accidental factor, that is, the injury was one which might have occurred in the presence of due skill and care.⁵⁵ This is not such an unusual act or omission which, in ordinary experience and knowledge, does not and should not occur when ordinary care is exercised.

The situation may be different where, while the patient is under anesthesia, he is injured in a part of his body remote from the surgical field. In the anesthesia case, the holdings are that no inference may be drawn from the mere fact that anesthesia was administered and that an injury occurred while the patient was under the effect of it.

B. Assault (battery)

The individual is the absolute master of his own body and he has the right to prohibit the medical and surgical treatment of it no matter what the provocation. Any laying on of hands upon a person without his consent is an assault (battery). In the medical case, any consent given by the patient for anesthesia and surgery must be "informed," that is, the patient has the right to know of the probable and possible consequences of it.⁵⁶

The courts are not slow to assert that, where consent to anesthesia and surgery has not been obtained, in the absence of an emergency an assault (battery) has been committed. But where there has been no injury or damage, the defect has been

⁵⁴ *Philipp v. Shaw*, 280 App. Div. 999, 116 N. Y. S. 2d 889 (1952).

⁵⁵ But see *Cavero v. Franklin General Benevolent Soc.*, 36 Cal. 2d 301, 223 P. 2d 471 (1950).

⁵⁶ See *Hirsh, Informed Consent to Treatment*, reprinted in *Tort and Medical Yearbook*, 631 et seq. (1961). It is the habit of some anesthetists to inquire of the patient as to what type of anesthesia is preferred, only to ignore the instruction. It should be noted that the Law Department of the American Medical Association has provided forms for consent to anesthesia as well as surgery and other procedures. See, *Medicolegal Forms with Legal Analysis* (American Medical Association, 1961).

deemed inconsequential. Where there has been a bad result, liability has ensued.⁵⁷

C. Allergies

In the medical work-up of any patient, an inquiry is made as to known allergic reactions. In his pre-operative visit to the patient, the anesthetist makes similar inquiry, particularly with reference to previous surgery and anesthesia. In the administration of anesthetic agents, however, there is not now existent any preliminary test for sensitivity which is a reliable guide to whether an allergic reaction will occur. Although there are some preliminary tests available in the case of some agents, for example, a skin test for a local anesthetic, these tests may show negative results but an anaphylactic shock may still develop. Furthermore, some people who say they are allergic to a specific agent are found not to be so, although for medicolegal reasons that drug should not be administered.

D. Spinal anesthesia

The administration of spinal anesthesia has fallen into a state of non-use in many parts of the country; yet, it remains the anesthesia of choice in others. Some authorities believe that the risk of serious sequelae is no greater for it than other types of anesthesia, but the morality rate and the possibility of nerve damage directly attributable to it is greater. As a legal proposition, causal relationship between the anesthesia and the injury is more susceptible of proof. For example, in one case,⁵⁸ the defendant anesthetist testified that the proper place to insert the needle in giving a spinal anesthetic was between the second and third lumbar vertebrae. The testimony was that the plaintiff had pointed out to another doctor a spot near the twelfth thoracic

⁵⁷ See *Keister v. O'Neil*, 59 Cal. App. 2d 428, 138 P. 2d 723 (1943), where a spinal anesthetic was administered contrary to the patient's instruction but no harm resulted. The court said that at most there was a technical assault, or breach of contract, for which only nominal damages could be awarded. Compare *Hall v. United States*, 136 F. Supp. 187 (D. La. 1955), *aff'd*, 234 F. 2d 811 (5th Circ. 1956), and *Woodson v. Huey*, 261 P. 2d 199 (Okla. 1953). In the latter case the patient instructed her physician not to give her spinal anesthesia and he assured her none would be given. A direction for general anesthesia was entered on the hospital record. The anesthetist administered a spinal anesthetic and it caused paralysis. The anesthetist was held liable, but not the surgeon.

⁵⁸ *Huber v. Protestant Deaconess Hospital Assoc.*, *supra* note 34.

vertebra where he believed that the needle was inserted and his parents noticed a spot after the operation to the left of his spine below the shoulder blade. The plaintiff's evidence was that his injuries would not have occurred had the needle been inserted in the proper place. The court held that a basis had been established for a reasonable inference that the anesthetist had deviated from accepted standards of practice.

There is some indication that all injuries to the spinal cord or nerves, including arachnoiditis, are actionable,⁵⁹ but there is little doubt but that in the best performed procedures there will be residuals which may persist for some period of time, such as headaches, sensations of burning and numbness in the lower limbs, and disturbances of the eyes and in breathing.

There is one spinal anesthesia case which has received a great deal of attention, particularly in the medical profession, which has criticized it severely.⁶⁰ A woman who had previously had spinal anesthesia was given it in connection with an obstetrical delivery and was paralyzed. The testimony was that it was bad practice to insert the needle where it might come in contact with the spinal cord. The evidence was that the defendant anesthetist had given it hurriedly and that the procedure had been completed within two minutes after she had entered the room. The defendant's contention was that the plaintiff's condition either resulted from a state of hysteria or to her sensitivity to the anesthetic agent. The court held it to be a jury question on the plaintiff's direct evidence of negligence or under the theory of *res ipsa loquitur*.⁶¹

The objection to the application of the doctrine of *res ipsa loquitur* to spinal anesthesia cases seems well founded since it would not seem that it should be distinguished from any other type of anesthesia as a legal proposition. In other cases of injury apparently related to the administration of it, recovery was denied where the medical testimony was that the immediate cause of the paralysis was hemorrhage resulting from the needle rather than rupture of the cord, as pleaded,⁶² and where, without further proof, it was held that there was no evidence of negligence

⁵⁹ *Ayers v. Parry*, *supra* note 51.

⁶⁰ *Seneris v. Haas*, *supra* note 37. Cf. *Wasmuth*, Court Dictation of Choice of Anesthesia, 6 *Clev.-Mar. L. Rev.* 461 (1957).

⁶¹ Compare *Mayor v. Dowsett*, 400 P. 2d 234 (Ore. 1965).

⁶² *Porter v. Puryear*, 258 S. W. 2d 182 (Tex. 1953).

merely upon a showing of injury, since a reaction was to be expected in a small percentage of cases without any fault on the part of the defendant.⁶³

Conclusion

Malpractice actions are "hard core" cases. They are difficult to prepare and try, and harder to win. Few attorneys are equipped to handle them. And not many physicians are willing to testify as an expert witness for an injured plaintiff in such a case. Nowhere is this more emphatically true than in the field of anesthesiology.

Although the courts have indicated displeasure with the "conspiracy of silence" in the medical profession,⁶⁴ and have broadened the rules of evidence to hitherto unheard of proportions,⁶⁵ the problem remains of how to persuade a physician to testify in court in this type of case, to stand up and be counted as it were. Those who have been willing to do so are branded by defense lawyers as professional witnesses. They are castigated by their brethren as pariahs. They have been threatened with cancellation of their malpractice insurance policies. They have been removed from the staffs of their hospitals.

If one could project the sense of this article into an actual anesthesia injury case, the trial lawyer would try his lawsuit on the theory that medical authorities on the subject of anesthesia state that complications or death chargeable to anesthesia can usually be traced to a human error in diagnosis, judgment or technique. They hold that it is the administration, choice of agent or dosage which plays the lethal role.

Should a trial lawyer be so naive as to predicate his case upon such a sound medical basis, however, he would soon discover that the state of anesthesia and the performance of surgical procedures are stresses. He would be defended upon the theory that the patient must have the reserve to withstand the stress. Viewed from this standpoint, if the patient could not endure the stress, there will be deaths about which one can only

⁶³ Hall v. United States, *supra* note 57.

⁶⁴ See, for example, Brown v. Keaveny, 326 F. 2d 660 (D. C. Circ. 1963). See also Mayfield, The Doctor's Dilemma, 37 Ohio Bar 1 (1964).

⁶⁵ Recently the Ohio Supreme Court held that a plaintiff in a malpractice case may call a defendant doctor and question him as an expert witness to help in establishing the claim. Oleksiw v. Weidener, 2 Ohio St. 2d 147 (1965). And see Annot. 88 A. L. R. 2d 1186.

say that the anesthesia and the surgery was "the last straw." This injury or death was not the result of negligence; the patient for some unknown reason could not stand the anesthetic.

Comes now the plaintiff's expert witness to refute such testimony. If you do not have one, you're sunk and you might better have settled the case before expending so much time, energy and money.

If the plaintiff has an expert witness willing to testify as to the standards of administration of anesthesia in the area and a deviation from that standard, he must then be prepared to surmount two great obstacles. First, he must prove that the event, or series of events, which led to the death or injury involved more than an exercise of judgment. Then, he must segregate the alleged negligent act of the anesthetist from the surgery performed as the proximate cause of the injury or death. It will usually be found that these requirements are impossible of performance.