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Introduction

It is not uncommon in surgical practice for someone who is not an employee of either a hospital or healthcare practice to assist a surgeon. Most commonly, these nonemployee assistants are present to represent a surgical device or equipment manufacturer. In some cases, these individuals actually participate in the surgery by assisting the surgeon in a variety of ways.

In this interesting case from the Southeast, a nonemployee surgical nurse assisted a surgeon performing cataract surgery. When a piece of equipment failed and a patient was injured, questions arose regarding who was responsible for ensuring that the equipment was in proper operating condition.

Facts

The patient was a 59-year-old female who presented to a MedPro-insured ophthalmologist for treatment of a cataract. After the patient was properly evaluated, the doctor determined that cataract surgery would likely be beneficial. The patient formally consented to the procedure.

The doctor planned to perform the cataract surgery at a small community hospital that did not have the resources to maintain the equipment necessary for this procedure. For that reason, the hospital contracted with the vendor of the lens implant and the equipment used for its insertion. The vendor also provided support to the ophthalmologist in the form of a trained surgical nurse who functioned as a scrub nurse. (The nurse performed in this capacity for the MedPro-insured ophthalmologist and five other ophthalmologists at other facilities.)

The procedure was commenced and proceeded normally, until a step in the process known as stromal hydration. During this step, fluid is injected around the portal incisions of the cornea to promote healing of those incisions. A syringe with a removable cannula is used for the injections. When the doctor pressed on the syringe, the cannula
separated from it and was “launched” into the ciliary body of the eye, causing bleeding, discoloration of the eye structures, and a vitreous hemorrhage. The doctor retrieved the cannula, and once the syringe and cannula were reassembled, they were used to complete the hydration.

Following completion of the surgery, the patient complained of continuous haziness of the visual field, which experts opined was permanent. Testing also showed visual acuity that was less than would be expected following successful cataract surgery.

The patient brought a medical malpractice suit against the ophthalmologist and the hospital, but not the vendor (as she was unaware that the scrub nurse who handed the ophthalmologist the syringe was not a hospital employee). At the doctor’s request, the case was resolved with a settlement in the midrange; defense costs were in the high range. A payment also was made on behalf of the hospital; however, that amount is not known.

**Discussion**

This case brings into focus several issues that may not be commonly recognized in surgical cases (or any medical treatment in which nonemployees are involved).

The first issue relates to informed consent. Simply stated, patients have a right to know who is going to be present in the operating suite and involved in their medical care. They also have the right to refuse the services of any of those individuals if they so choose. Having people in the operating suite — particularly when they are participating in the actual surgery — without patients’ knowledge and consent can lead to allegations that the surgery constituted a battery (a prohibited touching) or a HIPAA violation (if the hospital and vendor do not have a business associate agreement in place). Although these allegations on their own normally do not lead to findings of liability, they can complicate the defense of an underlying malpractice suit.

In this particular case, the question arises about whose responsibility it was to ensure that the cannula was properly secured to the syringe. From a patient safety standpoint, the most beneficial approach would be for two people to verify the security of the syringe and cannula prior to its use. The carpentry axiom “measure twice and cut once” certainly seems applicable here.

However, from a standard-of-care perspective, who had responsibility for ensuring the security of the cannula is not entirely clear. Competent experts testifying on behalf of the plaintiff opined that the scrub nurse certainly had a responsibility to properly attach the cannula, but the surgeon also had a duty to verify the security of the cannula prior to the hydration. Equally competent experts for the defense testified that the surgeon was correct in keeping her attention on the visual field at all times. Further, she had the right to rely on the scrub nurse to hand her a properly
secured syringe and cannula. The literature appears to be about evenly split on this issue.

From both a patient safety and a legal standpoint, it would have been beneficial if the scrub nurse’s duty to test all equipment prior to use was clearly delineated in a hospital protocol. However, no such protocol existed in this case. Also, a timeout prior to commencement of the surgery would have provided another opportunity to verify that all equipment had been tested and was functioning properly.

Some interesting contract issues also existed in this case. The physician and the hospital had a very typical relationship; the physician had been properly credentialed and was admitted to the medical staff. She and the hospital operated as separate legal entities, working together to provide care for their mutual patients. In this case, the doctor and the vendor had no formal relationship. Although the doctor utilized the vendor’s products, equipment, and staff, the hospital arranged these services without the doctor’s direct involvement in the selection process.

In contrast, the hospital and the vendor had a much closer legal relationship. In exchange for the hospital using the vendor’s products and equipment, the vendor had supplied the hospital with what is known as a “hold harmless agreement.” In executing the hold harmless agreement, the vendor agreed to pay the legal expenses and any liability that arose against the hospital as a result of any deficiencies in the vendor’s products, equipment, or the performance of the vendor’s employees. A similar arrangement did not exist between the vendor and the physician.

This arrangement between the hospital and the vendor placed the physician in the difficult position of having a codefendant (the hospital) who was not necessarily concerned with vigorously defending the case, because the vendor would cover any financial loss to the hospital.

The hospital’s priority might have been to resolve the case as quickly as possible to minimize any reputational damage, which potentially left the physician to “stand alone” at trial (not generally a desirable position). This situation might have been a factor in the doctor’s desire to settle the case rather than aggressively defend it.

**Summary Suggestions**

The following suggestions might be helpful to physicians who utilize nonemployee assistants in their care of patients:

- Patients should understand, through the informed consent process, that nonemployee assistants might be present during treatment, and — if applicable — that these individuals will be participating in the treatment.
- Hospital protocols should (a) clearly delineate that all equipment will be tested prior to use, and (b) specify who is responsible for testing.
• Physicians should understand what their relationship is to any nonemployees who will be assisting in treatment.

• When physicians are going to use products, equipment, or personnel supplied by a vendor, it is beneficial to understand the legal/contractual relationship between the vendor and the hospital (or other facility) where the treatment will take place.

Conclusion

Many years ago, President Harry S. Truman famously acknowledged that “the buck stops here.” However, for the buck to stop with the physician, she or he must have sufficient authority to be able to control all critical aspects of the medical delivery process, as well as adequate knowledge of any special relationships that may exist between the other parties, which could ultimately affect that process. Patient safety is always the first priority; when patients receive safe, high-quality treatment, their satisfaction goes up and liability exposure is minimized.