

LEGAL CONSIDERATIONS FOR OBSTETRICAL ANESTHESIA

Obstetrical anesthesiologists confront unique medical/legal issues. The medical needs and risk factors of their dual patients, mother and child, may very well be markedly different. For example the anesthesiologist must consider the effect on the fetus of any medication administered to the mother. Additionally, he/she must take note of how a pregnant persons body reacts to a particular agent as compared to a non-pregnant patient.

Broadly stated, it is the physician's failure to adhere to a nationally recognized standard of care that often leads to legal difficulties. The American Society of Anesthesiologists and the American College of Obstetricians and Gynecologists (ACOG), as well as individual hospitals, have published standards and guidelines for use of analgesia and anesthesia in obstetrics. The physician disregards or deviates from these guidelines at his/her peril.

There are certain acts or omissions which traditionally have given rise to medical negligence actions against obstetrical anesthesiologists. Failure to choose a drug appropriate to a patient's condition or using a drug which is contraindicated by her condition is obvious negligent conduct. It is important to remember, however, that the alleged wrong must have actually

caused the complained of harm. In a Washington, D.C. case, the court held that the administration of Demerol caused or exacerbated the baby's brain injury.¹ However, a Minnesota court held that if the drug manufacturer does not warn in its product literature that a drug is contraindicated for use in a particular form (i.e., oral dose) for a particular time (i.e., premature labor), the physician may not be liable.²

Failure to monitor a patient's condition during the administration of a drug can also have serious physical and medical/legal consequences. In many institutions it is common to have a certified registered nurse anesthetist (CRNA) actually administer the anesthesia. The anesthesiologist, who is supposed to be functioning as a supervisor, is not actually in the room. The American Society of Anesthesiologists has stated that CRNAs should work only under the direction of a physician trained in anesthesia. If the anesthesiologist's presence can not be secured immediately in the event of a problem, the anesthesiologist, the CRNA, and the obstetrician may well be open to a claim of negligence.³

It is important that the anesthesiologist be prepared to respond to any adverse reaction to a drug or procedure. A significant hazard of intubation, for example, is that the endotracheal tube will be improperly placed in the wrong location and that the patient may regurgitate and aspirate gastric contents. It is axiomatic, then, that the anesthesiologist should be practiced in the application of cricoid pressure. Failure to

do so during intubation, with aspiration resulting, may also possibly be actionable.

The anesthesiologist or obstetrician, who is providing analgesia, must be constantly watchful. If the physician fails to properly position the patient, it is possible that the weight of the uterus will obstruct the flow of blood from the legs and the pelvis back to the heart, resulting in a condition known as supine hypotension. The physician must be prepared for adverse, predictable results.

The obstetrician can also incur liability for misfortunes in the use of anesthesia or analgesia. In most cases, it is the obstetrician, not the anesthesiologist, who administers analgesics or sedatives. Extreme care must be taken that the patient is carefully monitored for respiratory distress or hypotension. It is always valuable to develop a good working relationship with the anesthesiologist who may be called upon to provide back-up in an emergency situation. Communication and consultation between obstetrician and anesthesiologist is essential, especially if any difficulty in delivery is anticipated.

Other rather obvious situations that can produce legal problems for physicians include failure to take remedial action to correct adverse reactions, prescribing or administering too much of a drug at one time, giving the drug over too long a period of time, or giving an excessive total amount of a drug over a period of time. It has been held to be negligence if the drug is clearly injected in the wrong place, and the patient's complaints of pain

are disregarded so that an antidote was not given.⁴ Also, it is negligence if the wrong method of administration (i.e., IV instead of IM) is administered, or if an excessive dose is used.⁵ A New Jersey court has held that there is a duty to test equipment used in delivering anesthesia, and a physician can be held liable for a failure to do that.⁶

Historically, some courts have taken the position that the surgeon controls the activities of those employed in the operating room. This "Captain of the Ship" theory was first enunciated in a Pennsylvania case in 1949.⁷ Its rationale is that the surgeon can stop the operation if he is dissatisfied with the performance of the others, such as the anesthesiologist. Most courts have abandoned this theory of liability because they recognize that anesthesiology is a complex and sophisticated area of medicine, requiring specialized training.⁸

If, however, the surgeon/obstetrician actually does control or has the responsibility to control the nurse anesthetist's actions, the surgeon can be held liable on a "borrowed servant" theory.⁹ This is most likely to happen in a non-urban, or small hospital which does not provide 24 hour anesthesia service. Because the anesthesiologist is sometimes delayed in arriving at the hospital once he has been called, the patient is put at risk. This can be a significant legal concern for the obstetrician.

Finally, a word about informed consent. Ideally, the doctor should discuss with the patient, before the onset of labor, the various anesthetic/analgesic options available. He should also

discuss the anesthetic options in the event of an unexpected Cesarean section. The risks and benefits of each alternative anesthesia option should be carefully explained, and the patient should have ample opportunity to ask questions. Whether this conversation takes place before the onset of labor or not, the risks of the proposed drugs and procedures proposed must be explained to the patient in any non-emergent situation. The physician should, of course, document this conversation in the record. Then, at the time of labor and delivery, the physician can review with the patient the options discussed earlier under less stressful conditions. For the consent to be "informed", the physician must give the patient the information she needs to make a rational decision. He must disclose all "material" risks, which include those most common or likely to occur and those whose consequences are significant and serious. He should also discuss with the patient the risks and consequences of not following the proposed procedures.

NOTES

1. Garfield Memorial Hospital v. Marshall
(District of Columbia, 1953).
2. Lhota v. Larson (Minnesota, 1976).
3. Keys v. Mercy Hospital of New Orleans
(Louisiana, 1986).
4. Frantz v. San Luis Medical Clinic (California,
1978).
5. Nolan v. Dillon (Maryland, 1971).
6. Terhune v. Margaret Hague Maternity Hospital
(New Jersey, 1960).
7. McConnell v. Williams (Pennsylvania, 1949).
8. 32 Med Trial TQ 377, Spring, 1986. See also
Thompson v. Presbyterian Hospital, Inc.
(Oklahoma).
9. Marsh v. Tilley Steel Co. (California, 1980).