

- McMahon Publications
- [Anesthesiology](#)
- [Gastroenterology](#)
- [General Surgery](#)
- [Infectious Disease](#)
- [Oncology](#)
- [Pain Medicine](#)
- [Pharmacy](#)
- [Specialty Pharmacy](#)
- [CMEZone](#)

Track Hemoglobin Changes in Real Time





Classifieds

ANESTHESIOLOGY NEWS

▶ SEARCH

[advanced search](#)

THE INDEPENDENT MONTHLY NEWSPAPER FOR ANESTHESIOLOGISTS

Follow Us [f](#) [t](#) [g+](#) Last Update: Sep 07, 2015

Email

Password

[Register](#) | [Forgot Password](#)

Remember me

- [Home](#)
- [Departments](#)
 - [Ad Lib](#)
 - [Blogs](#)
 - [Clinical Anesthesiology](#)
 - [Commentary](#)
 - [Correspondence](#)

- [Digital Editions](#)
- [Educational Reviews](#)
- [Finance](#)
- [Guest Editorial](#)
- [In Brief](#)
- [Pain Medicine](#)
- [Pharmacology](#)
- [Policy & Management](#)
- [PRN](#)
- [Technology](#)
- [Web Exclusives](#)
- [Medical Education](#)
 - [CME](#)
 - [Monographs & White Papers](#)
 - [Pocket Guides](#)
- [Supplements](#)
 - [Buyer's Guide](#)
 - [Corporate Profiles](#)
 - [Educational Reviews](#)
- [Buyer's Guide](#)
- [Archives](#)
- [Subscribe](#)
 - [e-Newsletter](#)
 - [New Print Subscription](#)
 - [Print Subscription Renewal](#)
- [Multimedia](#)
- [Conferences](#)
- [Classifieds](#)
- [Contact](#)
 - [About Us](#)
 - [Advertise](#)
 - [Contact Info](#)

Commentary



ISSUE: DECEMBER 2011 | VOLUME: 37:12

printer friendly | email this article | [2 Comment\(s\)](#)

Extubation Case Challenged Long-standing Legal Doctrine

by Kristin Adams Forner, MD

The practice of anesthesiology does not often come before the U.S. Supreme Court, but the case of Air Force Staff Sgt. Dean Witt had the potential to radically remake a feature of tort law that has been in effect for more than 60 years.

In October 2003, Sgt. Dean Witt arrived at Travis Air Force Base Medical Center with appendicitis. Three months later, following a routine appendectomy complicated by post-extubation laryngospasm, a failed attempt at resuscitation and anoxic brain injury, the family withdrew life support, and Sgt. Witt was dead.

Last June, the Supreme Court declined to hear the case Sgt. Witt's family brought against the hospital. In doing so, the justices tacitly upheld the Feres Doctrine—a decades-old prohibition against allowing the government to be held liable for negligence when military members are injured or killed while on active duty.

Established in 1950 with the decision *Feres v. United States*, the Feres Doctrine was the result of three separate cases brought before the court: the Feres case, in which a soldier was killed by fire in his barracks because of a defective heating plant; the Jefferson case, in which a surgical towel was accidentally left inside a soldier's abdomen following surgery; and the Griggs case, in which a soldier died at the hands of allegedly remiss Army surgeons. All three cases had in common negligence by military members that resulted in the death or injury of other military members while they were on active duty. All three asked the justices to determine whether these active-duty military members or their families were eligible for reparations from the government under the Federal Tort Claims Act (FTCA) of 1948.

Plane Crash Spurred Law

Congress passed the FTCA after a B-25 bomber accidentally crashed into the fog-shrouded Empire State Building in 1945, killing 14 people. The law as it ultimately developed allowed for retroactive provisions so families of the deceased could sue the U.S. government for monetary restitution.

The FTCA was enacted to allow private parties—civilians—to sue for actionable wrongs committed by agents of the government. The three cases within *Feres v. United States* asked whether active-duty military personnel could sue the federal government for harm caused by other representatives of the government. The court said no, and 60 years later, it stands by its initial decision.


By declining to hear *Witt v. United States*, the Supreme Court effectively decided that only Congress can change the meaning of the FTCA to allow active-duty military members to sue the government. Mike Navarre, a former Navy judge advocate and a member of the board of advisors for the National Institute of Military Justice, stated, "If you use Congress as a barometer as to the sentiments of the American people, Congress has had 60 years to deal with the Feres Doctrine ... and Congress has not dealt with it."

The Supreme Court reasoned then, as it has ever since, that members of the military have access to remuneration through the Veterans Benefits Act (VBA), and thus have no further claim on the public treasury. Indeed, the Congressional Budget Office has reported that if the Supreme Court were to reverse its decision regarding the Feres Doctrine, and active-duty military members could sue the government for damages, approximately 750 malpractice lawsuits would be filed each year, resulting in payments of \$2.7 billion.

Shortly after Sgt. Witt died, the Air Force barred the nurse anesthetist responsible for his death from practicing medicine within a military institution, and the state of California revoked her medical license. Sgt. Witt's family received \$350,000 in reparations from the VBA.

Given the state of the nation's economy and our ever-growing debt, Congress appears to be in no hurry to increase the benefits military members killed in the line of duty receive from the VBA, nor do they seem eager to allow them to sue the United States for further monetary gain by revising the FTCA. The Feres Doctrine stands as strongly today as it did when it was first enacted.

Dr. Forner is staff anesthesiologist and medical director for the Department of Anesthesiology at Wright-Patterson Air Force Base, in Dayton, Ohio. You can read more of her writing at www.docbehindthedrapes.com.

 printer friendly |  email this article |  [2 Comment\(s\)](#)

Comment on This Article

Disclaimer: This board is intended for non-commercial reader comments. The posting of advertisements or solicitation of any kind is prohibited. Contributors are expected to conduct themselves in an appropriate manner, refraining from personal attacks and profane, coarse or abusive language. Hit the "Report Abuse" button to

report comments that violate the rules and spirit of this board. www.anesthesiologynews.com reserves the right to remove without any notice comments that violate the intentions of this board. It is not intended to provide specific medical advice or to take the place of written law or regulations. The owners of www.anesthesiologynews.com assume no liability for the comments made on this board.

Submit

Comments: (2) show:

rob@n... wrote on: 12/22/2011 3:07 AM (EST) 1355 days ago

Dr. Forner wrote:

"Shortly after Sgt. Witt died, the Air Force barred the nurse anesthetist responsible for his death from practicing medicine within a military institution, and the state of California revoked her medical license."

The Major CRNA was still a nurse. I doubt that she had a medical license. As far as the claim that she was "practicing medicine" ...that's certainly debatable. However, it's much too simplistic to blame one person for the patient's death in this case. In truth, the entire USAF medical care system failed the patient. Let me count the ways:

- 1) Inadequate planning at HQ USAF level for anesthesiologist shortage due to failure to train/accession anesthesiologists in the late 1990s. HQ USAF and anesthesiologist consultants (Hi, Jay and Ann!) allowed AFI 44-119 to be instantiated without resigning their commissions in disgust (in order to protect their retirement benefits, cushy positions, and power, among other reasons). Boneheaded decision to place anesthesiologists under command of surgeons in the first place (given that many surgeons see us as the enemy who viciously cancel their sexy cases, rather than as board-certified colleagues who are trying to keep their patients safe).
- 2) Inadequate response by MAJCOM (AMC) to prior Sentinel Event findings from 1998. Approximately zero of the recommendations from the prior tragedy were implemented.
- 3) Inadequate measures taken by Medical Group to insure that previous OI 160-1, which mandated anesthesiologist involvement in medical care of very sick patients, superseded the requirements of the AFI (yes, a Medical Group OI can be more restrictive than an AFI...it takes intestinal fortitude, but it is possible).
- 4) Inadequate action taken by the Surgical Squadron Commander (SQ/CC) regarding prior episodes of poor performance by CRNA. SQ/CC allowed/encouraged CRNA independent practice to increase throughput (number of cases surgeons could do), regardless of medical appropriateness and quality of care. Hey, we always have the Feres doctrine to protect us if the patient dies, right?
- 5) Spineless "Medical Director" of anesthesia who allowed CRNAs to practice independently, even though he recognized the patient safety dangers.
- 6) Chief CRNA unwilling to police own ranks prior to tragic disasters, in order to save face and protect independent practice tradition at Travis.

Almost every Sentinel Event involves a cascade of failures throughout the medical care system, leading to the final adverse outcome. To quote the movie "Rising Sun": Fix the problem, not the blame (note: this is not a real Japanese proverb...but it is relevant to how the military works: find a fall guy/gal, destroy his/her life, and exonerate the Generals and Colonels who really caused the tragedy [see: Abu Ghraib, Wikileaks, the ongoing travesty of military "medicine", etc.]).

--

Rob Jones, M.D.

(Full signature block in prior comment, for those who care about such ephemeral things)

rob@n... wrote on: 12/21/2011 10:33 PM (EST) 1356 days ago

"So, what you are saying is that the system conspired to assassinate the patient."

--General (Dr.) R., Commander, David Grant Medical Center, Travis AFB, CA, December, 1998, after a similar incident resulting from CRNA independent (mal)practice

Dr. Forner completely missed the point in her recent article in Anesthesiology News (Extubation Case Challenged Long-Standing Legal Doctrine, Dec 2011). She spent 9 paragraphs defending the Feres doctrine from 1950, which shields the U.S. government from lawsuits by active duty members (including derivative lawsuits by their civilian next-of-kin), even in cases of egregious medical (or, in this case, CRNA) malpractice. As the ex-LtCol former "Medical Director" of the Anesthesia Flight at David Grant Medical Center, Travis AFB, CA, I am here to tell the world that what killed the patient was the inappropriate, unsupervised, and deadly independent practice of Nurse Anesthesia at Travis AFB from 1998 onward.

Across the USAF, anesthesiologist manning has been insufficient from about 1997 to today. The Air Force's only anesthesiology residency program at Wilford Hall Medical Center was slashed from 10 slots per year, to 3, to zero. Wilford Hall, the former flagship of Air Force medicine, was subsequently "right-sized" to an urgent care clinic as a cost-cutting measure. At the time of the incident in 2003, due to sheer poor planning by the USAF leadership, only one anesthesiologist was on duty at the Air Force's largest medical center on the West Coast. Sadly, he was not at all involved in the patient's care initially, because the Air Force allowed CRNAs to practice completely independently. In order to run 6 operating rooms plus pediatric sedation plus OB support with inadequate numbers of anesthesiologists for supervision, the Air Force had capitulated to the demands of CRNAs and surgeons to emasculate the role of anesthesiologists, thus totally destroying the Anesthesia Care Team model that had existed in the USAF for decades prior. CRNAs were allowed to practice independently according to Air Force Instruction (AFI) 44-119:

From: <http://www.e-publishing.af.mil/shared/media/epubs/afi44-119.pdf>

"7.5. Certified Registered Nurse Anesthetists (CRNA).

7.5.1. Background. CRNAs are registered nurses who have obtained advanced didactic education, clinical residency, certification, and are independently licensed to administer anesthesia. Nurse anesthesia practice includes but is not limited to pre-anesthetic evaluation/assessment and patient preparation; intraoperative anesthesia management and postoperative follow-up and evaluation. The CRNA practices within a healthcare system that provides consultation, collaborative patient care management, or referral as indicated by the health status of the client.

7.5.3. Scope of Practice:

7.5.3.1. May act independently in areas of demonstrated competency within their designated scope of practice as indicated by "Fully Competent" or code "1" on the privileges list for all American Society of Anesthesiologists (ASA) Classifications: 1, 2, 3, 4 or 5 including "E" for urgent/emergent obstetric care.

7.5.3.2. CRNAs will consult with an anesthesiologist or any other medical specialty for patients who require such medical consultation based on acuity of the health condition or complexity of the surgical procedure. Consultation will be based on the judgment of the CRNA in coordination with the attending surgeon. The CRNA remains responsible and accountable for determining when consultation with a physician specialist (e.g., anesthesiologist, cardiologist, internist) is needed during any patient encounter. These provider-to-provider consultations may be verbal, written, or electronic; will be documented in the patient's medical record; should include the name of the specialist consulted; and include a brief outline of the anesthetic plan developed or the recommended course of action."

So, according to the Air Force, anesthesiologists = cardiologists = internists as physician "providers" who may



or may NOT be consulted by the all-knowing, all-powerful (and usually higher-ranking) CRNA. Thus, in this sad case, when the anesthesiologist arrived in the PACU with a patient in respiratory arrest, he was not recognized as the leader of the resuscitation team. The Major CRNA had not "consulted" him, so she persisted in mismanaging the patient's airway, including prolonged, unrecognized esophageal intubation. Inadequate experience plus blurred lines of responsibility equals failure to rescue. Military rank trumps clinical knowledge and medical training in today's Air Force "Medical" Service.

This sad outcome should not have been a surprise. The Air Force had known about the dangers of independent CRNA malpractice since a similar, tragic outcome after extubation in October, 1998, also involving unrecognized esophageal intubation, which resulted in brain damage. As Medical Director, I forcefully spoke out, verbally and in writing, as an advocate of the Anesthesia Care Team model, wherein an anesthesiologist is involved in the care of every single patient requiring anesthesia. As a result, I was fired as Medical Director for insisting on medical direction of anesthesia care. I was then immediately given orders for a 3 year unaccompanied assignment "overseas" to Alaska on a usually accompanied tour without my two handicapped children and pregnant, active duty physician wife as retribution for my embarrassment of the entire command at Travis by speaking out against independent CRNA practice and for patient safety. Only appeal to the highest level of Special Needs in the Air Force reversed this petty and punitive attempt to silence me.


One thing Dr. Forner neglected to point out in her extensive essay was the fact that "medical director" means something totally different in the Air Force than in civilian practice. In the civilian world, a medical director is a senior physician who has the "line authority" to call the shots, and who customarily has the final say in determination of medical quality of care issues in his or her practice. The faux position of "medical director of anesthesia" was instituted in the Air Force as a fig leaf after the implementation of the Objective Medical Group (OMG) fiasco circa 1997, which made all "providers" equal, regardless of corps, when it came to military command. Nurses, CRNAs, pharmacists, optometrists, nurse midwives, PAs, and housekeepers became eligible to wield command authority over physicians, with the power to break the doctors' morale and careers at a whim. Fun fact: the Surgeon General of the Army in 2007 was a CRNA. Since the "medical director" of anesthesia has zero line authority over his/her subordinates, it is really the high-ranking nurses, CRNAs, and surgeons who run the show. Like the SGH (chief physician of a Medical Group), the military anesthesia "medical director" is a useless appendix on the org chart who risks career immolation if he or she speaks out as a patient safety advocate.

In view of the above, after having served my country in uniform from ROTC at Harvard in 1981, through USUHS, through military anesthesiology residency, until the end of my 11 years of payback after residency, I resigned my Regular commission as a LtCol in the USAF and forfeited all retirement benefits after 19 years on active duty in 2005. Unless the Air Force and the other U.S. military branches reverse the dangerous policy of allowing CRNA independent (mal)practice based on military rank, rather than medical training and knowledge, tragedies such as those at Travis will continue to occur, to the permanent detriment of our brave active duty members, their dependents, and our honored military retirees. The Feres doctrine is completely irrelevant to medical care standards, except to the extent that it shields incompetent military "providers" from legal sanctions for their malpractice, thus encouraging military commanders to "do more with less" by enabling substandard care. Since 2006, my website, Medicalcorpse.com, which I pay for out of my pocket and which does not accept ads, has documented this lamentable and worsening state of affairs. In the future, I would welcome Anesthesiology News to investigate the true nature of CRNA-run anesthesia care in the U.S. military before publishing self-serving and misinformed government propaganda pieces written by active duty anesthesiologists which extol the current broken, demoralizing (for anesthesiologists), and deadly (for patients) status quo.

Robert C. Jones, M.D.
ex-LtCol, USAF, MC
Harvard '85, USUHS '90, WHMC Residency '94
ex-Medical Director of Anesthesia, David Grant Med. Ctr, Travis AFB, CA
ex-Assistant Chief Anesthesiologist, Malcolm Grow Medical Center, Andrews AFB, MD

Recommend  (0) | Report Abuse 

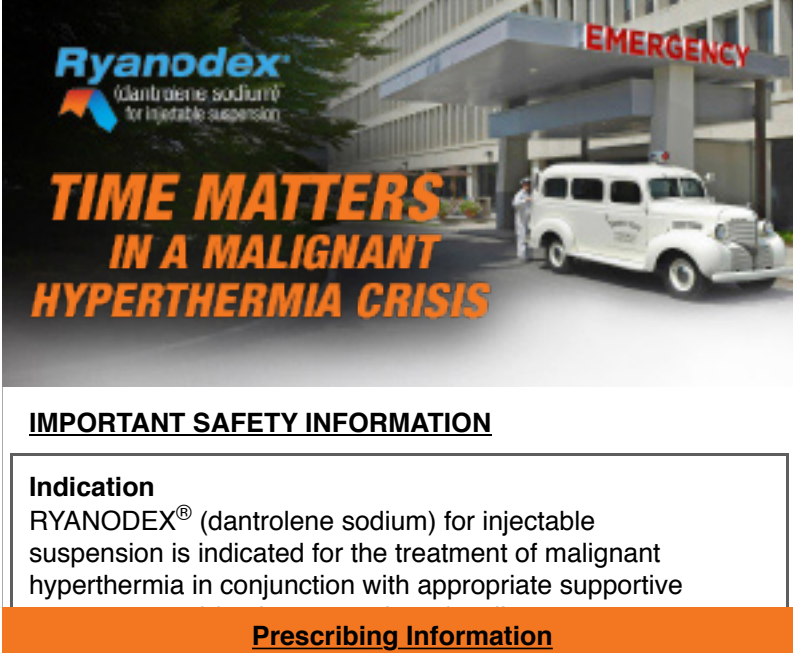
More in Commentary

- [Anesthesiologists Shouldn't Have To Knock Themselves Out To Achieve Interoperability of Health Information Technology](#)
ISSUE: AUGUST 2015 |  1
- [OR Talk: Professional or Else](#)
Talk is cheap: Oh wait, no, it's not ...
ISSUE: AUGUST 2015 |  5
- [Wingmen Forever: How the Anesthesiologist is Portrayed in Popular Culture](#)
ISSUE: JULY 2015 |  0
- [Welcome Change Comes to MOCA](#)
ISSUE: JUNE 2015 |  2
- [The U.S. Health Care System: Really the Best?](#)
ISSUE: JUNE 2015 |  4

[+ more Commentary](#)

- [Most Read](#)
- [Most Emailed](#)
- [Comments](#)
- [Twitter](#)
- [Successful Tracheal Intubation In Children With Difficult Airways: Seven Secret Techniques Every Anesthesiologist Should Know](#)
- [Airway Management Roundtable: Seven Questions](#)
- [Airway Risk Assessment: A Review of Current Evidence To Aid Clinical Decision-Making](#)
- [OR Talk: Professional or Else](#)
- [Submental Tracheal Intubation For a Patient With Multiple Facial Fractures](#)

 [Register for our free e-Newsletter](#)



Ryanodex
(dantrolene sodium)
for injectable suspension

**TIME MATTERS
IN A MALIGNANT
HYPERTHERMIA CRISIS**

IMPORTANT SAFETY INFORMATION

Indication
RYANODEX® (dantrolene sodium) for injectable suspension is indicated for the treatment of malignant hyperthermia in conjunction with appropriate supportive

Prescribing Information

EXPAREL[®]

(bupivacaine liposome injectable suspension)

Learn More 

about how
to use EXPAREL



PACIRA

PHARMACEUTICALS, INC.

PP-EX-US-0665C

It's everybody's BIS™



Nationwide Opportunities

- *Practice Options*
- *Career Growth*
- *Flexible Scheduling*

TEAMHealth.
ANESTHESIA

An advertisement for Ambu AuraGain pediatric sizes. It features a green and white Ambu AuraGain device on the left. The text on the right reads: "Ambu® AuraGain™ Pediatric Sizes Now Available (CLICK HERE TO SEE HOW)".

Ambu®
AuraGain™

Pediatric Sizes
Now Available
(CLICK HERE TO SEE HOW)



[about](#) | [archives](#) | [register](#) | [print subscription](#) | [e-Newsletter](#) | [contact info](#) | [advertise](#) | [rss feed](#) | [podcast rss feed](#) | [mobile app](#)

Copyright © 2004 - 2015 McMahon Publishing unless otherwise noted.

Anesthesiology News and AnesthesiologyNews.com are part of McMahon Publishing.

All rights reserved. Reproduction in whole or in part without permission is prohibited.