NURSING MALPRACTICE

Liability and Risk Management

Charles C. Sharpe

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Liability and Risk Management

CHARLES C. SHARPE

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Preface

As the practice of nursing continues to evolve, expanding clinical roles and applications of new technology have brought additional responsibilities and, concomitantly, increased risks of legal liability for the profession. This book was written to provide the nursing student, the professional nurse at any level of clinical practice—and collaborating health care providers—with an introduction to basic legal concepts and principles of malpractice, liability, and risk management. I believe that their more extensive incorporation into nursing education curriculums and application in clinical practice will enhance the professional growth, accountability, and recognition of the nursing profession. This is not a textbook on law, and I disclaim any intent to provide legal advice. That is the sole prerogative of an attorney.

In our litigious society, an increasing number of nurses are being named in malpractice lawsuits by patients turned plaintiffs. It is my hope that the knowledge and understanding of malpractice liability and risk management strategies will help to dispel many of the unwarranted fears and uncertainties prevalent in the nursing profession and mitigate the incidence and repercussions of malpractice lawsuits. For their own protection, and certainly for that of their patients, all nurses must be aware of their legal

rights and responsibilities. Promoting such an awareness and its application in professional practice is the primary purpose of this book.

Abbreviations

ADR	Alternative dispute resolution
AMA	Against medical advice
ANA	American Nurses Association
APN	Advanced practice nurse
CE	Consulting expert
CNS	Clinical nurse specialist
DNR	Do not resuscitate
HMOs	Health maintenance organizations
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NCSBN	National Council of State Boards of Nursing
NLN	National League for Nursing
NP	Nurse practitioner
NPDB	National Practitioner Data Bank
PSDA	Patient Self-Determination Act
TE	Testifying expert
UAP	Unlicensed assistive personnel

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1

The Law

DEFINITION OF LAW

The English word "law" derives from the Anglo-Saxon word "lagu"; this in turn comes from the Old Norse "lag", which means layer or stratum. Law is "That which is laid down, ordained, or established; a body of rules of action or conduct prescribed by controlling authority and having a binding legal force" (Black 1990, 884). It is the body of rules, regulations, or principles that have been prescribed by authority or established by custom; and which a society, nation, state, or community recognizes and enforces as legally binding on each of its members; and which must be obeyed and followed by all citizens subject to sanctions. These rules of conduct are embodied in the sources of our law in the United States.

For the professional nurse, laws provide a basis for nursing intervention in the provision of care to patients; they act to distinguish the roles and responsibilities of the nurse from those of other health care providers; and they define the boundaries of dependent or autonomous practice in various roles and clinical settings.

SOURCES OF LAW

There are four sources of law in the United States.

1. Constitutional law, which defines the structure and power of the federal government and the rights of all citizens under it.
2. Statutory law, which evolves from statutes enacted by federal, state, or local legislative bodies.
3. Administrative law, which deals with the enactment, implementation, and enforcement of laws, rules, and regulations by departments, bureaus, and other agencies established and maintained by a federal or state government entity.
4. Common law, which has largely evolved from case decisions made by federal and state courts.

Common Law

Common law, also called case law, is that body of law that has derived from custom or from the prior decisions of courts (precedents) rather than from legislation. Where no written statute exists, a court of proper jurisdiction is charged with resolving legal disputes in cases, and gradually such judicial decisions have formed our common law. It is the usual source of law in malpractice issues.

Stare Decisis

The concept of precedent forms the basis of the legal doctrine of *stare decisis*, which translates from Latin as "to stand on that which has been decided." This practice of permitting lower courts in a given jurisdiction to decide new cases with reference to prior higher court decisions in cases with the same or very similar legal issues is a cornerstone of the American judicial system. Judges are, as a general rule, required to follow precedents established in prior cases, but are not absolutely bound by them. They do, albeit reluctantly, at times depart from them as the unique circumstances and issues of a case before them may dictate. In complying with the doctrine of *stare decisis*, however, judges provide consistency, stability, and continuity in the law. In establishing new precedents, the courts replenish the law with dynamic innovation in response to an inconstant, ever evolving, society.

THE TWO PRINCIPAL SUBDIVISIONS OF LAW

In violation of order and logic, we must discuss the two principal subdivisions of law prior to a discussion of the two principal divisions. This, because the subdivisions of (1) substantive law and (2) procedural law can co-mingle with each of the two principal divisions, (1) criminal and (2) tort law—as the reader will see.

Substantive Law

Substantive law is that area of law that defines and regulates the rights of individuals with respect to one another and those specific wrongs, harms, duties, or obligations that can provide one person cause for an action in law against another.

Procedural Law

Procedural law prescribes the rules of conduct and the measures to be implemented in enforcing those rights and duties and in seeking redress. It defines the course of action that the parties in a lawsuit are required to follow at all stages of litigation. Procedural law directs and controls the legal process.

In a malpractice lawsuit both substantive and procedural law will apply. The elements of malpractice will be prescribed by substantive law. Procedural law will define such factors as the sequence of steps in the litigation process, the statute of limitations, and the matters of evidence.

THE TWO PRINCIPAL DIVISIONS OF LAW

The body of all United States law is composed of two principal divisions: (1) criminal law and (2) civil law. The subcategories of substantive and procedural law are incorporated into each of these two primary categories.

Criminal Law

A crime is an intentional wrong committed against the state—against society as a whole—as well as against individual victims. Criminal statutes define various crimes and prescribe the punishments to be imposed by the state on persons convicted of such crimes. In a criminal case, an official representing the state will prosecute and will endeavor to effect the penalty prescribed by criminal law. For such crimes as first degree murder, a defendant must be found *guilty* on the basis of proof *beyond a reasonable doubt*.

Criminal charges are rarely filed against health care providers. However, in March 1997, five nurses in New Jersey were indicted on charges of endangering the welfare of a patient who bled to death. In April 1997, three nurses in Colorado were indicted of criminally negligent homicide in the death of newborn. In January 1998, an emergency room physician in Elem Indian Colony, California, was awaiting trial for a charge of second degree murder in the death of an eleven-month-old boy. These cases have raised new concerns among physicians and nurses who now must be concerned

with the possibility of criminal prosecution in addition to civil litigation when their care is deemed to have fallen to the level of criminal negligence.

Civil Law

Civil law addresses the duties that exist between individual citizens or between citizens and the state. This excludes the duty not to commit a crime. Tort law, which addresses the infringement by one individual on the legally recognized rights of another, is a principal area of civil law. Malpractice is litigated in the area of tort law. Tort law and criminal law can converge in some instances. In such cases there can be an action by the state and also a separate civil action by an individual. In a civil case, a plaintiff must meet the burden of proof by a *preponderance of evidence*. That is, the evidence presented by the plaintiff must be more convincing to the trier than that presented by the defendant. A defendant in a civil action is found *liable*, rather than guilty.

THE LAW OF TORTS

The law of torts addresses personal, private transgressions, as well as fault and blame. Every person is responsible, or has a duty, to conduct himself or herself in an expected manner or according to defined standards; and, by failing to do so, may not cause another person to suffer. Should a person fail in that duty, he or she could be liable under tort law.

Most tort law is founded in common law—court-decided law (*stare decisis*). The substantive law of torts is concerned with those actions or omissions that constitute a breach of an established legal duty owed by one person to another and the harm to another person or his or her property caused by such breach.

Definition of Tort

A tort is a civil wrong that is committed by any entity against a person and that results in injury to that person, property, economic status, emotional well-being, or personal relationships. "Civil" in this case pertains to a citizen in his or her ordinary capacity, life, and affairs. It is a "private" offense, as distinguished from a crime that is a public offense.

The injured party (the plaintiff) may sue the *tortfeasor* (the defendant) for some form of compensation and pursues his or her lawsuit in a civil court. The redress sought in the civil lawsuit is usually monetary compensation in the form of "damages" awarded to the victim. The primary purpose

of tort law is to compensate individuals for losses suffered from the tortious actions of others.

TYPES OF TORT

There are two types of tort: (1) unintentional and (2) intentional.

Unintentional Tort

An unintentional tort is an unintended, careless, or accidental but wrongful act or failure to act that causes injury or harm to another person. This substantive area of tort law is known as negligence law. Negligence is defined as a failure to use that degree of care that any reasonable and prudent person would use under the same or similar circumstances. Its focus is on injury or harm that may result from carelessness on the part of another or by accident. An unintentional tort may arise from an act of commission or from one of omission. In either event the harm derives from some failure in caution or due care.

Malpractice is a distinct form of negligence—that which is committed by a professional while acting, and only while acting, in his or her capacity as a professional. There are four common elements usually found in unintentional torts of negligence:

1. a legal duty owed by one individual to another;
2. an act or a failure to act that breaches that duty;
3. an injury or harm to another; and
4. the injury or harm was the direct result of the act or omission.

To recover damages, the plaintiff has the burden of proving *each* of these four elements by a preponderance of evidence. Malpractice and each of these elements will be discussed in detail in chapter 2.

Intentional Tort

By definition intentional tort is an intentional, deliberate, willful, wrongful action that directly invades or violates the rights or property of another person. It is the purposeful commission of some act that is prohibited by law or the purposeful failure to act in conformance with the law or with acceptable standards of practice. Relatively few malpractice lawsuits brought against nurses derive from intentional torts. "The ethical concept of nonmaleficence—the obligation to 'do no harm' to a patient is the underlying

principle involved in the legal issue of intentional torts. If the principle of nonmaleficence were never violated, then no harm would ever come to patients, and there would be no grounds for lawsuits based on intentional torts" (Aiken and Catalano 1994, 136).

INTENTIONAL TORTS

In tort law, intent is the conscious decision to commit an act and intend the consequences. This is demonstrated by any statement of intent or by circumstantial evidence. The requirement of intent does not necessarily mean that the actor desired to do harm; it means that he or she intended to commit, or omit, an action and, by implication, also intended the consequences, whether or not they caused harm or injury. It is a general assumption in law that an individual intends the normal or expected consequences of his or her purposeful actions or behavior.

The intentional tort differs from negligence in that the action complained of must have been intended—the action was done voluntarily. Negligence can arise without intent. There may not be the breach of duty that is relevant only in negligence. In an intentional tort it is not required to prove the four elements of malpractice. Injuries are not at issue. The plaintiff is not required to show that actual injuries were sustained. The harm suffered lies in the invasion of the plaintiff's rights rather than any specific injuries as required in negligence.

A wrongful action that does not result in harm or injury cannot be grounds for a suit at law. If an alleged act of malpractice results in no harm or injury to a patient, the practitioner will not be culpable. However, in those instances where there is patent evidence of intrusion on a plaintiff's legal rights, the law can presume a degree of injury sufficient to sustain a lawsuit and the awarding of damages. The amount of damages—the amount of monetary compensation—which might be awarded to the plaintiff will be derived from the jury's subjective judgment of the extent of encroachment on the plaintiff's rights. Punitive (exemplary) damages can also be awarded in intentional torts. Such damages are rare in malpractice cases.

Elements of Intentional Tort

All intentional torts have three common elements:

1. an action that is offensive to another; the act constitutes an infringement on the rights of another; the motive may not necessarily be hostile; such an infringe-

ment was a consequence that should have reasonably been foreseen by the defendant;

2. the intent to commit such an act; the action or omission involved must be voluntary, deliberate—the individual carrying out the act must intend the consequences or present the appearance of such an intent; and
3. the consequences must be the direct result of the intended action or omission—there must be what the law defines as "causation".

INTENTIONAL TORTS AGAINST PERSONS

There are several intentional torts against persons that nurses might be charged with. These include assault, battery, intentional infliction of emotional distress, false imprisonment, defamation, and invasion of privacy.

Assault

Assault is a wrongful, intentional, statement or action performed by one person that causes another person immediate and actual fear, or reasonable apprehension, of being touched against his or her will in an injurious or offensive manner. The action can be an attempt or a threat to inflict injury or harm. It can be *any* action that generates apprehension or fear in another. Words and/or gestures could be sufficient depending on the circumstances. No actual physical injury or contact need occur.

Assault is any credible, reasonably believable threat. It is *threatened battery*. If there is any actual contact or touching, battery has been committed. An essential element in assault is the apprehension of being touched, and that is the only thing needed to prove a claim for assault. There must be an awareness, an anticipation, a knowledge, and a fear of immediate physical harm on the part of the victim. An unconscious or comatose patient could not be a victim of assault.

Battery

Battery is the intentional physical contact with another person in an injurious or offensive manner without that person's explicit or implied consent. It is any act of physical contact that is unapproved and unwarranted. It is the actual performance of an act of contact or personal physical touching that is only threatened in assault. The victim need not have any fear of immediate harm for the act to be considered battery.

Battery is the most common allegation involving nurses and intentional torts. There are several aspects of battery that the nurse must be aware of.

- First, if the requisite elements of battery are otherwise present, a single touch no matter how brief or how light constitutes battery.
- Second, no actual injury need occur. The patient does not have to suffer physical harm or experience pain of any kind.
- Third, there need be no fear, apprehension, or awareness of immediate harm on the part of the patient. An unconscious person can be the victim of battery.
- Fourth, the unpermitted touching of a individual's personal effects or of any such objects on that person or in his or her hand constitutes battery. Under the law, any personal item that is connected to an individual in any way is treated as an extension of that individual.
- Fifth, the contact required can be direct or indirect. The victim does not have to be touched personally. If a patient is struck, even inadvertently, by an object in the hands of a nurse, or by one that is set in motion by any action of a nurse, while in the act of a battery, that nurse may be liable.

Treatment without consent is the most frequently alleged act of battery involving nurses. If any health care provider conducts physical examinations, performs diagnostic procedures, or initiates treatments without first obtaining the consent of the patient (when this is necessary, appropriate, and possible) the health care provider can be liable for charges of battery.

For a plaintiff to prove the charge, he or she must provide evidence that he or she did not give consent for the treatment or procedure carried out by the defendant or that the defendant's conduct went beyond the limits defined by the consent that the plaintiff had given. Or it must be shown that he or she had withdrawn consent prior to the treatment or procedure that was then carried out with disregard of that withdrawal.

Often an allegation of assault and battery will be presented rather than one of negligence. When such a charge constitutes the basis of a lawsuit, negligence need not be proven. The very nature of—the action of—assault and battery provides the basis for a claim. As noted previously, the plaintiff is primarily charged with proving a lack of consent. Expert witnesses are not required in such proceedings. State criminal laws and tort laws provide for legal action in cases of assault and battery.

Intentional Infliction of Emotional Distress

This intentional tort is any extreme and outrageous conduct that is intended to cause, or effectively causes, another person to suffer *inordinate* mental distress and anxiety. It is a willful infliction of an emotional assault on another person's peace of mind. The conduct of the perpetrator must be

such that it exceeds the acceptable bounds of civilized behavior and human decency. It is an offense to the conscience.

Because it is often difficult to prove emotional distress, some jurisdictions may require evidence of a presenting physical illness as corroboration and/or that the distress be manifested for a significant period of time and require psychiatric or psychological intervention and treatment.

As offensive as they may be, epithets, invective, insults, humiliation, ridicule, and derision may not be enough to prove this tort in many jurisdictions. However, such intemperate displays could lead to charges of harassment. Under some state statutes, family members who witness such reprehensible behavior can also file suit and attempt to recover damages.

There are three conditions required to prove this tort: (1) the offensive conduct was egregious, outrageous, abhorrent, and beyond all decency; (2) the calculated intent of the act was to inflict inordinate mental distress; (3) the wanton behavior caused extreme, manifest, emotional distress to the victim.

False Imprisonment

False imprisonment is the intentional, unlawful detention of a person against his or her will where there is no valid justification or legal sanction for such confinement. The law of torts protects a person from such unlawful constraints on his or her liberty. The tort itself involves some form of restraint or confinement either by some physical or other means or by a threat of such. This may include a threatened use of force and also the apparent intent to carry out the action. (Kidnapping is a crime of abduction, unlawful imprisonment, and extortion involving the use of force and violence.)

Actual physical effort or action, including force, need not be involved. Any actions or speech that create a reasonable fear in the mind of a person that force might be implemented are sufficient to create false imprisonment. Words can restrain as effectively as walls. Generally, the victim must be aware of false imprisonment to claim injury from it. The duration of false imprisonment is not relevant in law. If the plaintiff can prove the imprisonment, the defendant must prove that it was lawful and justified and, therefore, not false imprisonment.

A nurse can be accused of false imprisonment when he or she restrains, secludes, or confines a patient in such a way as to deprive that patient of the right not to be so detained. This includes the improper use of restraint devices or confinement of a patient to a bed, a room, or to another defined area.

There are circumstances where detention of a patient is legally justified, if not in fact mandated. These include violent, mentally ill, or psychotic patients who are a threat to themselves and others; those persons who are confused, disoriented, or otherwise incompetent; and, by law, those exhibiting defined communicable diseases that threaten society-at-large. Institutions are required to detain such individuals by due process of law. Should forcible restraint be required by the circumstances at any time, only that degree of force that is reasonably necessary may be used.

Restraints as a Form of False Imprisonment

The use of restraints and their implications for charges of false imprisonment continues to be controversial. "Federal regulations now mandate strict procedures for using restraints in long-term care facilities, and many of these institutions are adopting restraint-free policies. So far, however, few hospitals have joined this trend—most still use safety devices and medications to limit patient movement under certain circumstances" (Calfee 1991, 36).

The Nursing Home Reform Act of 1987, which was to have been implemented in stages beginning in 1990, stipulates that physical restraints can be used only under certain circumstances. The statutes provide that competent residents have the right to refuse restraints. In addition, medications must have a medical justification and not be prescribed for purposes of control and sedation only.

In most states, a physician's written order, placed in the medical record, is required before restraints may be used. Such an order does not mitigate a nurse's responsibilities. On the contrary, it increases both the responsibilities and the risks. Standing orders, protocols, and policies and procedures are usually in place to be effected at the nursing staff's discretion. These may include pharmacological measures such as sedatives and tranquilizers and any mechanical apparatus such as vests, wrist or ankle restraints, and bed rails.

Nurses who restrain or seclude a patient without justification leave themselves open to a variety of charges, including false imprisonment, battery, negligence, and malpractice. In implementing these interventions, it must be demonstrated that they were necessary to protect the patient from personal injury or to protect others from injury by that patient. It must also be shown that this was the only feasible course of action at the time when other measures were evaluated and viewed as insufficient. Nurses must verify that, in their professional judgment, there was a valid reason for their action. If this cannot be proven they risk a lawsuit for battery and/or false imprison-

ment. If a patient, while competent, confirms an informed decision to refuse restraints, a signed release must be obtained to protect the institution and staff from liability.

If a patient's status indicates the need for some form of protective constraint, a physician should be contacted to personally assess the individual and write appropriate orders. In the event that a patient becomes markedly agitated, violent, or combative and must be subdued immediately, the nurse must do so immediately! A physician's order should be obtained as soon as possible afterward. This is a nursing responsibility, and failure to act promptly in this instance could leave a nurse open to charges of negligence or reckless endangerment. "As a general rule, in the acute care setting, the nurse is more likely to be held liable for failing to restrain a patient who should be restrained than for restraining one who should not be" (Fiesta 1994, 4). The circumstances surrounding the events must be thoroughly documented.

Seclusion or restraint may never be utilized as a punitive measure or for the convenience of the institution's staff, particularly when a short-staffing situation exists. Devices or drugs cannot be an expedient alternative for more appropriate intervention and management. They must not be forms of discipline or domination. A patient's age, in itself, is not sufficient justification for the indiscriminate use of such measures—particularly maintaining side rails elevated where such confinement may not be necessary. "There is no absolute liability for falls that occur in hospitals. There must be proof that the nurse had reason to foresee that a patient could be harmed by falling before the duty to protect the patient arises" (Aiken and Catalano 1994, 124).

Family members will, out of genuine concern or unreasonable fear, suggest or demand that a loved one be restrained or that restraints be removed (they may even attempt to do so). The nurse must use his or her own best judgment and not submit to such demands when such action is not justifiable. He or she must explore the family's concerns with them but not allow them to usurp the nurse's responsibilities.

It is a dangerous breach in standards of care for a nurse to agree to a family member assuming responsibility for an at-risk patient in lieu of appropriate restraining measures. The nurse has no legal justification for delegating his or her duties to anyone other than another qualified member of the institution's staff. All discussions with family members regarding the need and rationale for restraining a patient should be thoroughly documented.

Guidelines for Implementation of Restraints

Under the "least restrictive" doctrine in most states, when such measures must be taken they must be applied to the least extent as is possible—only to that degree that will effectively and adequately protect the patient or others from injury—only what is necessary and appropriate under the circumstances.

The individual applying a physical restraint device must know exactly how it is to be done for maximum effectiveness and patient safety. If the apparatus is applied incorrectly and the patient is injured as a result, the nurse could be held liable for all or a part of the injuries. Certain forms of restraints may be forbidden by law in any given jurisdiction or may be proscribed by the policies and procedures of the institution. A nurse could face liability for failure to remove restraints in a timely manner or from premature removal.

Care must be taken to avoid the use of undue force or even threats of such force. Such behavior could give rise to charges of assault and/or battery. Only a "reasonable" degree of force may be utilized in such efforts. If the patient is out of control, reasonable force is whatever it takes to check a potentially lethal rampage. If he or she is armed, deadly force may be the only recourse. Guidelines for documenting the use of restraints are shown in Table 1.1.

Table 1.1
Documenting the Use of Restraints

- A complete and accurate assessment of the patient's physical and mental status, and behavior, at the time of the decision
- The rationale, the determination of need—based on the assessment—evidence of clinical necessity—justification
- Alternatives, if any, that had been attempted beforehand and found to be ineffective
- A reference to the policy and procedure manual
- A citation of the physician's order
- The specific type of physical device utilized
- The site(s) of application of the apparatus
- The date and time the measures were implemented, and the intended duration
- A schedule indicating the times and by whom the patient was monitored and an assessment to include vital signs, level of consciousness, circulatory status, skin integrity, and other parameters.
- The patient's response and tolerance

- Effectiveness of the intervention as a safety measure
- A schedule of the times physical restraints were removed or loosened in accordance with policies and procedures
- The type of care, if any, required as a result of restraint
- Rationale and patient's status when the restraints are discontinued and removed
- A confirmation that restraints were, or should be, maintained longer than anticipated, and the rationale

Defamation

Defamation is the intentional publication, communication, or dissemination of false information that injures the good name, character, or reputation of the person who is the subject of such false statements. "Publication" as used in this context means that the defamatory statements are communicated in some way to third parties. Such material need not be presented to the public-at-large. Disclosure to a third party or several parties may be sufficient provided that they understand or interpret the statements to be defamatory. Disclosure to the subject, and to the subject only, does not constitute defamation.

If the defamatory information is made public orally, or in some cases by gestures, it is *slander*. If it is presented graphically, pictorially, in writing, or in any permanent format, it is *libel*. For this reason, libel is considered to be more serious than slander. No actual damage must be proven for slander but such must be proven for libel.

There are several rules or principles of defamation law.

- The information published is false and defamatory.
- It was made known to a third party or parties.
- The statements were not made only in jest.
- The subject was a living person; there can be no action in tort if the subject is dead.
- The individual harmed must be readily identifiable.
- The plaintiff must show that he or she was the subject of the defamation.
- The perpetrator intended to communicate false information.
- The information harmed the reputation of the plaintiff in some way.
- The individual who published the information is the cause of the harm.

Invasion of Privacy

Invasion of privacy involves four distinct rights:

1. the right to the exclusive use of one's own name and likeness;
2. the right not to be placed in a false or humiliating light in the public eye;
3. the right to be free from intrusion upon one's person or private affairs—the inherent right to be left alone; and
4. the right against unauthorized or unwarranted publicity of personal, private affairs or facts.

There are several elements that define invasion of privacy.

- The action complained of infringed on the plaintiff's right to privacy.
- Such an infringement was effected without the plaintiff's consent.
- The action and its consequences were offensive to the plaintiff.
- Information or facts divulged were very private and personal in nature.
- There was a disclosure of such information or facts to a party or parties who had no right to know or need to know.

Generally, any damages awarded in a case of invasion of privacy will be for the mental distress and emotional suffering that any normal, sensible person would be likely to suffer under the same or similar circumstances. Truth, a defense in libel and defamation, is not a defense in the tort of invasion of privacy.

Breach of Confidentiality

Breach of confidentiality is a failure on the part of a *professional* to keep all privileged, confidential information private. It is the unlawful publication of certain private facts about a person without that person's consent. Nurses are particularly vulnerable to claims of breach of confidentiality. Most often the breach occurs when a patient's name and/or other private information is discussed in a public area of the institution such as at the nurses' station, in an elevator, in the patient's room in the presence of visitors, or in the cafeteria. Indiscrete disclosure to a relative or any visitor of confidential information regarding a patient is another common basis of a claim.

Telephone calls are a major potential problem area for nurses who must be extremely cautious when divulging any information to a caller. They should be absolutely certain of the identity of the caller and the legitimacy of the inquiry—the need to know, the right to know. All such calls should be referred to a proper resource if there are any doubts or questions.

The nurse is especially cautioned in revealing any patient information to the news media. There are circumstances when the general public's right to

know may take precedence over another's privacy. Media reports on the status of the president's health, the hospitalization of a prominent public figure, the names of patients involved in major breakthroughs in medicine are some examples of this. Such persons must still be allowed their dignity and, to whatever extent possible, some degree of their privacy. A staff nurse, in the course of his or her routine duties, should not have the occasion, need, or urge to present himself or herself to the media.

Under certain circumstances the law permits the public disclosure of information to preclude possible danger or harm to the welfare of an individual or the general public. When the nurse, in his or her best professional judgment, and after careful consideration, determines that there is in fact a duty to disclose he or she might then divulge confidential information. If the information concerns a patient in a hospital, the initial revelation should be made to a nursing supervisor. A nurse's direct public disclosure would usually be done only if the nurse has been authorized to do so, and then the disclosure should be made in accordance with the employing institution's policies and procedures. In clinical practice, it is unlikely that a nurse would find himself or herself in a situation where personal initiative in direct disclosure would be indicated or appropriate. In a personal off-duty encounter, the duty would exist and the law would protect the nurse if he or she acted in good faith.

Statutes dealing with confidentiality vary by state. Virtually all of these disclosure laws provide for immunity from civil lawsuits against those required to report if the disclosure has been made in good faith. Common reportable information includes elder or child abuse, births and deaths, certain communicable diseases, and injuries suffered in the act of committing or attempting to commit a crime. Several states allow for the release of otherwise confidential information in criminal cases where such information is deemed relevant to prosecution of the case. A nurse is also protected by law when the information disclosed is essential to the proper and continuing care of a patient.

Each of the fifty states and the District of Columbia have implemented laws requiring the reporting of child abuse by certain professionals. These include nurses in all instances. Failure to report can incur punishment under criminal laws.

PATIENTS' BILLS OF RIGHTS

Unless defined by federal or state statutes, patients' bills of rights have no force in law. Such declarations by health care institutions or professional or-

ganizations have only as much authority as their source. Only those rights that have been incorporated into laws or regulations carry meaningful legal authority because they define sanctions and specific recourse in law for the patient seeking redress when these rights are deemed to have been violated.

All statements of patients' rights are, however, professionally and ethically binding. They carry the highest moral and ethical weight for each member of the nursing profession. Nurses have always incorporated patients' rights in nursing care. The first such bill of rights was prepared by the National League for Nursing in 1959. It was followed by statements issued by the American Civil Liberties Union, the American Hospital Association, and several other professional organizations.

A copy of a patient's bill of rights, derived from one source or another, is usually given to every patient at the time of admission. It is likely to be a compilation developed by the institution itself, and framed copies may be displayed prominently throughout the premises. Nurses and all other caregivers are expected to ensure these rights regardless of their source.

The patients' bill of rights has at times been characterized as unnecessary, even redundant. One writer laments: "Somehow it seems a sad commentary that patients' bills of rights needed to be written at all or that they had to be given statutory enactment to be enforced. The rights contained therein should be self-evident. All persons, whether patients or not, are entitled to dignity, consideration, and self-determination" (Guido 1988, 201).

From a legal aspect, perhaps the most significant purpose of patients' bills of rights is that they serve to inform patients as consumers of health care of the options available to them if and when such rights are perceived as having been violated or denied.

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2

Malpractice

DEFINITION OF MALPRACTICE

Malpractice is *negligence* on the part of a *professional only while he or she is acting in the course of professional duties.* This unintentional tort involves acts of negligence by an individual employed in a position where defined levels of knowledge, technical skills, and professional standards are prescribed for anyone assuming that position. It is a failure on the part of a professional to act according to such defined standards or a failure to foresee the consequences that a person having the same or similar knowledge, education, and skills should have foreseen. A "professional" includes a nurse, physician, clergyman, educator, and attorney among others.

NEGLIGENCE

A tort of negligence results when an individual fails to fulfill a required duty of care and that failure results in an injury to another individual. Negligence is carelessness. The negligent individual neither intends the consequences nor believes they will occur. This is the distinction between negligence and an intentional tort. Many of the acts previously discussed in the section on intentional torts would constitute negligence if there were no

element of intent. Negligence is generally defined as a deviation from those standards that a reasonable, prudent person should or would apply in the same or a similar situation. The hypothetical "reasonable person" is ubiquitous in the law.

Gross negligence (a consideration in an award of punitive damages) involves the determination of a reckless disregard for the rights or well-being of another, even when an injury to the person is highly likely, if not certain, to result from the act or failure to act. It is a deliberate and wanton indifference that is apparent in the act itself, let alone its consequences.

Malpractice, therefore, is a very specific form of negligence that takes into account the status of the individual as a professional and the standards defined for that particular profession. It is a violation of a duty to act in good faith and with reasonable care. As a general rule, lawsuits for negligence and for malpractice will involve the same elements. Any one can be liable for negligence, but only a professional can be liable and can be sued for malpractice.

REQUIRED ELEMENTS OF MALPRACTICE

In an alleged case of malpractice there are four elements, *each* of which must be proven by the plaintiff in order to find the nurse-defendant liable. These are the same elements which, as we have seen previously, must be proven in any tort of negligence. The plaintiff must present to the jury a preponderance of evidence that demonstrates unequivocally that all the allegations are more probably true than not. If successful, a judgment against the defendant will likely be made. These four required elements of malpractice are: (1) duty, (2) breach of duty, (3) injury, and (4) causation.

Duty

Duty is the obligation of due care owed by one person to another as appropriate for the circumstances and as may be dictated by law. In a malpractice lawsuit against a nurse, the patient must claim, and prove, that the nurse owed him or her a professional duty of care. At the time of the alleged incident there must have existed a nurse-patient relationship that created duty.

Duty incorporates the fundamental legal concept of personal accountability for our actions or omissions. Every human being, regardless of his or her occupation or status, has an inherent obligation not to injure or harm another person by a negligent act or omission. We are free to act provided that our actions do not in some way intrude upon or violate the rights of another. Duty dictates appropriate conduct in society and prescribes that each of us

act as a prudent, reasonable, individual who will exercise all possible care in avoiding any unreasonable risk to another.

In a nurse-patient relationship, duty involves the defined standards of nursing care that direct each nurse's conduct in his or her clinical practice. Duty is usually not an issue in a nursing malpractice case. The fact that a patient has been admitted to a hospital, and that a nurse who is an employee of that hospital has accepted an assignment to care for that patient (has created a nurse-patient relationship) usually establishes duty. It is not merely the nurse's employment status that creates the relationship, but also the establishment of a degree of reliance, of dependence, upon the nurse as a provider of care. This concept of reliance is the basis of duty and of the nursing process.

Foreseeability

Another common factor in nursing malpractice lawsuits is foreseeability. This concept is inherent in the required elements of duty and causation. It suggests that a reasonable, prudent person of average intelligence should realize and anticipate the nature and extent of the consequences of his or her actions or omissions. A given action or course of action can be expected to produce given results. A *predictable* harm that resulted from the absence of due care should have been foreseen.

In law, foreseeability holds every person responsible for the consequences of negligent actions that cause harm to another person to whom some form of duty is owing. Proving this element requires the patient-plaintiff to show that the nurse should have reasonably foreseen the outcome of his or her actions, given the circumstances surrounding the alleged incident at that time. The merits of the lawsuit will be judged on those facts. Proof cannot come from hindsight; it must be based on the nurse's perspective then, not the plaintiff's retrospective now. The general rule is that if the consequences were not foreseeable, there is no liability.

Breach of Duty

The second element that must be proven in a case of malpractice is breach of duty. This is defined as a failure to carry out the responsibilities of a particular position in a manner appropriate to that position. The nurse liable for breach of duty has failed in providing the required standards of nursing care defined for the profession. These incorporate all of the standards that should be applied by any professional nurse, with comparable experience and education, in the same or similar circumstances. In the courtroom these standards and the scope of nursing practice will be inter-

preted (not defined) by *nurse* expert witnesses and compared to those applied by the defendant. At issue will be what the standards of care were *at the time* of the alleged incident and if, and how, they might have been breached by the nurse-defendant. This will be a critical factor in a judgment of liability or innocence. Nursing standards of care are discussed more fully in chapter 4.

Injury

The third required element is that of injury ("injury in fact"), which is an *actual* harm of any kind that the plaintiff has experienced. The plaintiff must prove that he or she has suffered physical, emotional, or economic wrong. The primary purpose of tort law is to provide some form of compensation to an individual who has been harmed by a wrongful act of another. *Injury is the key element* in malpractice. The harm sustained by the plaintiff must be "compensable"—it must be a *legally recognizable* injury. If there is no injury, there is nothing to compensate for, and there is no malpractice; therefore, there can be no liability. The mere fact of an injury does not necessarily create liability. Liability arises when the injury is the result of a nurse's failure in the standards of care.

Claims for emotional injury are generally not sustainable where there has been no physical injury, and the courts may not allow such suits. The exception is where there is evidence that the actions of the nurse-defendant were extreme, outrageous, or grossly negligent. Patients can and do sue for mental anguish and psychological injury; however, courts in many jurisdictions have usually been disinclined in awarding monetary compensation for such claims. In a recent court case in Pennsylvania, the judge commented that the legal system is not charged with compensating for "every minor psychic shock incurred in the course of everyday life; the law is not the guarantor of an emotionally peaceful life and cannot protect any of us from the emotional slings and arrows of daily living" (*Pennsylvania Jury Verdicts* 1993, 17).

The question arises as to what should be done in that instance where negligence has occurred, but the patient was not harmed in any way and is unaware of the event. Is there a *legal* duty to disclose the incident of negligence to the patient? Since the patient was not the victim of any injury, there is no legal duty to disclose. No injury means no liability under the law. From a professional, ethical, or moral perspective, however, imposing such ignorance on the patient could be tantamount to victimization. When appropriate, a direct and honest revelation of human error by a nurse will serve

better than an inadvertent discovery by the patient or his or her family. Established trust, honesty, and mutual respect can be major factors in a plaintiff's decision to sue should any incident of nursing malpractice warrant.

Causation

To prove causation, the fourth element in malpractice, the plaintiff must establish a *causal connection* between the breach of duty that is claimed and the injury that is alleged to have resulted from that breach. It is the concept of cause and effect seen in the physical sciences, in cosmology, and in law. It proposes that a given action or combination of actions will produce a given result. In litigation it is known as the "but for" criterion. But for the action (or omission) of the defendant, the injury could not have been sustained by the plaintiff. *Causation in fact* will be established. The defendant's conduct was the *proximate* and *substantial* cause of the resulting harm done to the plaintiff. The claim made is that the nurse's breach of duty is the most likely and probable cause of an injury that otherwise could not have occurred—there was "cause in fact".

Proximate cause (legal cause) will be determined if it can be shown that the action of the defendant was the substantial cause, the "next" cause, of the plaintiff's injury. The injury was the natural, continuous result of the defendant's negligence. The doctrine of foreseeability is the standard test for proximate cause, and a plaintiff will recover damages if it can be shown that the defendant should reasonably have foreseen that, as a consequence of his or her action, the plaintiff was at risk for injury. Proximate cause requires consideration of foreseeable consequences.

THE LEGAL DOCTRINE OF *RES IPSA LOQUITUR*

Res ipsa loquitur is an exception to the requirement that a plaintiff must prove all four elements of malpractice. The *inference* of the defendant's negligence is known as *res ipsa loquitur*, which translates from Latin as: "The thing speaks for itself." It is a legal principle, a rule of evidence, that proposes that negligence on the part of the defendant can be inferred from the very fact that there was an incident which caused harm to the plaintiff. The rule affirms that the obvious nature and extent of the plaintiff's injury may *infer* negligence by the defendant and, therefore, liability. The injury itself speaks, it accuses.

This doctrine is applied only when the injury is such that it could ordinarily not occur unless negligence was the causative factor. In the instance where a professional duty of care existed, the nurse-defendant's negligence

was the most likely cause of the patient's injury, and the nurse had *exclusive control* over the action, the doctrine of *res ipsa loquitur* will most likely be invoked. The burden of proof then shifts to the defendant who must then show that the plaintiff's injury was the result of a cause other than the alleged negligence of the defendant.

Causation can be the most problematic element in a case of malpractice. A plaintiff may be unable to prove a claim of negligence by, or ascribe blame for the harm sustained to, any one of a number of individuals named as defendants. In this instance, a court may apply the doctrine of *res ipsa loquitur* to assist the plaintiff in sustaining a claim. In effecting this rule, the court imparts a measure of equality to the plaintiff's position where this may have been lacking due to an unwarranted disadvantage imposed on the plaintiff. What the court has done is to permit the plaintiff to attempt to prove negligence by presenting circumstantial evidence against a defendant who, alone, may have full knowledge of the exact cause of the plaintiff's injury.

The court will require that three conditions be met before invocation of the rule of *res ipsa loquitur*:

1. Given the circumstances surrounding the alleged incident, there is reasonable cause to believe that the injury could not have otherwise occurred had there been no negligence on the part of the defendant. Such an injury is one that would not ordinarily occur except in a concurrent incident of negligence.
2. The instrumentality, the agency, of the injury was under the exclusive control and direction of the defendant.
3. The plaintiff did not contribute in any way to his or her injury.

When *res ipsa loquitur* is applied it usually obviates the need for the plaintiff to present testimony of expert witnesses. It also removes from the plaintiff the burden of proving all four of the required elements of malpractice; only injury and causation need be proven.

THE LEGAL DOCTRINE OF VICARIOUS LIABILITY

The legal doctrine of vicarious liability imposes and imputes liability on one person for a tort committed by another acting as agent or employee. In a suit for malpractice, the institution itself is invariably named as a defendant because it is seen to have "deep pockets". The institution as an employer is included in a suit under the doctrine of vicarious liability ("substitute liability"), which holds an employer responsible for the acts of employees. In the search for the deep pocket, the plaintiff's attorney might include as defen-

dants any number of staff who may have had no direct involvement in or responsibility for the alleged incident of malpractice. No matter how remote their contact with the plaintiff, they can be initially embraced by the claim under vicarious liability. Most will be "unsuited" later. In legal theory, vicarious liability is addressed in four concepts: (1) ostensible authority, (2) corporate liability, (3) *respondeat superior*, and (4) borrowed servant.

Ostensible Authority

This legal doctrine affirms that a hospital, or any such institution, can be held liable for any negligence on the part of an independent contractor providing care or treatment for a patient if and when the patient can reasonably assume that the contractor is an employee of the hospital. The patient is the hospital's patient first, and the independent contractor's patient second. It is the hospital that may be held ultimately responsible for such contractors even though they are not employees—as a patient might assume. Independent contractors might include physician groups operating specialty services such as an emergency room, radiology department, or pathology laboratory. Advanced practice nurses including nurse practitioners and clinical nurse specialists can also provide various services as independent contractors.

Corporate Liability

The focus of this doctrine is on the institution as an incorporated entity. Under the law a corporation is a "person" with clearly defined legal responsibilities. These corporate liabilities are over and above those inherent in the concept of vicarious liability and include such areas as safety and security for patients, employees, and visitors, maintenance and condition of the hospital's physical plant and all equipment utilized, organizational and management policies and procedures. The institution is held responsible to monitor all aspects of its day-to-day operation, and each of the personnel involved in those functions, in a reasonable effort to identify all foreseeable risks. It is these foreseeable risks that may be the measure of its liability. Certain aspects of professional staffing also come under this doctrine such as a failure to carry out appropriate employment prescreening to confirm the background and credentials of prospective medical or nursing staff applying for clinical privileges.

Janine Fiesta confirms that: "More recent court decisions have expanded the hospital's direct obligation to ensure not only a proper level of hospital management and operations and the appropriate conduct of employees and

agents, but also the clinical competence and performance of all practitioners granted clinical privileges. . . . This developing doctrine of corporate liability has major consequences for the nursing profession. It is now the nurse's responsibility to communicate significant management information such as physician, staffing, and equipment problems" (Fiesta 1994, 142).

Virtually every hospital has a risk management department whose primary functions are to identify, analyze, reduce, and eliminate those factors that represent actual or potential hazards, and in so doing diminish the risk for lawsuits and possible financial losses. The objective is to assure the maximum safety of patients, employees, and visitors by preventing the preventible accident before it occurs or reoccurs. Whenever an untoward incident is reported, risk managers will examine the circumstances to determine the likelihood of a lawsuit or the potential for a claim and plan appropriate strategies and future preventive measures.

Respondeat Superior

Under the legal doctrine of *respondeat superior* a principal-employer is liable for any injury or harm to a third party that is caused by the agent-employee while acting in the scope of employment. It is vicarious liability. This is a very ancient concept in common law that has it origins in the relationship of a servant to the master in the very earliest civilizations and social orders. It translates as: "Let the master respond." Every person is responsible for the management of his or her own affairs whether this is done personally or through servants or agents. In a malpractice suit against a nurse, a master-servant relationship is defined. The hospital is the "master"—employer; the nurse is the "servant"—employee—and the master must answer for the conduct of it servants.

A hospital can be held indirectly liable for a nurse's negligent acts carried out in the scope and course of his or her employment and which may cause injury to a patient of the hospital. The doctrine applies to acts of commission or omission. Both parties can be held liable on the basis of an employer-employee relationship. The hospital may be named as a defendant, and the nurse may not be.

For the hospital to be held liable under *respondeat superior* it must be shown that, as an employer, it directed and controlled the actions of its employee, and that the alleged malpractice occurred while the nurse, as employee, was acting while on duty and within the scope and course of his or her employment. In such instances the nurse must have carried out an act of negligence while on the hospital's premises, during a time he or she was

actually assigned for and on duty, and while performing nursing duties defined by the job description. The principle of foreseeability is usually applied here, and many court decisions confirm that an employer should be able to foresee that an employee might be able to act in any given way and what the consequences might be.

There are several other elements that are considered in applying this doctrine. These questions include:

- Was the unit or site one to which the nurse was normally assigned for duty, or was he or she working in an unfamiliar area?
- Did the nurse act in any way primarily to benefit the interests of the hospital—his or her employer?
- To what extent did the nurse's actions conform to or deviate from those defined by the scope of practice?
- Could an employer have anticipated such actions and their outcomes?

An employer may claim that the nurse was, in fact, not on duty or acting outside the scope of employment and thus attempt to avoid liability. If the actions by the nurse can be demonstrated to have been outside the defined scope of practice the hospital may be absolved. In this event, the accused nurse may stand alone in defending the allegations.

The concept of *respondeat superior* is applied much more readily in the litigious climate of today in an increasing number of nursing malpractice suits. Prior to the last decade or two, the physician and/or the hospital were required to answer for the conduct of nurses, and as the "masters" they were usually named exclusively as defendants in claims of malpractice. The nurse, as "servant," was merely carrying out the binding orders of the master (physician) and was usually viewed as not culpable. That tradition was swept aside as nursing came to be recognized as a science and as a profession with concomitant legal liabilities. Nurses must now also answer for themselves.

Borrowed Servant Doctrine

This is another doctrine based on vicarious liability. It is also known as "the captain of the ship" doctrine and is very similar to *respondeat superior*. This addresses negligence on the part of a nurse while he or she is working under the control or direction of an acting superior or supervisor—the "captain"—who is not the nurse's ordinary supervisor or manager. This temporary captain may be an independent contractor to whom the nurse is

assigned or "loaned". The nurse is then a borrowed servant under the control and direction of the master and should not have to bear the entire burden of blame or liability that might result from carrying out the captain's orders.

Application of this doctrine in malpractice cases appears to have waned somewhat over the years, due in part to the increasing complexity of medical and nursing care and technological procedures. In today's health care setting and practice, it can be extremely difficult to assign individual blame when a number of disciplines and practitioners participate in the care of an individual patient. In such collaborative endeavors the principle of joint liability may be the only feasible recourse in defining defendants in malpractice litigation.

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3

Defenses in Malpractice

PRINCIPAL TYPES OF LEGAL DEFENSE

Under the law, an attorney can offer two principal types of defense on behalf of the nurse who has been named as a defendant in a suit for malpractice. The first is "defense of fact" which will contend that there was, in fact, no breach of duty; or there was a breach of duty, but that it was not the cause of the patient's alleged injury. The attorney will then attempt to provide a variety of alternative facts, causes, or circumstances, which, the attorney will contend, led to the injury. In those instances where a suit is seen to be clearly indefensible, an offer of a settlement may be the only feasible recourse. The second type of defense is "defense of law." An example of this is a statute of limitations in a given state.

Defense of Fact

Specific defenses will be offered based on the type of tort that forms the basis of the lawsuit. These include *affirmative defenses* that are defined in substantive law. Affirmative defenses will be presented in an effort to show that there were certain facts or circumstances that obviate the claims of the plaintiff. They are not denials of the truth or facts of the plaintiff's claims.

Rather, they are assertions of reasons why the defendant is not liable. They are a challenge to the plaintiff's legal right to bring the action. Affirmative defenses can be presented in cases of intentional and unintentional tort.

Defenses in Intentional Tort

There are four defenses in intentional tort.

- Absolute need: The action taken was imperative given the circumstances. There was no feasible alternative.
- Self-protection or the defense of another: Such situations permit the use of *reasonable* force if an individual believes he or she is going to be harmed and there is no possible option. The degree of force must be reasonable under the circumstances.
- Consent: The plaintiff had consented to the defendant's action.
- Authority of law: The defendant's action was required by law.

Defenses in Unintentional Tort

Defenses in unintentional tort include the following.

- Contributory negligence: Most states have abolished this defense; however, the concept is particularly relevant to nursing practice. In this defense, the patient-plaintiff is implicated in the incident that caused his or her injury. If it can be shown that the patient contributed to the alleged injury in any way, the patient may not be allowed to recover full damages. This can be very difficult to prove in the circumstances of an ill or injured person and may not be proven in the case of the patient who is disoriented, confused, or irrational.
- Comparative negligence: This is now the law in a majority of states. There will be an attempt to prove that *both* the patient and the nurse contributed to the injury. Under this doctrine, a plaintiff who was contributively negligent can recover damages; however, the amount awarded will be reduced in proportion to the plaintiff's degree of negligence.
- Assumption of risk: This legal doctrine provides that a plaintiff may not recover damages if the patient willingly and knowingly accepted the risk of a medical procedure. The risk can be assumed by an expressed agreement or implied by the patient's knowledge of the risk and actions based on this knowledge. This doctrine is directly related to the issues of informed consent, which will be discussed in chapter 11. This defense will maintain that the patient knew and fully understood all of the risks involved in the procedure; willingly consented to it; and in so doing, accepted any and all consequences, including the alleged injury.
- Unavoidable accident: An inevitable event or set of circumstances was the cause of the injury. The cause was accidental—and only that.

- False claims: The charges and allegations being made by the plaintiff lack sufficient credibility or proof to sustain the claim that the nurse is liable for malpractice. If the court finds in the defendant's favor the case will be dismissed. The plaintiff may have exposed him- or herself to counter charges by the defendant.
- Sovereign immunity: Historically this doctrine precluded lawsuits against the federal or state governments. Plaintiffs were thwarted in any attempts to sue such political entities for negligence. Under the Federal Tort Claims Act, the federal government is now amenable to such suits, and most of the states are no longer immune from tort liability.
- Consent: Voluntary, which can be written, oral, or implied. This may come from the patient or from one authorized to give it.
- Truth: A defense in a suit for defamation if the defamatory statement is true in its entirety.
- Privilege: Another defense in defamation that allows the divulgence of privileged information where required by law. If such disclosure is made without malice and in good faith, there is no liability.

Defense of Law

The two principal defenses of law are (1) statutes of limitations and (2) Good Samaritan laws. These vary by state.

Statutes of Limitations

A statute of limitations is an example of a procedural law that was defined in chapter 1. A statute of limitations delimits the period of time within which a plaintiff is allowed to bring an action in law for malpractice. In most states the lawsuit must be initiated within a prescribed time frame beginning on the specific date on which the plaintiff knew, *should have known*, or *discovered* that an act of malpractice was the cause of the alleged injury. If the plaintiff fails to file his or her petition for damages (complaint) within the time frame mandated by the law, the plaintiff may forfeit the right to sue.

In law, the statute of limitations is an example of an affirmative defense. It is the defendant who must show that the statute has, in fact, run out. If the court concurs in this assertion the plaintiff cannot pursue the lawsuit against the defendant. When the specific date on which the statute commences becomes an issue, the attorney for the plaintiff will pursue any possible extenuating circumstances and petition the court to extend the statute based on any credible cause.

Each state has incorporated a provision for a statute of limitations in the medical malpractice laws that have been enacted. As a result there are many

variations in the period of time allowed and in the guidelines for determining it. When the statute of limitations becomes a point of disputation, the court will look to the definition framed by the state in determining an appropriate and applicable interpretation. Statutes dealing with the general laws on personal injuries may be applied in a malpractice suit. There are several procedural rules involved in these laws. These have been implemented to assist in fixing the precise date on which a statute of limitations begins to run. Examples of these procedural rules are shown in Table 3.1.

Table 3.1
Procedural Rules in the Statute of Limitations

- Occurrence Rule: The statute begins to run at the moment of, on the date of, the injury.
- Discovery Rule: The statute begins to run on the day the plaintiff actually *discovers* that he or she has been injured by an act of malpractice. In applying this rule the court will consider whether or not the plaintiff *could have*, or *should have*, discovered the alleged injury at any preceding time. That is, would this injury have been apparent to any reasonable person? "Discovery" can be interpreted in several ways: (1) the date the plaintiff determined that an act of malpractice actually occurred, (2) the date on which the plaintiff learned that the injury was the result of such an act, (3) the date on which it is determined that the injury sustained is of a degree and nature to warrant a malpractice suit to recover damages.
- Termination-of-Treatment Rule: The statute begins to run on the date of the plaintiff's last treatment. This rule is applied when a plaintiff's injury is alleged to have been the result of, and occurred during, an ongoing treatment regimen. During that time it might not be possible to identify a specific date or incident when the plaintiff might have sustained the alleged injury.
- Minors: The laws regarding minors vary by state. Some states define the statute of limitations according to the age of a minor on the date of his or her injury. In some statutes there may be no specific provision for minors. The rights of parents or legal guardians also varies. Most states provide for an extension of the time period within which a minor, or the parents or legal representatives of a minor, may act to initiate a lawsuit. This is usually one to two years beyond the legal age of majority—eighteen or twenty-one—as defined by the particular jurisdiction.
- Incompetency: This discovery rule will usually be applied in the case of an incompetent patient or in the event that such a patient recovers competency and/or is declared competent.
- Wrongful death: Wrongful death rules permit survivors to file lawsuits based on negligence or intentional acts. In this event the court may determine that the statute begins to run on the date of the patient's death; survivors, as plaintiffs, must file suit accordingly.

- Fraud: A proven allegation of deliberate fraud, concealment, or deceit perpetrated by any parties to the defense could extend the statute of limitations for an *indefinite* period of time.

Good Samaritan Laws

Each state has a Good Samaritan law. These special negligence statutes have been enacted to provide protection from liability for negligence for anyone who endeavors to assist a victim at the scene of an accident, disaster, or other emergency situation. Individual state laws define those who are covered including professionals and nonprofessionals. Usually, only those personnel with a legal "duty to rescue" as defined by a state law are obliged to render aid in emergencies. These might include fire fighters, paramedics, emergency medical technicians, and law officers. Every nurse should know the provisions of the Good Samaritan law as it applies to the scope of nursing practice in his or her state.

Any person who does intervene may be sued, regardless; but the Good Samaritan law presents a formidable defense unless one's efforts have been wantonly careless or grossly negligent. The law will not provide protection for intentional harm or recklessness. Because of the protection these statutes provide, health care professionals and laypersons alike should be more willing to offer their help when and where needed, knowing that the law provides a measure of protection from lawsuits arising from allegations of negligence. Their first obligation is to do no harm. If they give their best in an effort to aid they should have no cause to fear legal reprisal.

As a general rule, unless required by a specific state statute, there is *no legal mandate* requiring a nurse or anyone else to render assistance to a victim in an emergency situation. The ethical or moral mandate to assist is one that the individual must define personally. Nurses who believe themselves inadequate or lacking in the proper clinical knowledge or skills demanded in the particular situation may have reasonable cause not to intervene.

Unless a nurse stops at the scene of an accident or presents him- or herself at the site of a disaster or any type of emergency with the intent to render assistance, he or she is under *no legal duty* to any victim. No one can lay claim to a nurse's professional skills or knowledge, and a nurse has the full right to withhold or deny services. The nurse's legal duty is created at the moment he or she initiates care and establishes a nurse-patient relationship. At that instant duty is established, and the individual will be held to the defined standards of nursing care. The legal duty, therefore, is one of reasonable care, and the law will protect only the nurse who pro-

vides such care. The Good Samaritan law cannot be invoked if one is grossly negligent.

Once the nurse initiates intervention, the victim becomes his or her "patient," and the nurse is then required to remain with the patient until one of the following events releases him or her from this duty:

- The victim refuses intervention or directs the effort cease.
- It is readily apparent that the victim is in no imminent danger.
- Qualified medical personnel arrive and assume care.
- His or her personal safety or life becomes at risk.
- He or she is directed to leave the scene by proper authority.
- The nurse is exhausted and cannot continue his or her efforts.
- Their intervention is to no avail. Despite all reasonable rescue efforts on the nurse's part, it is readily apparent that the victim is going to die and intervention will not prevent it.

At the time of this writing, only two states have a duty-to-rescue law; these are Vermont and Minnesota. In Vermont, any individual who recognizes that another person is at grave risk or whose life is threatened as a result of an injury is required to assist provided that one's efforts do not place him or her at similar risk. The law in Minnesota is similar. In all other states a nurse is not required to intervene. The general exception is when a nurse (or any other citizen) is in any way responsible for an accident and the victim's injuries. All state laws require individuals to stop at an accident in which they are involved. A nurse may be required not only to stop, but to assist any victims as well.

In most instances these laws are applicable only to such events that are encountered beyond the health care provider's place of employment. The Good Samaritan statutes do not cover allegations of negligence that occur in the scope of employment. When nurses are traveling to or from a job site or are engaged in personal activities at home or elsewhere, they are solely responsible for the legal consequences of their actions. This is one of several reasons that it is essential for a professional nurse to maintain a personal malpractice insurance policy.

A final point is that the nurse who accepts monetary compensation for the intervention he or she may have provided to a victim could forfeit his or her right of protection under a Good Samaritan law. By soliciting and/or accepting such payment, the nurse could establish a "fee-for-service" situation which, in effect, is a business arrangement, and which may prevent the nurse from invoking the Good Samaritan defense.

4

Standards of Nursing Care

DEFINITION OF STANDARD OF CARE

The American Nurses Association defines "standard" as an: "[A]uthoritative statement enunciated and promulgated by the profession by which the quality of practice, service, or education can be judged" (ANA 1991, 22). Nursing standards of care define the levels of skill and knowledge and the quality of patient care required and expected of any member of the profession carrying out the nursing process in a similar setting and under similar circumstances. It is that degree of care that is considered minimally adequate for, and acceptable from, each member of the nursing profession possessing a common body of skills and knowledge.

> Nurses often express concern regarding their responsibilities for various ethical issues, and they should be aware that their legal and ethical responsibilities are not identical. . . . In the absence of a [legal standard], the nurse must be guided by the ethics of the profession and by personal moral standards. . . . [T]he law requires a basic minimum standard, whereas the ethical standards of the health care professional may require a higher standard of care in a particular situation. (Fiesta 1994, 179)

The fundamental premise of all such standards is that nurses must protect their patients. Standards have been created to provide practitioners with

those guidelines necessary to accomplish this objective. By defining the acceptable and appropriate level of quality care, they facilitate the protective duty of the nurse in clinical practice. They are the bases for competent, therapeutic, and safe nursing care. They represent the duty each nurse undertakes to exercise that degree of ordinary and reasonable care that will assure that no preventable harm comes to his or her patient.

APPLICATION OF STANDARDS OF CARE IN NURSING MALPRACTICE

In a nursing malpractice suit, it is these standards of care that will be the criteria used to determine if the nurse-defendant is liable for negligence. The courts will look to current, national, minimum standards, and they will also consider all relevant internal standards of the employing institution. These will provide the evidence that will prove or disprove that the nurse did or did not breach his or her duty. Duty may be defined as the applicable standard of care. The verdict will be dictated by a consideration and judgment of what any reasonable and prudent nurse with the same or similar experience and education would have done under the same or similar circumstances.

The plaintiff will be obliged to demonstrate that:

- published standards of care were in existence, disseminated, and readily available to the defendant;
- the standards that the plaintiff presents to the court were applicable and appropriate to the circumstances;
- the defendant should have known those standards;
- the defendant should have applied them;
- the defendant failed to apply them;
- the nature and extent of the defendant's breach of duty is evident; and
- the defendant's breach of duty caused the plaintiff's injuries.

Whether or not standards may be admitted in any given malpractice proceeding will depend on applicable principles and theories of law, the nature of the proceeding, the court of jurisdiction, and the relevancy of the standards themselves. No standard is guaranteed admission as evidence. If it is to be introduced as such, it must be shown to be germane to the issues and must overcome any objections to its validity. It must be authoritative, pertinent, and specific to the facts of the case.

Compliance to a standard will be gauged by the degree of conformity, incompetency, negligence, or gross negligence alleged of, or demonstrated

by, the defendant. Ideally, presentation of standards of care will facilitate the determination of liability. To protect the rights of all parties, however, these must be legitimate interpretations of the care that was reasonable, appropriate, and expected given the circumstances surrounding the alleged incident. In every malpractice suit against a nurse, there will be the allegation that the nurse has breached his or her duty—has failed in the standards of care. Most often these standards are *the* criteria used in civil law in torts of professional negligence.

Standards of care may also be considered in a determination of a nurse's liability for violation of a state's nurse practice act or in proceedings involving charges under criminal statutes. The nurse practice act of any state may or may not incorporate standards of practice. There may be no reference to them in the statutes or in rules and regulations promulgated under the statutes. If they are not embodied in a statute they are not law—they are merely guidelines. However, they are guidelines that have the utmost legal significance for every nurse. Nurse practice acts are discussed in more detail in chapter 15.

EXPERT WITNESSES AND STANDARDS OF CARE

In cases of negligence (unintentional torts) standards of care are relevant. They are not relevant in intentional torts. Expert witnesses are usually required in malpractice suits to interpret the appropriate standards. Predefined nursing standards should be and typically are elucidated by nurses employed as expert witnesses. The role of the nurse in this capacity is to present to the court the accepted standards of care that would have been expected and required in the circumstances of the alleged incident of nursing malpractice and to present an *opinion* that the defendant met or did not meet those standards. The defense attorney for a nurse accused of malpractice would likely protest a physician testifying as to the standards of nursing care unless the procedure under consideration involves a skill or function that either a physician or a nurse may routinely perform.

SOURCES OF STANDARDS OF CARE

There are a number of variations in standards of care. They can be based on the nature of care to be provided, the setting for and the level of that care, and the competencies and required credentials of the subject caregivers. Standards can be very general and couched in language and provisions that apply to a very broad group, or they can be quite specific and applicable primarily to a defined group or subgroup within a profession and thus "profes-

sion specific". There are two basic sources of standards of care and the criteria upon which compliance will be evaluated. These are (1) external sources and (2) internal sources.

External Sources

The primary external sources of standards of nursing care include the following:

- The Joint Commission on Accreditation of Healthcare Organizations: The JCAHO publishes the *Accreditation Manual for Hospitals* annually. The manual defines, in general terms, the standards for each department in a hospital including the nursing department. The hospital's policies and procedures are derived or revised using these. (JCAHO 1993, 79–84)
- State statutes (nurse practice acts): These, together with various rules and regulations issued under the statutes, define the requirements for licensure, grounds for actions against licensure, and the scope of practice. State boards of nursing may publish standards in the nurse practice acts or in the rules and regulations enforcing the acts. These may guide the court in a determination of nursing malpractice.
- American Nurses Association (ANA): The publications catalog of the ANA lists a number of generic standards applicable to various nursing clinical practice settings and specializations.
- National League for Nursing (NLN): The NLN defines the standards of nursing education at all levels. Ultimately these should be transferred to standards of care as high standards of teaching should engender high standards in professional practice.
- Nursing textbooks and professional journals (*not* nursing magazines): These must be accepted as authoritative publications whose authors are considered experts in their field. Many of the journals are published by the various national nursing specialty organizations and associations.
- Professional nursing organizations and accrediting agencies: Most of the nursing specialty organizations publish and distribute standards applicable to their members. It is an inherent right of any profession to define the credentials for admission to, and continuing association with, the group and the conduct required of each member.
- Federal and state statutes: Relevant laws include those applicable to Medicare, Medicaid, and Social Security.

Internal Sources

Internal sources of the standards of nursing care include the policy and procedure manual of the institution and a nurse's particular job description.

Policies and Procedures of the Institution

A policy is a general statement of a goal or a purpose. Procedures are the steps defined to attain goals or desired outcomes. A policy and procedure manual is not necessarily the definitive source for standards of care. It may merely be an accumulation of protocols, standards, and guidelines that have been in place since the last accreditation visit by the JCAHO. These may not reflect revisions and updates directed by the annual *Accreditation Manual.*

Not all policies need be in writing to be accepted as such. An unwritten policy with which all nursing staff is familiar is a valid policy. The problem of potential liability arises when the hospital fails to confirm such awareness among all staff members. For maximum protection of all concerned, all policies and procedures should be in writing, disseminated, and available to all personnel.

It is essential that a policy and procedure manual be updated constantly so that the professional nursing staff utilizing it is functioning at all times under the most currently defined standards of practice. All policies and procedures need to be consistent with both national and state standards. The nurse who relies on the content of an outdated manual incurs an unwarranted liability. Nurses should demand that administration provide them with current standards where and when deficiencies are identified.

Every nurse must have a thorough knowledge of the institution's policies and procedures, particularly those that bear directly on a particular position. In cases of nursing malpractice, courts have usually permitted introduction of a policy and procedure manual in defining applicable standards of care. The nurse who acts in compliance with the hospital's policies and procedures can affirm in his or her own defense that these standards have been met. Employee handbooks provided to nurses, and which may include rules, regulations, and selected standards, may be equally binding and could be used to demonstrate deviations by a nurse that can be considered failure to meet a standard of care.

The merits of the hospital's policies and procedures and the content of their standards of care will, to some extent, be dictated by the level of care provided by the hospital, its location, and its affiliations—if any. A university medical center may be held to higher standards than those expected of a rural community facility. However, this is no guarantee of a higher caliber of patient care. A hospital may draft and implement standards of care that are superior to those it has considered as prevalent in its general area of service. The nursing staff of that institution will be held to those standards, as high and as demanding as they may be. Every effort should be made to assure that all standards of care are realistic and attainable. The minimum

standards of the institution should be reasonable and not impose undue onus—professional or legal. If a hospital prescribes standards that are inferior to those prevailing, the nurse will be held to those that have been defined as acceptable by and for the profession—those in prevalent use.

A policy and procedure manual may contain a statement condoning the use of independent judgment by the nurse in certain situations. When such discretion is allowed the nurse need be especially cautious and aware of the heightened potential for liability. Every nurse should be thoroughly familiar with the section of the manual that presents the institution's chain of command.

Job Descriptions

A nurse's job description may or may not include a definition of the standards of care applicable to his or her particular position and duties.

APPLICATION OF STANDARDS OF CARE IN NURSING PRACTICE

Standards of nursing practice enhance the professional standing of nursing. They are the criteria, the touchstone, that validate professional nursing practice. However, the number and variety of nursing standards confound and confuse nurses. The ideal would be a formulation of a body of national standards that might provide a more cohesive, systematic, and consistent approach to patient care. An embodiment of generic standards could serve to improve standards of care generally, patient care directly, and the status of the profession inevitably. Efforts must continue to coalesce local, state, institutional, and organizational standards into a useful, manageable, and universally applicable and acceptable resource. Specialization presents the most formidable challenge.

It has been said that: "[S]tandards of care are what everyone would like to see rather than objective statements of how things really are. . . . A common concern has been that standards often have no basis in sound scientific research. They are more often than not based on the 'textbook' patient and case studies" (Moniz 1992, 59). In short, they can be overly generalized statements of ideals with questionable relevancy to the fluid realities of clinical practice and limited applicability to the dynamics of the experiences and exigencies encountered moment by moment.

Those same standards, which have served to distinguish the nursing profession and enhance public awareness and appreciation, will also increasingly expose nurses to closer scrutiny, greater expectations, and greater liability. As court decisions during the past two decades show, an ominous

trend of inclusion is likely to continue as increasing numbers of nurses will be called upon to defend themselves in malpractice litigation.

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5

The Nurse at Risk for a Malpractice Lawsuit

COMMON BASES OF NURSING MALPRACTICE LAWSUITS

There are a number of common bases that have been consistently identified as giving rise to malpractice lawsuits against nurses. These can be grouped into seven principal categories:

1. Safety: Failure to ensure patient safety and make this a priority—incidents of patient falls continue to be a major cause of malpractice suits against nurses who did not recognize possible risk factors and/or failed to take appropriate preventive measures.
2. Medication administration errors: Most such errors are the result of failure to follow the basic techniques and guidelines of medication preparation and administration. Parenteral medications are a primary risk. One or more of the six "rights" had not been observed: the right (1) patient, (2) medication, (3) dose, (4) route, (5) time, and (6) technique.
3. Assessment and monitoring: Failure to properly monitor, assess, and report a patient's status—this has been identified in a majority of malpractice lawsuits.
4. Procedures and treatments: Improper or inadequate nursing intervention—not following the institution's policies and procedures, including risk management principles.

5. Equipment misuse, defect, or failure: Using equipment without proper training; failure to test equipment before use, and to read instructions, specifications, and warnings; attempting to repair, adapt, or modify equipment—the increasing use, complexity, and sophistication of medical devices have created innumerable possibilities for injury and liability.
6. Communication: Breakdown between nurse and physician or among other members of the health care team, not listening to the patient—the nurse can be liable for failure to report the errors or impairment of others responsible for patient care.
7. Documentation: Inadequate documentation in nurses' notes is a *principal* factor in adverse court decisions in malpractice lawsuits.

A failure in any one of these seven general categories can turn the best practitioner into a defendant. It is a common misconception that injuries occur principally in the high-tech, high-stress, and fast-paced setting of emergency rooms or intensive care units. In actuality, the more "mundane" setting of a medical-surgical unit and the routine tasks of basic patient care have been identified in a predominant number of patient injuries and negligence suits.

THE NURSE MOST LIKELY TO BE SUED

The nurse who may be at greatest risk of being sued is one who appears oblivious or unresponsive to the needs of his or her patients. The nurse may fail completely in identifying and/or responding to the needs of either the patient, the family, or both. This individual may be rigid, autocratic, and peremptory in his or her interpersonal relationships with both patients and peers. This is the nurse who is perceived to *give* care, but not *to* care.

The practitioner who attempts to care too much is also at risk. The conscientious, dedicated nurse who oversteps the limits of his or her clinical skills, training, and professional knowledge in providing what may well be meticulous care, places him- or herself and the patient in jeopardy. No matter how well-intentioned, the nurse who accepts an assignment, or has an assignment imposed on him or her for which he or she is not prepared by education, training, or experience may be inviting a malpractice lawsuit.

THE PATIENT MOST LIKELY TO SUE

There are several traits or behaviors that have been consistently identified in the litigious patient. If a patient (or a family member) exhibits any responses to nursing or medical interventions that appear unwarranted or

irrational, and that persist in spite of sincere efforts to resolve them, such an individual may be predisposed to filing a lawsuit. The nurse can expect to hear suggestions, hints, or outright threats and warnings of an intent to sue. These must be documented in detail and risk management staff should be advised.

Before this patient leaves the hospital, he or she may have asked for, and written down, the name of every caregiver that patient has encountered. Just prior to discharge, the patient, or a family member, will demand to review the medical record—if he or she has not already made such demands during the course of his or her stay. Throughout their hospitalization such individuals will constantly criticize or question the staff regarding every detail of the care they are being given. They may be observed taking notes of conversations or events. These patients may be angry, hostile, abusive, even combative. Nothing will mollify them. They will overreact to every perceived deficiency, criticism, or slight, no matter how trivial. As any nurse knows, this may be an unwitting attempt to project their fear, anger, and stress onto others.

The opposite of the angry, violent, verbally or physically abusive patient is the inordinately passive one. This is the individual who displays constant and excessive dependency on his or her caregivers. The caregiver is challenged to persuade this person to assume some responsibility for his or her own care and recovery. An even greater challenge is presented by the patient who is determined to assume full responsibility for, and direction of, the medical and nursing regimen. This individual will participate selectively or not at all. At any given moment this patient may decide to discharge him- or herself regardless of all efforts of dissuasion. *Document* such behaviors!

PREVENTING A LAWSUIT

Having identified the type of nurse who is likely to be sued and the type of patient who is likely to sue, there are several strategies for health care providers that may help keep both parties out of court.

- Be a *patient advocate* at all times.
- Carry out the nursing process meticulously.
- *Document* that care meticulously. This may be *the* most important factor in personal risk management.
- Know and apply the standards of nursing care.
- Know and utilize the institution's policies and procedures.
- Recognize the limits of your knowledge and skills.
- Constantly strive to improve your knowledge and skills.

- Nurture professional growth in yourself and others.
- Assume professional accountability for your own actions, those of your peers, and those of your subordinates.
- Cultivate an awareness of the legal and ethical issues surrounding nursing practice.
- Listen to your patients. Address their fears, needs, and anger.
- Approach each patient with sincerity and concern.
- As difficult as it may be, try to treat the "difficult" patient as you would the pleasant, cooperative patient—as a professional should.
- Above all, protect your *patient first*, then yourself. Identify all risks—in your patients, yourself, your peers, and your environment.

OTHER INSTANCES OF POTENTIAL LIABILITY

There are several other situations that can involve nurses—particularly those in any supervisory capacity—in potential liability for malpractice.

Unlicensed Assistive Personnel (UAP)

At a congressional hearing in Washington on October 19, 1994, several nursing associations, including the American Nurses Association (ANA), addressed the profession's concerns with the growing trend in the American health care system directed at reducing hospital costs by cutting registered nurse staff and replacing these professionals with Unlicensed Assistive Personnel (UAP). The nurses who testified affirmed that such efforts are shortsighted and in the long run will prove ineffective in achieving the goal of cost reduction. The legal risks and implications of these measures to the nursing profession have just begun to be examined and could open a whole new field of legal questions, cases, and precedents.

Changes in the health care industry, particularly the trend toward managed care, will continue to place cost-cutting pressures on institutions. This, in turn, is likely to result in increased utilization of UAP for direct, hands-on patient care in selected clinical nursing settings. These may be called "care support associates", "multiskilled technicians", "patient care technicians", "patient care associates", or simply, "technicians". This national trend began in California in the latter part of the 1980s, and has become widespread. The traditional role of the professional nurse is being reevaluated as concepts of patient care and staffing change and evolve. A number of nursing schools are now training UAP.

The ANA has been monitoring the educational preparation and the utilization of UAP for four decades and has continued to do so in response to widespread deficiencies or differences in state nurse practice acts regarding the education, training, utilization, and legal status of such personnel. The delegation of patient care, and the registered, licensed nurse's legal accountability is defined in most acts. At the time this book was being prepared, only the state of Oklahoma had a certification procedure for UAP. Other states have been considering legislation that would place education and licensure of UAP under the jurisdiction of a state's board of nursing.

In its 1994 report on this topic (*Registered Nurses and Assistive Personnel*) the ANA affirmed that the registered nurse is responsible, legally and clinically, for the actions of those UAP assigned to them and under their supervision in the provision of patient care. The ANA's position on the replacement of licensed professionals with unlicensed staff confirms their belief that:

> Patient care and safety are at risk due to decreased levels of registered nursing staff in health care institutions across the country. . . . Many hospitals, as part of their process of restructuring the workforce, have established new staffing patterns that have diminished the quality of care and may put patients' and providers' safety at risk. . . . [The] ANA believes that safety and quality of health care services are the highest priority and an obligation for health care institutions. . . . Regrettably, many health care institutions appear to be losing sight of this fundamental mission and instead are focussing on saving money by cutting the nursing staff. (American Nurses Association 1994, 11)

The increasing use of UAP has raised serious and legitimate questions and concerns among professional nurses regarding patient safety and well-being and the quality of care being provided by such personnel. Nurses have protested the decreasing numbers of professional nursing staff being utilized in patient care together with the increasing responsibilities, legal liability, and risks inherent in supervising the UAP who are *displacing* them. Their fears are grounded in a perception that UAP are *replacing* them.

The registered nurse, or any other health care provider, who delegates patient-care tasks to such personnel must be aware of the implications of legal liability under the doctrine of vicarious liability. In delegating responsibility, the nurse becomes a *supervisor* (as discussed later in this chapter). Supervision is defined as assigning, guiding, directing, monitoring, and evaluating a subordinate. This imputes responsibility and potential liability whether or not the nurse is physically present at all times. The nurse becomes liable if he or she failed to assure that the patient received proper

care—that is, the same degree of care that would have been given by the nurse, personally. The UAP must function as a *supplement, not as a substitute* for the licensed professional!

A practitioner increases exposure to legal liability when he or she fails to follow certain guidelines in delegating patient care. Such oversight could leave that individual open to a charge of breach of duty. Examples of such failures are outlined in Table 5.1.

Table 5.1
Potential Failures in Delegating Patient Care to UAP

- Fails to assess a patient personally and thoroughly before delegating care of that patient to UAP
- Fails to personally monitor the patient's ongoing status
- Assigns UAP to patients whose status or complexity of care demand a licensed professional nurse as primary caregiver
- Delegates tasks or procedures to UAP that are the exclusive prerogative of a registered nurse—by law or by the policies of the institution
- Delegates tasks or procedures to UAP without confirming that such staff have the proper training or experience for the assignment
- Fails to supervise UAP adequately; the nurse at risk is the nurse who assumes that someone else will do his or her job
- Fails to document the details of the assignment and the patient's response

Supervisor Liability

Nurses, by education, training, and tradition, are sometimes imbued with a conviction that they are personally responsible for *every* minute detail of patient care and, consequently, *every* mishap. This perception is misguided and can be self-destructive. Liability in the law demands individual responsibility from the individual in whom that responsibility is invested.

The nurse responsible for supervising, delegating, or assigning professional and nonprofessional staff faces a gamut of legal risks and liability exposure. As a practitioner moves away from the bedside and into a management position, the risks of malpractice in patient direct-care decisions declines but is supplanted by the risks inherent in managerial and supervisory decisions—any of which could ultimately involve a claim of malpractice.

On May 23, 1994, the United States Supreme Court, in a five-to-four decision (written by Justice Kennedy) found that a professional nurse who, using independent judgment, directs the actions of others as a duty of his or her position can be considered a *supervisor*. A statutory definition of a nurs-

ing supervisor, therefore, is any nurse engaged in assigning, overseeing, and providing "responsible direction" for the performance and actions of licensed staff or unlicensed assistive personnel. Justice Ginsberg, in a dissenting opinion, maintained that staff nurses, as professionals, should not be considered supervisors while carrying out their routine duties which, by their nature, involve independent judgment in assigning, directing and, supervising other staff. The justice opined that the definition of the majority was far too broad and its implications too sweeping (Furmidge and Barter 1994, 10).

A supervisor, in delegating assignments, transfers responsibility for the performance of the assignment but retains ultimate accountability for the consequences. Assignment is a delegation downward; co-assignment is delegation laterally. Ultimately, *responsibility* does not shift and situate in either direction. It simply extends and encompasses. A nurse as supervisor will be legally liable only for personal acts or omissions while acting in the capacity as a supervisor. His or her liability can arise when he or she fails to assign and/or supervise properly. A supervisor can be found negligent in assigning *any* staff member to a patient or a unit for which the individual—by declared or demonstrated lack of education, training, or experience—is clearly unsuitable. It is a generally accepted principle that control is concomitant with accountability. The individual who creates and controls the assignment of a subordinate is responsible for the consequences.

Inadequate Staffing

The administrators (including nursing) of an institution are charged with providing and maintaining levels of staffing that will ensure a reasonable degree of patient safety and quality of care. This obligation has been confirmed in numerous court decisions and is addressed in the legal doctrine of corporate liability that was discussed previously in chapter 2. Under this doctrine an institution can incur liability for any harm to a patient that occurs as a result of deficiencies in staffing—including number and caliber of staff.

Floating

An inevitable outcome of institutional downsizing will be short staffing. It follows that nurses will increasingly be required to train for and float to various units. A reluctant nurse who responds too rashly to a short-staffing situation may be at risk for a lawsuit. As professionals, nurses are responsible for cooperating in the institution's, and in their own, duty to provide a reasonable level of patient care and to maintain patient safety. Individuals

who refuse to accept a float assignment do so at their own peril. If the hospital has a clearly defined policy on such alternative assignments, and these contingencies are included in a job description, the nurse who refuses to float may find him- or herself sunk! The exception is the individual who has a *written* contract, policy, or agreement of some kind that specifies those units to which he or she will be assigned exclusively.

Refusing to float simply because of uncertainty, anxiety, or fear is not a legally or professionally tenable argument. There are times when nurses are professionally, ethically, and legally obligated to decline an assignment. In these instances the nurse's right to refuse must be based on a demonstrated, *documented* lack of training, education, or experience required for the proposed assignment. If an individual sincerely believes that he or she is lacking in these, the nurse should not accede. In the event that disciplinary action is taken against the nurse or he or she is discharged, legal recourse could be possible.

In these situations the nurse must advise the appropriate supervisor of his or her convictions and concerns. These should be communicated in writing if possible and a personal copy retained. The nurse should not be intimidated and should not talk him- or herself into a false sense of confidence and capability. Convictions should be expressed and reservations affirmed. If protests are refuted, the nurse can proceed on one of two courses: (1) take a stand, refuse, and open oneself to disciplinary action or (2) concede, accept, make a best effort to prepare and report for duty. The latter choice, made under duress, should be documented in the nurse's personal anecdotal records.

There will inevitably be times when inadequate numbers of professional nursing staff can potentially compromise the quality of patient care and jeopardize patient safety. In such instances the patient with *a nurse lacking in certain skills and experience is preferable to the patient lacking a nurse.* If there are no other viable options for the patient, the nurse should accept the assignment. The law will expect nothing more than that degree of care that any reasonable and prudent individual would provide under the circumstances. It recognizes that every professional nurse should be able to function to some degree in any clinical setting with a basic repertoire of nursing skills. It will not expect or demand perfection. However, that individual will be expected to seek all appropriate and available supervision and guidance. Constantly weigh the risks and remember that the safety of the patient is the paramount concern.

Abandonment

Abandonment is a nurse's failure to act as circumstances dictate. It is breach of duty. It is a wrongful act of omission and, under the law, a form of

negligence. A nurse who fails to assess and monitor his or her patients in a continuous, timely manner could be guilty of abandonment. The individual who refuses to work overtime when overriding needs of patient care demand such effort might be charged with abandonment. So also the nurse who leaves an assigned unit without proper permission or without adequate notification. Refusing to float could be construed as an act of insubordination and/or abandonment unless the individual can show that a contract, a hospital policy, or a documented lack of required competencies precluded acceptance of an assignment.

Giving Advice

Nurses are frequently called upon for advice and assistance in other than clinical situations. Before responding to any requests for advice, or services as a volunteer, one should consider several questions:

- Am I covered under my personal malpractice insurance policy for any potential liability?
- Is my action within the scope of nursing practice as defined by the nurse practice act of my state?
- Am I qualified by training, experience, and education?
- Is my advice or action consistent with defined standards of nursing care and appropriate to the situation?
- Will I be able to defend or justify my action if necessary?
- Am I the appropriate source of advice or intervention, or must I decline and provide a referral to an alternate source?
- Will I create the impression that what I propose is the most feasible or the only course of action?
- What would another nurse do in this situation?

A nurse should *never*, under any circumstances, offer any advice that could be construed as *medical* in nature. This is tantamount to *practicing medicine without a license*. This is a *crime*! A nurse should never speculate or offer opinions regarding the signs or symptoms of illness in others. Medical diagnosis is the sole prerogative of the physician, and the nurse is obliged to refer the individual with such questions to a physician.

It is very unlikely that a relative, friend, or neighbor of a nurse would consider the act of approaching him or her with casual or serious health questions or concerns to be the initiation of a nurse-patient relationship or the establishment of duty. However, if the well-meaning nurse receives such re-

quests willingly and perpetuates a dependency relationship by continuing indiscriminate advice or intervention, he or she may be creating and cultivating duty and, consequently, liability. The *best advice* about giving advice is *don't give advice*!

Volunteering Services

The same considerations in providing advice apply in the volunteering of one's services. The nurse-volunteer should first confirm that such activities are covered under a personal malpractice policy. He or she should also inquire about the insurance coverage of the organization with whom he or she will be affiliated during the volunteer experience. The nurse-volunteer will be held to the same standards of professional care in this setting as in a clinical setting. It is advisable that the nurse who provides such services personally document these in as much detail as possible without compromising confidentiality.

If any procedures, treatments, or medications are to be given, the nurse should request and review all appropriate physicians' standing orders or protocols before initiating these. When acting as a volunteer the nurse should never request or accept any form of compensation that could be interpreted as establishing a fee-for-service relationship.

LIABILITY RISKS IN ADVANCED PRACTICE NURSING

The evolution of nursing science and the expansion of the scope of nursing practice has produced an increased body of knowledge as well as multiple levels of nursing. These are most exemplified by the emerging role of the advanced practice nurse (APN). The professional designation "advanced practice nurse" is an umbrella term, which includes primarily nurse practitioners, nurse anesthetists, nurse midwives, and clinical nurse specialists. There are some who might assert that this distinction represents a fragmentation rather than an advancement.

The need for APNs is expected to increase by 300 percent by the year 2000. This growing trend reflects a combination of health care consumer demand, a vigorous campaign by the nursing profession, and our evolving health care system with its increasing emphasis on cost containment. "The demand for nurses practicing in advanced rules with greater autonomy has increased. Federal regulations requiring statutory recognition of advanced nursing for third party reimbursement have been a catalyst in many jurisdictions for the regulation of advanced nursing practice" (National Council of State Boards of Nursing 1993a, 1).

There has been an increasing incidence and recognition of the merging and duplication of many facets of medical practice and those of other health care providers—particularly APNs. Many physicians consider this encroachment and usurpation rather than extension and enhancement. Increasingly APNs are functioning independently in primary care settings, autonomous from the direct or indirect supervision of a physician. Health maintenance organizations, Medicare, Medicaid, and other insurers are beginning to expand the accreditation and utilization of nurses in roles traditionally reserved for physicians. The medical establishment has vehemently opposed the concept.

All fifty state boards of nursing have language that addresses APN practice (National Council of State Boards of Nursing 1993b, 1). In recent years, twenty-six states have passed laws permitting nurse practitioners to provide health care services without subservience to a physician. A number of others, including New York and California, still require oversight by a physician. In every state except Illinois, APNs are permitted prescriptive privileges with varying restrictions.

At this time, the trend is a nascent one. As the federal government and the various states enact new laws, the roles and responsibilities of the APN will continue to evolve and expand as will increased risks for legal liability. The nursing profession and the legal system are just beginning to address the issues involved in advanced practice nursing. There have been malpractice lawsuits involving APNs and there will be many more. There have been many lawsuits initiated by physicians alleging that APNs were engaging in the unlawful practice of medicine, and there will be many more. It is hoped that future nursing research will address the implications of the role and the concomitant issues of legal liability.

"The public has a right to the access to health care, and to make informed choices regarding selection of health care options through knowledge of the area of expertise, qualifications and credentials of individuals who provide health care" (National Council of State Boards of Nursing 1993a, 3). The public has a right to seek redress in law if their choices prove injurious.

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6

The Legal Process

STEPS IN THE LEGAL PROCESS

Malpractice lawsuits against health care providers can vary widely in the bases, issues, questions of law, and complexity of a particular case. There are certain procedural requirements common to all such cases. These are defined in the applicable rules of the court (state or federal) that will have jurisdiction in the lawsuit. Most civil cases are tried in state courts. Each lawsuit begins with an event that gives rise to a claim of malpractice—the basis for legal action—and ends with either a settlement by the parties or a judgment by a court. From beginning to end, a variety of legal maneuvers intervene. The legal process is outlined in Table 6.1. Each step in the process will be discussed in further detail.

Table 6.1
Steps in the Legal Process

Incident of alleged malpractice and alleged injury

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Injured party retains an attorney

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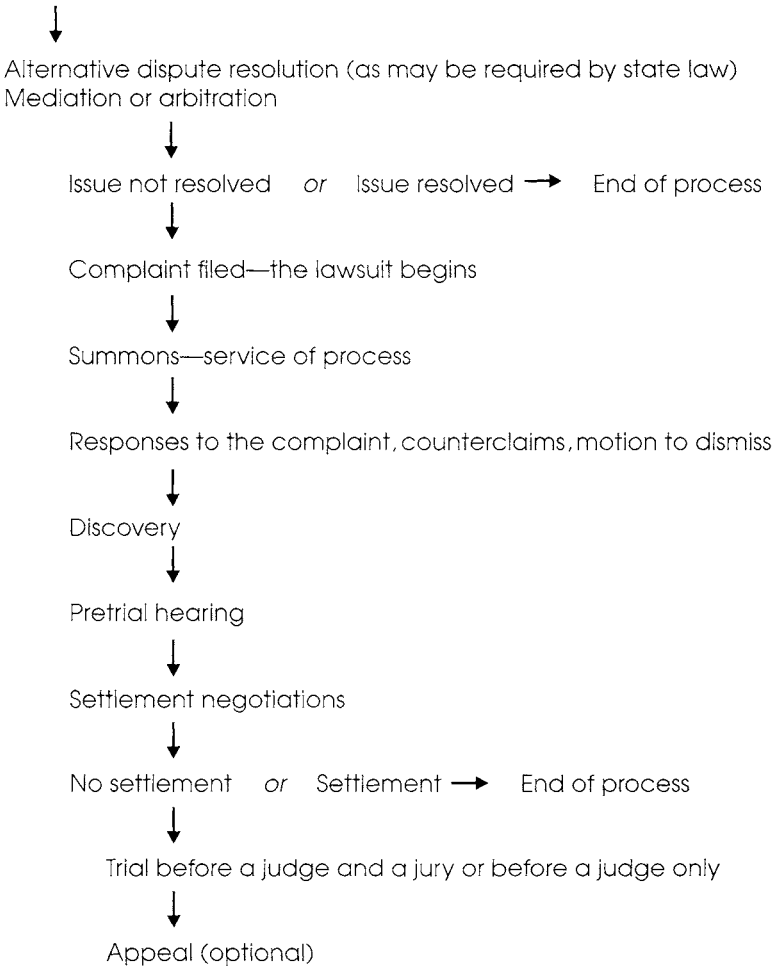

INITIATION OF A MALPRACTICE LAWSUIT

Most states have clearly defined rules, procedures, or protocols that all members of the legal profession are expected to adhere to under threat of censure, revocation of a license to practice, and disbarment. These include a requirement that an attorney must present a legitimate rationale for the filing of a lawsuit, including the intent of filing in good faith. The attorney who initiates a suit that is deemed frivolous, or that lacks any inherent merit, can be subject to censure or disciplinary action by the appropriate bar association.

The *parties* in a lawsuit are the plaintiffs and the defendants. The plaintiff is the party who initiates the lawsuit. A malpractice lawsuit can begin when a patient perceives himself or herself to have suffered an injury of some kind at the hands of a health care provider. If the patient has died, the next-of-kin might make the decision to sue, particularly in a claim of wrongful death. If the patient has been adjudicated to be incompetent, a legal guardian might initiate the suit.

The patient, now plaintiff, will then contact an attorney—ideally a reputable trial lawyer with extensive experience in malpractice litigation. It is at this time that many potential litigants are rebuffed in their efforts. A very large percentage of suits are turned away by lawyers because they are specious, the claims are tenuous at best, no serious injuries have been sustained, or the amount of damages that could be recoverable are minimal.

Pursuing a case of malpractice can represent a significant commitment of time and money on the part of an attorney whose anticipated fee is usually contingent on the amount of damages awarded by a court or the amount of compensation offered in any settlement. If the anticipated amount is considered insufficient to cover desired fees and projected expenses, an attorney might decline the case. It is the attorney's prerogative. However, there are many lawyers who will accept a case on its merits alone and provide their time and talents to ensure a client's welfare. They will serve *pro bono*—that is, without consideration of personal financial compensation. If the plaintiff's assertions and claims are considered to have merit, the attorney can elect to accept and pursue the case and the legal process formally begins.

PRETRIAL ACTIVITY

Prior to the beginning of any eventual trial, there are a number of processes and procedures that are undertaken by both parties in the lawsuit. The following are descriptions of these several activities.

Informal Investigation

At this stage, the patient-plaintiff and any witnesses are interviewed; medical records and other relevant documents are obtained and reviewed. Expert witnesses or consultants will be retained to review the medical records and prepare their opinions. The objective of the investigation is to identify and locate any and all factual evidence that could be used by either side to support his or her case and impeach the parties, evidence, or witnesses of the opposing side, or which could be the basis of a settlement offer.

It is estimated that 90 to 95 percent of malpractice suits are settled out of court, most after the lawsuit has been filed but before a trial begins. In these instances, pretrial investigations, informal or formal, provide each side with the opportunity to assess the issues, the merits of the claims, and the strengths and weaknesses of their case, and come to a much quicker, less expensive, and less adversarial resolution of the case.

Prelitigation Panel

Before a malpractice lawsuit reaches the trial stage the plaintiff may be required by state law to submit his or her case for review by a prelitigation panel that can be an arbitration panel, a medical review board, or a medical tribunal. Such requirements vary by state. A prelitigation panel may be made up of physicians, nurses, dentists, or other health care professionals, and usually includes lawyers as well. The attorney for the plaintiff submits the claim and all evidence forming the basis of the claim to the designated panel for review. Unless arbitration has been directed, or other requirements are defined, the suit proceeds to trial following this review procedure. These proceedings can add six months to one year to a legal process that normally can go on for three to five years. Many critics consider this a needless, expensive delay that works to the disadvantage of a plaintiff. To defendants they represent a means of discharging nuisance suits and frivolous claims.

Alternative Dispute Resolution

Once a plaintiff files the lawsuit, the court system takes over and the process and timing of events is determined by the formal rules of the system. The process, by its nature, is structured, adversarial, and time consuming—very time consuming! More and more cases that have traditionally been decided within the judicial system are now being settled by alternative dispute resolution (ADR). A court trial is no longer the only option in settling civil suits. A trial is generally the last resort desired by parties in the legal process because of the time, costs, and uncertainties involved in pursuing a lawsuit in which there may be no significant damages or issues.

For these reasons, many civil lawsuits are referred to alternative dispute resolution that could include: (1) negotiation—the parties in the suit meet informally to resolve the matter and consider terms of a settlement agreement, (2) mediation—a neutral third party acts as an intermediary who *proposes*, but does not *impose*, solutions on the parties, and (3) arbitration—a neutral third party (or a panel) makes a decision that may or may not be legally binding on the parties.

Alternative dispute resolution invests control of the dispute process in the parties themselves. Each side is permitted to reach a mutual agreement on when, where, and how long they will meet, what will be discussed, who will be present, and whether the final decision will be binding or nonbinding on the parties. The final decision can be arrived at in a matter of hours, days, or perhaps months.

In some instances, judges who are overburdened with case loads are ordering the parties in certain lawsuits to attempt ADR. Cost containment efforts in the health care industry have motivated hospitals and health maintenance organizations (HMOs) to resort to ADR in efforts to resolve disputes.

Negotiation

The parties themselves and/or their attorneys, meet privately in an effort to resolve the issues and come to a settlement agreement without outside intervention.

Mediation

In mediation, the mediator, an independent third party, endeavors to bring both sides together to negotiate an agreement. An effort is made to make the proceeding a meeting of minds rather than a confrontation of wills. If an agreement is reached, it is a contract that is then legally binding on both sides. If either side fails to comply with the terms, either side could be liable for breach of contract. If no agreement can be reached in spite of the mediator's efforts, the dispute can be pursued further by a lawsuit or by arbitration.

Arbitration

Arbitration is a more formal process. There is some semblance of a court proceeding here. There are opening statements, presentation of evidence, examination and cross-examination of witnesses. As in mediation, a neutral third party—individual or a panel—considers the argument of both sides in the dispute and is then charged with deciding in favor of one side or the other. That decision is final, binding, and enforceable on both sides if both have previously agreed that the decision would be so. An appeal to a court of proper jurisdiction is possible. However, the courts have shown some reluctance to overturn decisions in arbitration and in some cases have not accepted jurisdiction over such matters.

Filing of a Lawsuit and Service of Process

These next steps are magisterial rather than maneuvering. They are the setting out of one's position rather than the jockeying for it.

Filing of a Lawsuit

Filing the lawsuit is the first formal step in the process of litigation. It establishes the date on which the suit officially begins, and it informs the court of jurisdiction of the suit, which now becomes a matter of public record.

The first step is the filing of the *complaint*. The complaint is a list of the claims that are being made by a plaintiff against a defendant. It identifies the parties and states the cause of action. The purpose of the complaint is to introduce the cause of the action that has been filed, invoke the jurisdiction of the court in which the action is being filed, present the claims, and advise a defendant of why and by whom he or she is being sued, and for what form of damages. It is a formal declaration of all the general allegations of injury that the plaintiff will endeavor to prove were caused by the defendant.

The complaint will also contain a statement of the court's jurisdiction, ("jurisdictional allegations") in the matter. It also constitutes a formal request to the court for redress under the law in the form of a judgment for the plaintiff ("prayer for relief"). There will be a demand for remedy, usually money damages in a specific amount, if this is permitted by law. The complaint must be filed within that period of time prescribed by procedural law—the statute of limitations. These statutes vary by jurisdiction and type of case.

Summons

A summons identifies all parties in the lawsuit and indicates the court of jurisdiction in which the case will be tried. It also directs a defendant to respond to the complaint within a specified time period. It "summons" the defendant to appear and defend him- or herself.

Service of Process

A copy of the complaint and the summons is "served on", delivered to, the defendant. This is *service of process*. Before a court can exercise its jurisdiction over a defendant—before a lawsuit can formally begin—the court must have proof that the defendant has been officially and legally notified of the lawsuit and the defendant's need to respond to it. Service of process also gives the court personal jurisdiction over a named defendant; this is necessary to enable the court to impose any legally binding judgment on the defendant. Collectively, the formal documents filed in a lawsuit in

which both plaintiff and defendant state facts, claims, issues, and defenses in the case are called *pleadings*.

Discovery

The formal investigation that involves the exchange of information and documents between attorneys for opposing sides is called *discovery*. This process of exchange is governed by court rules of procedure and sanctions. Generally all information that is not privileged, that is relevant to the lawsuit, or that might lead to additional admissible evidence is discoverable. It is at this stage of the legal process that both sides make every conceivable effort to "discover" all the evidence, facts, circumstances, events, and details that may be relevant to the alleged instance of malpractice. In addition to such information, facts, and data, the process will also assist the plaintiff's attorney in identifying any additional possible defendants; and either side may identify witnesses to facts of the case. Discovery will preserve all of the information derived for possible use at a trial.

The purpose of the discovery process is to assure that all of the parties in the lawsuit are fully informed of all of the facts and of all the contending claims regarding the facts. These include both the evidence and the witnesses to be presented by either side. The objective is, ideally, to provide both sides with an equal advantage in the overall preparation of their case and the strategies and tactics they will pursue in prosecuting or defending it. The case can then be tried on the merits, the evidence, of the case. Ideally it eliminates any untoward surprises and trial by "ambush".

The process of discovery serves to define the primary issues of dispute in the case so that in the event of a trial the focus will be on these, resulting in a more expedient trial. If all parties agree on the facts and issues, discovery can facilitate an out-of-court settlement or possibly a summary judgment. If the process reveals that there is, in fact, no basis for the lawsuit, it can result in a summary judgment or dismissal of the case. Discovery is the longest and most arduous step in the legal process. Under certain conditions, the courts can impose limits on the discovery process.

MECHANISMS OF DISCOVERY

There are various methods used in obtaining information and facts relevant to the alleged incident of malpractice. Which means of discovery and the extent to which employed will be directed by the nature and complexity of the case and the amount of damages claimed. The mechanisms of discovery include:

- interrogatories: written questions submitted to any party;
- requests for production of documents and things;
- motion for an order to submit to medical examination of a party;
- request for admission of facts;
- reports and opinions of experts; and
- deposition: oral statements of a witness or party questioned under oath.

Interrogatories

Interrogatories consist of a series of written questions submitted by each side in the lawsuit to the parties on the opposing side. These questions may request very specific information and detailed answers, or they may be very general in nature. The total number of questions permitted under procedural rules can vary by state as can the time allowed for responding to the questions. The usual time permitted is thirty to sixty days.

Interrogatories may request answers the content of which can be considered confidential or privileged by either side, and they can refuse to answer such questions. In this case, an attorney can file a motion requesting a court to direct the answering of any questions that are demonstrated to be relevant to the case.

Each side must submit its written answers to the questions under oath. Under no circumstances should a nurse-defendant attempt to formulate answers and respond to the interrogatories without the direction and supervision of an attorney. The attorney will review each question with the nurse and collaborate on an appropriate, consistent response. The nurse-defendant may be requested to prepare preliminary drafts of answers. The final phrasing of the answers must be done very carefully to avoid any ambiguity or any suggestion or actual admission of liability. Neither side will wish to provide any more information in a response than is absolutely necessary.

It is in responding to the interrogatories that the patient-plaintiff is initially confronted with the duty of accurately and honestly presenting the details of the injuries alleged. In answering, he or she is challenged to define the nature and extent of those injuries—physical and/or emotional—which form the basis of the lawsuit. The assertion of blame for these will be found in the complaint.

The interrogatories directed to the plaintiff will attempt to elicit extensive and detailed facts regarding past medical history, occupational status—past and present—and any history of prior suits or insurance claims. They may attempt to explore the plaintiff's economic, social, edu-

cational, and family background. The questions could delve into very personal aspects of the respondent's past and present lifestyle.

A primary focus for the questions by the defense will be the plaintiff's medical history. The responses to these questions will be compared with the medical records and may also provide a resource for locating other medical records that can then be obtained and reviewed for possible relevancy. Such a review and comparison should reveal any attempt to hide any facts such as prior medical conditions, hospitalizations, treatments, and evidence of prior noncompliance with a medical regimen.

The medical records will be examined for evidence of any contributing or alternative causes of the plaintiff's alleged injury—particularly his or her own acts or omissions. Should any discrepancies or contradictions be identified in comparing past medical records with the present ones or with information in the interrogatories or the deposition, the defense will use these in an attempt to impeach the credibility of the plaintiff.

The details of the allegations will be compared with past and present medical records to determine if the injuries now claimed are new, or if they are a recurrence or exacerbation of a prior condition that in some way may have contributed to the present complaint. The objective is to place the plaintiff in the position of having to prove that the injuries claimed were the result of, and caused by, the defendant's act of malpractice. A review and analysis of the medical record may demonstrate that the patient was not injured or, if an injury actually occurred, the nurse-defendant is not liable.

Interrogatories directed to the nurse-defendant will include the nurse's education, professional credentials, past and present employment history, any prior incidents of malpractice suits, actions by state boards, criminal history, certain personal data, and clinical knowledge and details specific to the alleged incident.

Reports and Opinions of Expert Witnesses

In the interrogatories, each side will require the name, address, and title of every expert witness who is expected to be called at the trial. The particular subject they will address and a report of the general nature and substance of the facts and opinions to be expected in their testimony is also requested, together with a summary of the bases, the authoritative sources, for their opinions.

In nursing malpractice cases, nurse expert witnesses are usually retained by attorneys for both plaintiff and defendant. The standards of nursing care are *interpreted* (not established) by the testimony of a nurse as expert witness. His or her duty is to give an opinion on breaches in the accepted stan-

dards of nursing care, if any, the nature and extent of any injury, and causation. Note that the *opinions* of an expert witness are admissible in a trial. He or she does not serve as witnesses to facts. Professional nurses also function as *consulting* experts in cases of nursing malpractice. In this capacity, their opinions and reports are considered "attorney's work product" and are generally not discoverable. The roles of the testifying and consulting expert are discussed in detail in chapter 16.

Requests for Production of Documents and Things

The second procedure in discovery may be the request for production of documents and things. Each side requests the opposing side to provide any and all items in any form that would be relevant to the conduct of the case, the issues, the allegations, and which might be used as evidence. Certain information may be considered nondiscoverable and protected from disclosure or release. Many states, by statute, close certain files to public scrutiny, including that of attorneys involved in litigation.

Motion for an Order to Submit to Medical Examination of a Party

For the order to submit to medical examination of a party method of discovery, the defendant's attorney may file a motion requiring a party to be examined by a physician of the defendant's choice or by a physician mutually agreed on. This is in effect a second medical opinion. The objective is to confirm and define the nature and extent of the injuries claimed by the plaintiff and to determine his or her present status both physical and emotional. Another purpose is to identify the plaintiff as a possible malingerer.

Request for Admission of Facts

The request for admission of facts tactic of discovery consists of written requests presented by each side to the other. These ask that certain facts relevant to issues in the suit be admitted or denied. These could be such things as dates, times, locales, or other basic facts or details on which both sides can readily agree or disagree. The purpose of this request is to have the opposing side admit certain facts that will then not have to be proven or contested at a trial by separate evidence. Limiting the number of facts or issues in dispute can facilitate an expeditious trial.

Deposition

A deposition is the questioning—the examination and cross-examination—of a party, a material witness, an expert witness, or any other individual who has been placed under oath. The individual being interviewed under oath (deposed) is called the "deponent." The questions are presented to the deponent by the attorney for each side in the action. The questions may be in writing ("depositions on written questions"), but the answers must be given orally under oath. The most commonly used procedure is oral questioning ("depositions on oral examination"). In either type, the oral testimony of a deponent is recorded by a court reporter, a stenographer, or other individual legally authorized to administer an oath. An official transcript of all testimony is prepared, and a copy is given to both sides for review of content and accuracy. Unlike the respondents to interrogatories, the individual deponent is expected to answer an appropriate question spontaneously and in his or her own words. The purposes of the deposition are shown in the Table 6.2.

Table 6.2
Purposes of the Deposition

- Discover any and all relevant facts, documents, or other evidence
- Determine each deponent's knowledge and/or version of the facts, any evidence in support of that version, and the location of such evidence
- Identify any and all other individuals who may have evidence
- Assess the strengths and weaknesses of the opposing side
- Prescreen and evaluate all potential witnesses
- Establish the course of action, tactics, and strategies to be pursued
- Elicit evidence that might facilitate a settlement
- Define the nature, extent, and possible causes of the injuries claimed
- Determine the defendant's financial resources—including any insurance
- Prepare a transcription of all testimony given for later use at a trial
- Possibly impeach the trial testimony of a deponent

Deposition is the primary method of discovery. It is typically the most prolonged and most arduous stage in the discovery process. Unlike interrogatories, the deposition provides a pretrial opportunity for attorneys to question individuals other than the parties. A deposition on oral examination is a dress rehearsal for a trial. Because the deposition is that component of the legal process that a nurse, as defendant or testifying expert, is most likely to encounter personally, its protocols will be discussed in some detail

in chapter 8. This will include a number of tips and strategies for the nurse in preparing for and surviving a deposition.

SETTLEMENT

At any time in the legal process—prior to or even during a trial—the parties may agree on an out-of-court settlement. It is usually in the best interests of the parties to settle a case out of court, and attorneys will make every effort to assist their clients in reaching a settlement. Ordinarily it is proposed and agreed upon during pretrial negotiations as an alternative dispute resolution. It is estimated that only 5 to 10 percent of all malpractice suits that are filed progress to a trial; and of those that do reach this stage, only 10 percent actually end in a verdict by a jury.

Such a settlement is *not an admission of liability* by a defendant. It is very often the most expedient way to dispose of the case, and, significantly, may be the least expensive way in the long run. A malpractice insurance carrier will weigh the cost of a settlement against the cost of defending the suit, particularly legal fees, for the prolonged duration of the pretrial proceedings, a trial, and any subsequent appeals. This is a business decision. If the defense determines that their case is very weak or virtually indefensible, they may seek an early settlement as the most feasible alternative when faced with the possibility of a large award in damages to the plaintiff.

Under the terms of his or her malpractice insurance policy, a nurse named as a defendant in a case may play no part in an out-of-court settlement. It might be negotiated, decided, and effected without any prior knowledge on his or her part. The nurse-defendant's consent may not be sought or even necessary. The terms of the insurance policy will define rights, if any, in this decision. For this reason every nurse should read his or her malpractice policy very carefully and understand its provisions completely. (For a detailed discussion of malpractice insurance see chapter 13.)

The compensatory damages (money award) acceded to in a settlement are usually not disclosed to the public. This can be mutually agreed upon by private agreement among the parties, or nondisclosure may be directed by a judge under penalty of contempt of court. However, any and all amounts paid out in damages on behalf of a defendant, either by jury award or in a settlement must, by law, be reported to the National Practitioner Data Bank. (The Data Bank is discussed in chapter 14.) Various states also require the reporting of such payments to appropriate state agencies such as boards of medicine or nursing.

THE TRIAL

A trial can be held with or without a jury, that is, before a judge only. The constitutional right to a jury trial need not be exercised. In most states and in the federal courts, one of the parties must request a jury trial or the right to such a trial is presumed to be waived. The trial is the final stage in the legal process—unless an appeal from a trial verdict is made. It comes after all the proceedings of the discovery process have been completed. The entire process from complaint to trial can take anywhere from three to five years. As previously noted, relatively few malpractice lawsuits ever reach the point of a trial. The greatest majority are settled out of court and well before the attorneys and parties are prepared to enter a courtroom to plead the case. The stages in a typical trial are shown in Table 6.3.

Table 6.3
Stages in a Trial

1. Calling, questioning, and selection of a jury (*voir dire*)
2. Opening statements, introductory remarks, by the opposing attorneys
3. Presentation of the plaintiff's case by examination of witnesses
4. Cross-examination of the plaintiff's witnesses by the defendant's attorney
5. Presentation of the defendant's case by examination of witnesses
6. Cross-examination of the defendant's witnesses by the plaintiff's attorney
7. Plaintiff's rebuttal
8. Defendant's rejoinder, rebuttal
9. Closing arguments, statements
10. Instructions to the jury (if a jury trial)
11. Verdict—by a judge or by a jury

DAMAGES

The complaint filed in the court of jurisdiction contained a "prayer for relief"—a demand for judgment for the plaintiff and for some form of relief. Usually this is in the form of *damages*. The terms "injuries" and "damages" are frequently used interchangeably; however, in the context of malpractice there is a distinct difference in meaning for these two terms. Patients sustain damage. They sue for damages. Damages is the amount of monetary compensation that the plaintiff claims from a defendant for injuries (damage) received at the hands of the defendant. It is the amount of money that the court awards when a judgment is entered for the plaintiff or which is received in an out-of-court settlement. The primary purpose of awarding damages is to

compensate the injured party, to attempt to restore him or her to his or her original status or condition insofar as is possible. There is no intent to punish the defendant by awarding compensatory (*general* and *special*) damages. That is the purpose of *punitive* damages.

Types of Damages

There are three types of damages that may be awarded in malpractice cases. These are (1) general, (2) special, and (3) punitive.

General

Also called "soft" damages, general damages are inherent in the injury per se. They are the natural and direct result of the defendant's negligence. These include physical pain and suffering—past, present, and future—and any permanent disability and/or disfigurement deriving from the injury.

Special

Also called "hard" damages, special damages actually have been, or are most likely to be incurred but not necessarily *directly* from the defendant's negligence. These may represent financial or economic losses and include such costs as medical bills, charges for hospitalization, treatments, rehabilitation, and medications. Included here are loss of income—past, present, and future—and funeral expenses.

Punitive

Punitive or "exemplary" damages may be sought to *punish* the defendant for the egregious nature of an act that the court has deemed malicious, grossly negligent, or wanton. The defendant's act will be the primary focal point in a consideration of such an award, and the plaintiff will be charged with demonstrating that the defendant's conduct warrants punitive damages. A nurse may be seen to have committed very serious errors in judgment or to have failed very badly in the standard of care; however, it is rare that a charge of nursing malpractice would result from gross negligence—a willful, reckless, and malicious act that would warrant an award of punitive damages.

Punitive damages are typically awarded in amounts double or treble those of other damages already imposed. Although they have been relatively uncommon in malpractice cases, there has been an evident increase in the number of such awards over the past several years. Punitive damages have particular significance to a nurse because they are virtually *never covered* by a malpractice insurance policy.

The practitioner should not be surprised to find direct correlation between the amount of damages claimed and the limits of his or her malpractice insurance coverage. Any claims for damages beyond the amount of coverage typically requires the patient's attorney to prove justification for punitive damages. This is rare, as most damage claims fall well within policy limits. If punitive damages are awarded, they are not covered by malpractice insurance and must be paid out of personal funds. Claims for punitive damages often include allegations of fraud or malicious intent to harm. (Lobb, Riley, and Clemens 1994, 4)

In March 1998, the United States Supreme Court (in *Kawaauhau et vir. v. Geiger* [97–115] 113 F3d848, affirmed) eased the way for physicians and others (including nurses) who lose malpractice or personal injury lawsuits to escape damage judgments by filing for bankruptcy. In a unanimous decision, written by Justice Ginsburg, the Court affirmed that malpractice damage judgments can be discharged through bankruptcy unless the defendant intentionally caused an injury. The decision resolved diverging opinions among lower courts where, in some instances, a claimant was allowed to collect from a bankrupt debtor who intended to perform some negligent act that resulted in injury, even if the debtor did not intend to cause a specific injury.

Justice Ginsburg wrote:

> The word "willful" . . . modifies the word "injury," indicating that nondischargeabilty takes a deliberate or intentional injury, not merely a deliberate or intentional act that leads to injury. Had Congress meant to exempt debts resulting from unintentionally inflicted injuries, it might have described instead "willful acts that cause injury." Or, Congress might have selected an additional word or words, i.e., "reckless" or "negligent," to modify "injury." Moreover, as the Eighth Circuit observed, the (a)(6) formulation triggers in the lawyer's mind the category "intentional torts," as distinguished from negligent or reckless torts. Intentional torts generally require that actor intend "the consequences of an act," not simply "the act itself." (Restatement [Second] of Torts §8A, comment a, p.15 [1964])

REFERENCE

Lobb, Michael L., Gary C. Riley, and April M. Clemens. 1994. The legal nurse consultant's role on the defense team in a medical malpractice lawsuit. *Network* 5 (4) (April): 3–7.

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7

Surviving Notification of a Nursing Malpractice Lawsuit

THE NURSE AND THE LEGAL PROCESS

A nurse can be involved in the legal process in several different ways—as:

- defendant;
- expert witness for either side;
- consulting expert for either side;
- witness to facts;
- plaintiff;
- member of a jury;
- nurse-attorney; and
- nurse paralegal.

THE NURSE AS DEFENDANT

Practitioners who have an understanding of the basic principles and doctrines of law, the legal process, and what will be expected of them in the event that they are named as defendants in a malpractice suit will be much better prepared for the anxiety involved in what can be a long, frustrating, and tedious experience. Being named as a defendant in a lawsuit can be a

very stressful experience; the uncertainties of being led into and through the labyrinth of the legal system can compound the stress.

The nurse-defendant's attorney will define the direction and course of the proceedings from the outset. Knowing precisely where you are at any given time and what lies ahead on the route—the detours and the obstacles—will make the journey much easier. Make your lawyer your team partner, your collaborator, and your guide.

The defense attorney you may be required to retain personally, or who will be appointed by your malpractice insurance company, is called your "attorney of record". You have a right to review the qualifications and experience of any attorney assigned to you. You should demand an attorney who is most competent, experienced, and qualified to handle your case.

An insurance company has a great deal at stake in any malpractice claim, and it is to the company's advantage to employ only those attorneys whose credentials and litigation experience will protect them from exposure to financial loss or minimize such loss. That attorney has a legal duty to act in your best interests as well as those of the insurer. Your interests, however, should be his or her priority. If you feel that the attorney has not defined that priority, you have the right to request another attorney. If it would ultimately be shown that the attorney failed to represent you adequately, or in some way was deficient in protecting your interests, you could have legal recourse in a malpractice lawsuit against that attorney.

The attorney should contact you within several weeks to set up an appointment for an initial conference. Make the appointment as soon as possible. At the initial meeting, ask the attorney to review your mutual expectations and duties and outline what you may expect to happen. Request an overview of the applicable law, the proposed case strategy, and a tentative timetable. At that time, you should be given an opportunity to review and discuss the complaint so that you may identify any claims that you consider false or inaccurate.

From the outset, you must provide your attorney with your full cooperation. It is essential that he or she be apprised of *all* facts relevant to the charges against you. It is essential that he or she know everything that could be of value in preparing a defense for your case. From your initial meeting to the final resolution of the case you must be completely honest with your counsel. This includes any and all relevant personal facts about yourself, including any prior criminal convictions or civil judgments against you. All potentially damaging information must be divulged before it is discovered by the opposing side and used against you. You can lie to your physician, you can lie to your clergyman, but *never lie to your attorney*!

You must have no hesitancy about revealing the most intimate, or even damning, information to your attorney if it is in any way relevant to the charges against you. All such communication with your lawyer is considered by law as *privileged*; and, therefore, *not discoverable* by the opposing side. Never try to second-guess your attorney!

You may not be able to remember any or all of the details surrounding the alleged incident of malpractice, but a review of the medical record will refresh your memory on these. All other relevant information you can provide to your attorney must be as complete and accurate as possible. Propose any other possible causes of the alleged injury other than your alleged negligence. Suggest possible expert witnesses who may be able to support your defense.

An integral part of preparation is an assessment of the strengths and weaknesses of the case as a means of planning an appropriate defense strategy. Under no circumstances can you or your attorney permit the opposition the advantage of knowing more than you do. You are an integral part of your defense team. You will be required to—expected to—play an active role in your defense. A deliberate failure to do so could immediately void your malpractice insurance coverage and remove your appointed attorney from your case!

The Role of the Nurse as a Defendant

The nurse-defendant must effectively assume the role of defendant and not completely relinquish his or her interests to the attorney. Defending yourself against a malpractice lawsuit requires a collaborative, informed, and dedicated effort on your part, and vigorous ongoing participation in your defense team. The role and responsibilities of the nurse as a defendant are shown in Table 7.1.

Table 7.1
The Role and Responsibilities of the Nurse-Defendant

- Become *your own best* defense, resource, and advocate
- Assume your role as an active member of a defense *team*
- Participate in, monitor, and understand the process
- Make your efforts and contributions valuable—and valued
- Confirm that you are interested and cooperative
- Keep informed of all facts, issues, and events
- Ask relevant questions and insist on intelligible answers
- Make yourself accessible to your attorney at all times

- Request that your attorney be accessible to you as necessary
- Check on the progress of the lawsuit at reasonable intervals
- Verify that your case is proceeding as expeditiously as possible
- Confirm that your defense is in the hands of a competent attorney
- Verify that your attorney is aggressively pursuing your best interests
- Educate your attorney about nursing standards and procedures
- Prepare a list of authoritative references relevant to the case
- Copy articles, prepare a read file, do your homework
- Review the medical record in detail
- Prepare and provide your notes, your memories, of the alleged event and provide your written or dictated notes to your attorney *only*
- Compile a list of possible expert witnesses to support your case
- Be receptive to any overtures regarding an out-of-court settlement

WHAT TO DO IF YOU ARE SUED

In the event that you notified that a lawsuit has been filed naming you as a defendant, you should take certain steps immediately.

- If you are covered by a personal malpractice insurance policy, notify your insurance carrier *immediately*.
- Document this notification in some way (e.g., certified mail).
- Read your insurance policy for specific instructions and follow these *precisely* regarding defined time frames and procedures of notification. Failure to do so could *void* your policy.
- If applicable, notify your employer immediately. Contact the risk manager *only*.
- Set up your own personal file. Secure this file, and *never* reveal its existence to anyone but your attorney.
- Meet with your attorney as soon as possible. Insist on this!

WHAT *NOT* TO DO IF YOU ARE SUED

The news that a lawsuit has been filed against you is likely to be a very stressful experience. In a stage of confusion, frustration, and anger, a defendant can become immobilized or take various irrational and self-damaging actions. The following suggestions are made to help avoid making things worse than they might appear to be.

- Do *not* attempt to avoid service of process. This could prove very detrimental to your case.
- Do not ignore the lawsuit. A *judgment by default* might be entered against you.

- As a general rule, *do not discuss the matter with anyone* other than your attorney.
- *Never* discuss the lawsuit with your co-workers. (Anything you say could be used against you later.)
- *Never contact the plaintiff*, the plaintiff's family, or the plaintiff's attorney. Do not accept any overtures for such contacts and inform your attorney of any attempts.
- Without the knowledge and consent of your attorney, do not surrender any notes, documents, or records of any kind to the plaintiff or to the plaintiff's attorney.
- As a general rule, it should not be necessary for you to consult your personal, family attorney. This will incur a needless expense. His or her services should not be necessary if an attorney of record has or will be appointed for you. Your personal attorney may be of some help in pointing you in the right direction at the outset but will not be included in the proceedings unless you elect to retain (and pay) him or her yourself.
- Do not let the allegations and their implications immobilize you in what may be a time of crisis mentality.
- Do *not not do* anything.

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8

Preparing for and Surviving a Deposition and a Trial

DEPOSITION PROCEDURES AND PROTOCOLS

Prior to the actual deposition date, a nurse-defendant (or nurse expert witness) should meet with the attorney to begin preparing for the experience. There are several points that should be reviewed.

- Exactly what will be your role in the proceedings?
- What will be expected of you?
- What can you expect?
- Who will participate in the deposition?
- Will the plaintiff be present?
- What types of questions can be asked?
- Who will ask the questions?
- What is the examining attorney like?
- Where will the deposition take place?
- How long might it last?
- In testifying, what should you be wary of; what can cause problems?
- Will the attorney be able to coach or help you in any way during the deposition?

Witnesses other than adverse parties in a suit must, as a general rule, be subpoenaed. Parties usually attend after some form of notice and without service of subpoena. A nurse who is requested to testify at a deposition as a fact (material) witness is not required to do so and has the right to demand a subpoena, which is the only legal recourse to force compliance with such a request. If a subpoena is issued, the prospective witness is then required, under penalty of law, to appear for the deposition.

At a deposition the individual who presents testimony (the deponent) can represent either side. This individual may be a defendant, a witness to the facts (material witness), an expert witness, or the custodian of relevant documents. The proceedings are basically a very structured process of examination and cross-examination. The ground rules will be presented to each witness at the outset of the proceedings. Everyone present will be identified for the record.

The deponent is placed under oath, and all statements made are recorded by an official court reporter or other stenographer, or by any individual legally authorized to administer an oath and take such testimony. The locale is usually the office of the attorney who requested the deposition. The procedure is the same for parties, witnesses to facts, and expert witnesses.

Well in advance of the actual date of the deposition, the plaintiff's attorney will have subpoenaed all records and materials relevant to the lawsuit, including any materials in the hands of the defendant. It is essential, therefore, that a nurse named as defendant does not take any personal notes, memos, diaries, or any such written or taped information to the deposition. This would make them discoverable by the plaintiff's attorney, and they could be used as evidence against the nurse. All documents or other materials in the nurse's hands must be prescreened to identify any privilege that might apply to them. Any such materials should have been given directly to the attorney as soon as possible, thus making them attorney's work product and nondiscoverable. At the deposition the examining attorney may ask you if you have kept any personal journals, diaries, or anecdotal records. Under oath, you must confirm that you have or have not done so.

With the approval of your attorney, you can take anything to the deposition that you both agree will be helpful; however, anything you do bring might be identified by the examining attorney as an exhibit and retained for possible later use in court. If you are directed to bring documents of any kind and refer to them in answering questions, copies must be given to the opposing attorney.

Each side will have a copy of the plaintiff's medical record at hand. When questioned about a specific fact contained in the medical record, the

nurse should refer directly to the record and not attempt to answer from memory. The necessity of the defendant reviewing the medical record thoroughly before deposition and again before trial cannot be overemphasized.

The procedures of the deposition anticipate those of a trial. As a general rule, the attorney who requested the deposition will begin the examination and will propose most of the questions to the deponent, whose own attorney will object as necessary. The lawyers for each side will conduct a direct examination of the deponent, and each side will have the opportunity to cross-examine.

The questions that can be asked of the deponent may be very specific, very personal, or very general. At times the questions may seem completely irrelevant to the issues. Much wider latitude is allowed in a deposition than in a courtroom, and the scope and intensity of the questions can be much broader. The questions asked at a deposition are not limited by the same rules of admissibility of evidence as those in testimony at a trial. Therefore, virtually any relevant question may be asked, including any that might lead to additional discoverable evidence. A nurse-defendant may be asked to assist in preparing questions for the plaintiff.

A deponent is not required to answer each and every question. However, any question that is deemed relevant to the issues in the case should be answered. These can include questions that might not be admissible in a trial. You can invoke the Fifth Amendment and refuse to answer any question that you consider self-incriminating. Should you have already answered a question pertaining to the same topic, you may have forfeited the right to claim the Fifth Amendment when succeeding, relevant, questions are presented to you.

Your attorney will be present to advise you and to object to any questions that he or she considers self-incriminating, ambiguous, vague, confusing, or irrelevant. Attorneys are required by law to preserve your legal rights and maintain your best interests. A deponent can invoke lawyer-client privilege and cannot be required to answer any questions that derive from communications with his or her attorney. These are considered privileged and confidential and the content or nature of these communications is not discoverable. Ultimately a judge and only a judge, in a court of law, can direct that a witness must answer a question.

The deposition can be an adversarial encounter for all participants. The attorneys endeavor to learn if there is anything a deponent is trying to cover up or hold back. In this effort they may resort to browbeating, insinuation, derision, accusation, and insult. Any tactic may be attempted in an effort to reduce a deponent to a state of confusion and contradiction. There is no per-

sonal motive in this behavior. The attorney is simply doing what is required to obtain information. He or she has the right to examine or cross-examine a deponent. A deponent may not like the attorney, the line of questions, or the tactics used, but this is no reason to become overtly hostile toward the attorney. Evoking such behavior by a deponent simply makes the attorney's task easier.

The lawyer for either side is going to probe and press each deponent in an attempt to find weaknesses. If the individual can be controlled in a deposition, he or she might be controlled to advantage in a courtroom to make or break a case.

The Deposition Transcript

Each deponent has the opportunity to review the transcript of his or her testimony and clarify, correct, or expand on any of the answers. The recorder of the deposition testimony will forward a copy of the complete transcript to each attorney who in turn should provide the appropriate deponents with a copy. Read it very carefully making separate notes as you go. Rules vary by state regarding changes and/or additions that can be made to a transcript. You cannot change an answer, but you may correct any portions of the transcript that you believe to have been misunderstood or mistranscribed by the recorder. Your comments or corrections must not be made anywhere on the transcript; convey your thoughts to your attorney verbally or by confidential memo. Any corrections must be made on the forms that may accompany the transcript. When you and your attorney have agreed that the transcript is accurate, you will sign it and remit it and the accompanying forms with comments and corrections to the deposition recorder.

You should retain a copy of these documents for your personal file. If the lawsuit should proceed to trial, you can expect to be asked many of the very same questions that are detailed in the transcript of your deposition. You can also expect to be presented with any number of additional questions that may have been derived from the transcript—from what was asked and from what was not asked. A competent trial lawyer will carefully review the transcript both to develop and to anticipate answering such questions. You should have advance knowledge and preparation for such surprises.

THE EXPERT WITNESS AT A DEPOSITION

The nurse who testifies at a deposition or a trial as an expert witness can expect the opposing counsel to ask questions that are designed to discredit the "expert" credentials of the witness or to confirm that the nurse is truly an

expert, and then weigh his or her expertise and credibility against his or her own testifying experts. Questions will be rephrased or repeated to elicit inconsistencies or contradictions. An attempt will be made to show that the *expert* witness is an expert *witness*, a *professional witness*. It is the testifying expert's role to educate the attorneys, the judge, and the jury while not sounding pompous, condescending, or overly pedantic. An expert witness should *never* address a subject or issue that is outside his or her area of experience and expertise. The role of the expert witness will be discussed in more detail in chapter 15. The topics of the questions the expert witness can expect are shown in Table 8.1.

Table 8.1
Questions That May Be Addressed to an Expert Witness

- General personal information
- Educational background
- Employment history
- Professional clinical nursing experience, particularly in the area of the alleged malpractice
- Membership in professional organizations
- Experience in presenting lectures, seminars, and workshops
- Authorship of published or unpublished works
- Prior experience testifying as an expert witness
- Fees that have been received for such services
- Authoritative sources that witness will cite
- Standards of nursing care
- Opinions on breaches in standards of nursing care
- Opinions on cause of alleged injury
- Various hypothetical questions, situations, scenarios
- History of any adverse action by a state board of nursing
- Defendant in civil or criminal lawsuit
- Prior judgments or convictions

PREPARING FOR A DEPOSITION

Knowing what to expect is the best preparation for a deposition. Proper preparation will give the witness the necessary confidence to survive the ordeal. An experienced malpractice litigation attorney will be invaluable in this respect. Trial lawyers who specialize in malpractice frequently find themselves sitting across the table from a familiar professional opponent, and they remember his or her temperament, tactics, abilities, and successes. Your attorney, in formatting the best possible case, should allow some time

to provide you with a coaching session. The attorney can do this personally, or it can be done by a nurse litigation consultant collaborating with the attorney on the case.

He or she will be able to anticipate the nature and generally the content of the questions that could be asked by the opposing side and be best able to educate and prepare you. These are the same or similar questions they would want to ask and are likely to have asked in numerous cases in the past. The attorney may propose a mock deposition in which he or she assumes the role of the opposing counsel who will examine you. Some attorneys feel that an extensive predeposition review of case materials may not be helpful to a deponent, or that a mock deposition may make their client's responses sound overly rehearsed.

Begin to prepare yourself by carefully reading a copy of the medical record and making your own chronological summation and interpretive notes. As you do this, try to anticipate any possible questions. Unless you are given a working copy, do not write any notes or comments in the record itself. Any such information included in the record in any way could make it discoverable and your own notations could be used against you. Any such annotations or comments should be labeled as attorney's work product and should be retained by your attorney to prevent discovery.

THE DEPOSITION

The nurse-defendant's experiences, responses, expectations, and the impressions made at a deposition can be described in four scenarios: (1) answering questions, (2) interacting with the examining attorney, (3) collaborating with his or her own attorney, and (4) his or her personal deportment and appearance.

Remember, your attorney will be present. He or she will guide and support you. Your attorney cannot answer for you, but can tell you when you should not answer by objecting to any question deemed inappropriate. It is your right to consult your attorney at any time for direction, explanation, or clarification. This must be a team effort.

SURVIVAL TACTICS FOR THE DEPONENT

For a deponent to survive a deposition, he or she should follow the ABCs and a D.

A. Answering

- Tell the *truth* and convey that idea in each response.
- *Never lie*! Remember that you are under oath. *Lying under oath is perjury*—a felony, a *crime*.
- Each answer must be as truthful and as accurate as possible.
- Do not attempt to distort or hide the facts; this could impeach your credibility and severely compromise your defense.
- Be sincere, open, and forthright at all times.
- Do not equivocate or try to manipulate the facts in such a way as to present yourself or your case in a more favorable light.
- *Never admit any liability or blame*!
- *Never mention that an incident report was prepared.*
- Make no attempt to justify your actions or decisions, or propose your rationale for them.
- Offer no excuses for any of your actions.
- Unless asked, do not mention the names of any other persons.
- Never blame or accuse others.
- Do not make denigrating remarks about others.
- Do not make prejudicial comments of any kind.
- Do not try to evade a question or change the subject.
- Make each answer as positive as possible.
- Do not state dates, times, or any other facts or data unequivocally if you are not absolutely certain of them. Avoid such words as "always" and "never".
- *Do not give an opinion* in answer to a question unless you have been deposed as an expert witness.
- If specific facts are requested, answer only to the extent of your direct knowledge of such facts.
- Do not substantially change an answer without good reason.
- Qualify, explain, or expand an answer only if it is absolutely necessary.
- Avoid such qualifying statements as "maybe", "possibly", "if", "perhaps", "to tell the truth", "honestly", "I think", "might have", and other such vague phrases.
- Do not speculate, theorize, or hypothesize.
- *Never make assumptions.*
- *Never guess!*

- If you are asked to approximate, estimate, or guess, phrase your response so that it is clearly qualified as such.
- State directly if you do not know an answer or that you do not remember. Say: "I do not know" or "I do not remember". These are acceptable, truthful, and appropriate answers.
- Never say *what* you do *not* know.
- Answer the question asked and only that question.
- Do not give the opposing attorney more information than is required by the question. Doing so could provide ideas for a new line of questioning.
- Do not volunteer any information. The whole purpose of the deposition is to make the examining attorney "discover" the facts.
- Make the examining attorney ask questions.
- You are not there to educate the examining attorney or present him or her with any advantage.
- Do not fall into the "pregnant pause" trap. If the examining attorney reacts to your answer with a long expectant silence, ignore it.
- Answer each question in as few words as possible. The best answer is the briefest, most direct. A succinct "yes" or "no" is usually adequate and always advisable.
- Be direct and to the point in answering each question.
- Each answer should be as concise and as unambiguous as possible.
- Do not respond to a question with any information or data of which you do not have firsthand knowledge.
- You can provide hearsay information if this is requested but only if it is clearly identified as such.
- Do not attempt to answer until the attorney has finished the question.
- Confirm to yourself that you fully understand the question before attempting to answer it.
- Do not allow yourself to be pressured or rushed in answering.
- Do not let the examining attorney force a "yes" or "no" answer; say what you must say to answer the question completely.
- Take as much time as you need to formulate your response.
- Pause for a moment or two before answering. This provides your attorney time to object to a question that may be inappropriate.
- An objection is your signal to immediately stop answering a question.
- If a question is ambiguous or unclear, ask that it be clarified, repeated, or rephrased. You do not have to say why.

- If the question is long, convoluted, complex, or compound, request that it be simplified. You do not have to say why.
- Do not anticipate questions. You may be reasonably certain of what is going to be asked next. Wait until it is asked.
- If the examining attorney attempts to cut you off, affirm that you have not finished speaking, and continue your answer.
- If he or she persists, remain silent and wait for your own attorney to present the question to you again in their examination.
- Correct what you believe to be any errors in facts stated by opposing counsel.
- Respectfully challenge any erroneous assumptions.
- Be alert for a series of leading questions in quick succession.
- Be alert for hypothetical questions; these are for the expert witness only, not the fact witness.
- Do not answer questions by gestures or by nodding or shaking your head. All responses must be oral, audible, and clear so that they can be accurately recorded in the transcript.
- Avoid the use of slang, jargon, idioms; use proper grammar.
- Do not rely on your memory; it may lead to errors or contradictions.
- Utilize the medical record and any other resources as necessary.
- Take your time in finding any document you need.
- If you must use medical or scientific terms, be sure you use the correct term in the correct context.
- You may be asked to spell such terms—be prepared.
- Ask to examine any document that opposing counsel refers to in framing a question.
- If you are given documents or other items to examine or identify, do so very carefully before answering any questions.
- If you have been deposed and are testifying as a nurse expert witness, do not readily accept the opposition's cited authors as the sole authorities on the subject.

B. Bandying, Badgering, and Browbeating

- Do not be intimidated. Take control!
- Keep your wits about you.
- Do your best to maintain your self-control.
- Do not get excited or upset.
- Try very hard not to loose your temper and become visibly angry.

- Do not let yourself become sarcastic, testy, or irritable.
- The opposing attorney may do his or her utmost to rattle you and provoke you. This is a test to see how well you will stand up in a courtroom before a jury.
- Stay calm.
- You will be challenged; do not react in kind.
- Maintain your composure, even when being blatantly provoked.
- Be assertive but not aggressive.
- Do not take an overly offensive or defensive stance.
- Defend yourself, your dignity, and your rights.
- Confirm that you will not be bullied or intimidated.
- Be extremely cautious of overly agreeing with the examining attorney.
- Do not become inordinately friendly with the opposing attorney. Remember this person is an adversary. He or she is not your personal enemy but is not your friend.
- Be polite, courteous, and respectful.
- Look directly at the attorney when you are being asked a question and when answering.
- *Never argue.* You can not win. You can challenge, dispute, or disregard, but do not allow yourself to be drawn into an argument. The deposition must not turn into a battle of wits or egos. Remember, this is not a platform for debate. The experienced trial attorney has an undeniable edge here.
- Play to beat the attorney at his or her own game.
- Do not make it easy for him or her!

C. Collaboration and Communication

- As a general rule, never sit beside your attorney when being questioned.
- Request that you be seated so that your attorney is directly in your view.
- Do not turn and look to your attorney for help in answering a question. He or she cannot do this in a deposition or a trial.
- A deponent is expected to answer each question spontaneously as best as he or she can, and in his or her own words.
- Constantly looking toward your attorney may prompt a criticism or a challenge from the examining attorney, who may accuse you of uncertainty, lack of conviction, lack of self-confidence, or of hiding something.
- Stop speaking immediately whenever your attorney interjects.
- Listen very carefully to any objection being made by your attorney. It may provide clues to an appropriate answer.

- As necessary, you can write notes to your attorney, or quietly ask questions while sitting at the table.
- Do not communicate with your attorney when someone else—attorney or deponent—is speaking.
- It is not advisable to ask your attorney questions or make any statements regarding the case that could be overheard by opposing counsel or by any one else.

D. Deportment

- Maintain your self-control at all times.
- Remember: It is *your* deposition!
- Be honest and credible.
- Be positive.
- Present yourself as a professional at all times.
- Look and act confident.
- Exude competence.
- Be cordial, polite, and civil throughout the proceedings.
- Try to be as relaxed as possible.
- Do not embellish or exaggerate.
- Do not emote—no hyperbole, theatrics, histrionics.
- Never allow yourself to appear weak, apologetic, repentant.
- Do not play for sympathy. You will get none of it here.
- Do not whine or complain.
- Do not appear cavalier, blasé, or overly casual.
- Do not surrender under a salvo of interrogation.
- Be organized, come prepared.
- Be knowledgeable, but do not be pedantic. Unless you are an expert witness, you are not there to teach.
- Try not to sound "rehearsed", "coached", or "canned".
- Speak only when spoken to during your examination.
- As a general rule, do not interrupt another.
- Speak slowly, clearly, and loud enough for all present to hear you.
- Stop speaking when your attorney or opposing counsel begins speaking (unless the latter is interrupting you).
- Your body language will speak volumes about you. Always be aware of your posture, movements, and facial expressions. Do not testify with your arms crossed. This could indicate a defensive, hostile posture.

- Make yourself as comfortable as possible before you start.
- Sit up straight; sit still.
- You may hold something in your hand, but hold it still.
- Avoid touching yourself or your clothing unnecessarily or too frequently.
- Do not look at your watch; this can convey the impression of impatience.
- Do not try to be amusing, tell jokes, or quip. This is not the time for it.
- Make a best effort to appear very interested even when the proceedings may become very boring.
- Remain alert and attentive, particularly when you are being questioned or when another deponent is testifying.
- You may look around during pauses but always keep your gaze up.
- Do not sit staring abjectly at the table or at the floor.
- Do not allow yourself to be intimidated by the presence of the plaintiff and/or the plaintiff's family. They may have been instructed to sit in your line of sight and stare hostilely at you.

Deponent's Personal Appearance

How a witness presents him- or herself can make a favorable or unfavorable impression in a videotaped deposition or live—before a jury. The witness should:

- Appear neat and well groomed;
- dress for and act the role of a professional;
- wear conservative, comfortable clothing;
- not wear excess or oversized jewelry; and
- not reek of perfume or aftershave lotion.

THE TRIAL

In the absence of a settlement, the day might eventually come when the nurse-defendant may be faced with the demands of appearing and testifying at a trial. This is the final personal step in what may have been a long ordeal. This day may never come, or if it comes it may end very abruptly. However, the nurse must be prepared.

Preparation for a Trial

The prospect of a trial presents some new challenges and new learning needs. Prior to the actual date of the trial, there are a number of things you,

as a defendant, should do. Some of these you can do alone, others you will do in collaboration with your attorney.

Request that you have an opportunity to meet with your attorney at a convenient time, and for a reasonable number of times, to discuss the case to that point and the implications of the impending trial. Discuss the strategy and any possible defenses he or she proposes to use in your behalf. To prevent inadvertent disclosure, the attorney may decline to reveal a plan to you. Ask for an honest appraisal of your situation—the weaknesses as well as the strengths of your case. During the meeting, ask for a brief outline of the court proceedings—what you can expect, what will be expected of you. This is also a good time to discuss the possibility of a settlement.

Much of this preparation will be a review of documents and records that you should have examined previously in preparation for the deposition. Reexamine the complaint, the medical record, and all other documents relevant to the case. Refresh your memory on the details, the facts, and the allegations. Make copious notes, but be sure that only you and your attorney have access to them. If you have not already done so, prepare a detailed, chronological summary of all the events surrounding the alleged incident. If this has already been done, review it carefully and add any additional information as necessary.

Read the transcript of the deposition, particularly your testimony. Review a videotape of the mock deposition and/or trial that your attorney may have conducted. Study your performance, and critique yourself objectively. Identify those mannerisms or speech patterns that might be considered distracting should you have to take the stand in court. Make an effort to correct these. Rehearse, but try not to show it. Your testimony should not sound memorized or "canned".

Conduct of a Witness During a Trial

Virtually all of the suggestions and cautions that have been made previously regarding a deposition apply to the conduct of a witness in a courtroom. If you have survived the deposition and learned from it, you are reasonably prepared to face the trial. The protocols and procedures of a trial are different from those of a deposition. The examining attorney may be more constrained by courtroom etiquette, rules of evidence, and other procedural laws, and may appear less aggressive here.

There are several other differences you need be aware of in testifying in a courtroom.

- You should have carefully reviewed your deposition transcript to confirm your answers to previous questions and avoid contradictions.
- Listen very carefully to the opening statements of each attorney.
- When answering a question in the courtroom, direct your response to the jury or, if it is not a jury trial, to the judge.
- Look at each member of the panel as you speak.
- Try to observe any subtle clues as to which jurors may be sympathetic. Focus on them. Win them over.
- During the times you are not testifying, maintain your appearance of interest, alertness, and confidence.
- When other witnesses are testifying, study them and the jury's reaction to their testimony.
- You may speak quietly to your lawyer, but do not do so when another witness or attorney is speaking, and *never* do so when the judge is speaking.
- *Under no circumstances should you or any of the parties speak to a member of the jury outside of the courtroom.* This is immediate cause for a *mistrial*.
- As a general rule, do not discuss the case with anyone beyond the confines of the courtroom.

9

Defensive Documentation

NURSING DOCUMENTATION AS A RISK MANAGEMENT STRATEGY

Defensive charting is one of the best ways to protect any health care provider from exposure to legal liability. *Chart with a jury in mind*! Careful and complete documentation of nurses' progress notes is a principal method of reducing the risk of liability in nursing malpractice lawsuits. They may sustain or preclude a suit for negligence from the outset. They may support or undermine the nurse-defendant before a jury in the event of a trial. In a negligence suit, nursing documentation will be as critical a factor as the nursing care itself. A nurse's notes should provide answers to questions at issue in a lawsuit. They should not prompt more questions or raise additional issues. Poorly written notes can be a veritable gold mine for the patient-plaintiff's attorney.

The presumption in law may be that if an event is not documented, it did not take place, and if it is not written in the record, the nurse did not do it (or even consider doing it). The maxim familiar to every student nurse and practicing nurse is: "If it was not charted, it was not done." This is frequently a contentious issue in malpractice litigation. It is a misconception that should be rejected as unrealistic—as an unattainable performance or unrea-

sonable demand made on a nurse. In a deposition, or in court, however, the plaintiff's attorney (and their *nurse* expert witnesses) may make every possible attempt to convince a jury of the literal truth of this assertion. The defendant's attorney will endeavor to show that, although there may be an apparent omission, the action in question was the nurse's "usual practice", which routinely need not be documented.

Nurses cannot possibly function as court reporters or stenographers, transcribing the minute details of every event or conversation. However, if a nurse-defendant's notes do not corroborate his or her testimony, the nurse-defendant will be challenged to persuade the jury to accept as credible his or her version of the events surrounding the alleged negligence. Regardless of the sworn testimony, the written entries in the medical record will serve as the definitive statement of what actually transpired.

Objectives of Documentation

There are two principal objectives for documentation of patient care. The first is to communicate to all members of the health care team essential information regarding the patient's history, present status, response to care, prognosis, and the nature and extent of care required, provided, and anticipated. The increasing trend in specialization has created opportunities for assessment, treatment, and care by a variety of nurses, physicians, and other professionals. It is essential that each health care provider be aware of the findings, opinions, actions, and recommendations of others.

The second objective is to protect each of these many team members from the risk of legal liability or mitigate that risk as far as possible.

NURSES' NOTES

To accomplish defensive documentation, each nurse's note should incorporate certain objectives and elements, follow a generally prescribed format, and utilize an acceptable quality and style of writing. When corrections or addenda are necessary, certain guidelines should be followed consistently.

Objectives of Nurses' Notes

Nurses' notes should incorporate as many of the following objectives as possible.

- Confirmation of the type, extent, and quality of care that is provided in each patient care assignment—the nursing process

- Evaluation and verification of patient responses to, and outcomes of, nursing interventions
- Affirmation that such care meets the acceptable standards of nursing care and that the nurse's interventions were safe and therapeutic
- Demonstration of legal and professional responsibility and accountability and conformity with all applicable statutes, rules, and regulations
- Protection of the rights of all parties involved
- Interdisciplinary communication of all significant information in order to coordinate and facilitate continuity of care
- Compilation of data for continuing application in risk management, quality assurance, research, care planning, case management, discharge planning, fiscal administration, and the education of students and peers

Essential Elements of Nurses' Notes

An acceptable nurse's note should include several essential elements.

- Current, complete, and accurate information that reflects a continuing assessment of the patient's status and progress
- Pertinent and significant data; exclusion of trivia
- Identification of actual and potential needs and concerns of the patient—physical, psychological, social, and spiritual
- A description of nursing interventions addressing those needs
- The patient's response to the nursing interventions
- Confirmation of continuity of care
- Patient teaching

The exact content of patient teaching during the course of hospitalization is highly variable, and would be prescribed by the individual's diagnosis, medical and nursing regimens, constant changes in status, identified learning needs, and many other factors. Discharge teaching can be more significant from a legal aspect, and is detailed later, in Table 9.2.

General Format of Nurses' Notes

In addition to the essential elements outlined previously, a nurse's note should include several other characteristics and components that can add to its clarity, utility, and effectiveness as a defense in any potential liability. Every note should be as descriptive as possible and include complete, accurate, and appropriate patient data. This information must be as objective as

possible. There should be little or no subjective commentary. Where a subjective statement is indicated it should be supported by observed facts, direct quotes, or accurately paraphrased statements of the patient or another reliable source.

The nurse must be cautious in making unfounded conclusions or assumptions, or in offering personal opinions. Conclusory statements such as "normal", "fine", "good", "well", "assume", "seems to", "appears to be", or the cliché "in no acute distress" should be avoided. Such statements are vague and ambiguous. Any such judgments must be accompanied by supporting facts or data present elsewhere in the medical record. The language of the notes must be as concise and clear as possible. Brevity is ideal. Clarity is essential.

There must be no attempt to keep any secrets. Include all of the facts, and let them speak for themselves. Do not attempt to put any "spin" on them, downplay them, or manipulate them in a self-serving way. The nurse must chart everything that is relevant and significant—including errors and omissions. As discussed previously, if it should be determined that a nurse has deliberately attempted a cover-up, this in itself could be the basis for a lawsuit. And if such efforts could be proven to be an attempt at fraud or deliberate deceit, this could have very serious criminal implications, and may extend the statute of limitations indefinitely. There have been many malpractice lawsuits arising from accusations of what a nurse did *not* do. What is *not* in the medical record may be as critical as what is in it. What is omitted, deliberately or inadvertently, can have serious connotations in the event of a malpractice claim.

There must *never* be any language in a note indicating or admitting *liability*—on the writer's part or on anybody's part. No attempt should be made to rationalize or justify one's actions. Do not include such wording as "accident", "accidentally", "incident", "mishap", "error", "unexplained", or "somehow". State the facts as you know them and *only* the facts!

The patient's chart is not a forum for debate. Its primary function is to record the care that the patient received and identify those who provided it. This is not the place to criticize or characterize other members of the health care team. Derogatory remarks, personal comments, unflattering observations, and all other unprofessional language do not belong here. This it not a medium to assign or infer blame, accuse, or incriminate. Personal conflicts, disputes, or petty vendettas must not be aired in the medical record. This is not the proper arena for "chart wars". The chart is not the appropriate means to catalog complaints about short staffing, overwork, or inadequate conditions. A plaintiff's attorney will find a cloth-of-gold among any dirty laun-

dry. When interpersonal conflicts or work-related problems arise, as they surely will, discuss them privately. Do not document them publicly.

Generally Acceptable Writing Style

Nurses are required to document in accordance with defined standards—for example, those of the ANA, the JCAHO, and the institution itself. Each nurse should endeavor to develop his or her own style of documentation and use it consistently to facilitate quick and accurate charting that can be individualized to each patient. A properly written note, no matter its length, should reflect proper grammar, syntax, and spelling. Slang or jargon should be excluded. If the nurse intends to use medical terminology, it must be the correct terminology.

The events described should be presented in some logical and chronological order. Each new topic should be started on a new line. Each note must be dated and the correct time indicated. Times can be noted under the date or, if a summary note is being written, the progress of events can be shown within the body of the note by indicating the time of each event. A new line for each time and event is preferable. Military time should be used in all medical records where this is permitted by the institution's policy and procedure manual. All dates and times must agree—among documents and throughout the record. Nurses should never chart before the fact. Charting in advance could compromise credibility. Notes should never be backdated.

Ambiguous abbreviations or symbols have been identified as a consistent problem in documentation. Misinterpretation of these has been the cause of many patient injuries and deaths, and the basis for numerous allegations of negligence. All abbreviations must conform to those listed in the institution's policy and procedure manual or, in the absence of such a list, to those included in any authoritative medical dictionary. Any symbol or abbreviation that could possibly be misinterpreted should be eliminated. The general rule is: "When in doubt, write it out."

Handwriting must be legible. Sloppy writing can convey the idea of sloppy patient care. Such apparent laxity will be exploited by the plaintiff's attorney in front of a jury. A nurse-defendant's illegible scrawl will be projected on a screen before a jury and he or she will be asked to decipher it for the benefit of the viewers. If the nurse is not able to read his or her own handwriting or persuade the court of his or her interpretation of it, a question of tidiness of intellect or habits of work may arise in the minds of the jurors.

Every note, flow sheet, medication administration record, or any other document that requires a signature with an entry must have that signature. A

nurse should sign legibly with his or her full name and title. Some institutions permit the use of initials for a first name; this is acceptable. However, a full signature is preferable. Initials are acceptable in restricted spaces in the columns of sign-off blocks when a corresponding signature is indicated elsewhere on the document to identify the owner of initials.

There should be no blank spaces, lines, or pages in a progress note. Such spaces can invite "refinements" or "sanitization" in previously written notes. A single line should be drawn through such spaces or large areas can be hatched off. A common practice of nurses is to leave empty lines before their own notes to accommodate another provider's note and preserve the time sequence. This practice should be eliminated. A late entry is much more acceptable and can defuse any questions of manipulating the record. Late entries are discussed in a following section.

Correcting Entries

It is inevitable that an individual will make a minor error in writing a note or in recording data. It may be the wrong spelling or choice of word or the wrong selection of a chart. Check the name on the chart before opening it and beginning to write anything in it. A common error is pulling a chart according to the patient's room number—a number that can change abruptly during a shift. The nurse must always be aware that even well-intentioned attempts to correct errors could, in the hands of a plaintiff's attorney, damage his or her credibility and impugn all of his or her documentation. From a legal aspect the nurse should observe certain precautions in correcting entries. A number of these are shown in Table 9.1.

Table 9.1
Correcting Entries—Cautions

- Avoid using the words "error" or "mistake". These might convey the idea of faults in clinical procedures or skills. Use such words as "delete", "void"," disregard", "mistaken entry", "incorrect entry", or "erroneous entry".
- *Never* attempt to erase an entry.
- Do not use correction fluids to provide a new substrate for an entry.
- *Do not obliterate* an entry in any way. Any entry that must be corrected must remain readable and legible.
- Draw a *single line* through an incorrect word or phrase and write the correct information *next* to it on the same line if this is possible. This confirms to the reader that the correction was made at that instant. Otherwise write the correction above the line.

- Revised text placed *above* a lined-out entry might raise a question as to exactly when that modification was inserted into the record. Include the date, time, and your initials.
- A later clarification within the body or at the end of the note, or an addendum in a later progress note, will suffice if there is inadequate space on the line to reflect an afterthought.
- Write any addendum indicating the correct information with a specific reference to the site of the incorrect entry.
- Do not attempt to squeeze lengthy corrections onto or between lines of previously written text.
- Write nothing in the margins.
- It may be necessary to recopy pages of progress notes. Each copy must be identified as such, and all original copies must be identified as such, and *retained* in the medical record.
- Once any document can be considered as an official part of a patient's medical record, it cannot be removed or discarded. In the event of a malpractice lawsuit, a suspicion, and certainly a confirmation, of any missing documents will severely prejudice the defendant's case and may leave him or her open to charges of fraud.

Late Entries

Nurses should make every effort to avoid unnecessarily long intervals between their entries in the progress notes during a shift. There should be no substantial gaps in the chronology. These could infer neglect or even abandonment. In those many instances when the demands of the day prevent even the most efficient nurse from writing notes coincident with events, or when some significant detail is forgotten, a late entry is acceptable. Provided that the information is clear, complete, and accurate, the fact that it is not recorded contemporaneously with care should not present a problem.

A late entry or one that is not in proper sequence will not come under suspicion unless there is a discernible ulterior motive. Any significant prior omissions phrased and presented as concurrent or new entries could impeach all of the nurse's notes. Late charting could be suspect if there is a pattern evident. If certain individuals habitually write such notes, a question of their competency, integrity, and efficiency might be raised in the event of a lawsuit.

A late entry may be inserted in the medical record within a reasonable time provided a full explanation for the entry is included. Any such entry should be written as soon as possible after the fact and in the first available space in the progress note with a precise reference to the previous place in the notes where it properly belongs. It must include the exact date and times of the events described. It must be clearly identified as a late entry.

Writing or Signing Notes for Others

The general rule regarding writing a note for another is: *Do not* write a note for another! It is a very risky practice that could leave all parties exposed to legal liability. There may come a time when a nurse inadvertently omits a significant comment from the progress notes to which he or she now has no immediate access. In such an instance, the individual may telephone another staff nurse and request that the dictated note be incorporated into the record as a late entry. The recipient of the request may make the entry provided he or she makes absolutely clear that the recipient did not perform, participate in, or witness the actions described; that the information was dictated, and by whom. The note must be countersigned by the originator as soon as possible thereafter. If a staff nurse is required to chart the care given by an ancillary staff member the notes must provide specific details. Any such notes must make it very clear as to who performed the duties described.

Signing or countersigning a progress note written by another, or a verbal order, attests that the signer read the entry and is verifying that the content is correct. If what they are attesting to is incorrect, they could be held liable in a claim of malpractice. If a nurse has no direct knowledge of the veracity of a note, he or she should not countersign it. If a nurse does sign a note that is seriously deficient or erroneous, he or she could share liability in the event of litigation. Countersigning a note does not necessarily imply that the individual personally performed or witnessed the actions described therein. However, it does affirm that he or she reviewed the content of the note and, by a signature, approved the actions indicated, affirmed that the procedures were carried out and that they were appropriate.

Only those staff authorized by the policy and procedure manual to chart in a medical record should be permitted to do so. The manual may require that a nurse countersign any notes written by ancillary staff (e.g., UAP) where this practice is permitted. Before signing, the staff nurse should read the subordinate's notes very carefully, direct any corrections, revisions, or additions, and then sign it. A countersignature also confirms that the actions of the individual who wrote the note were, in fact, within the scope of practice and that he or she has the proper training and degree of competence required.

NURSING DIAGNOSES: LEGAL ASPECTS

Nursing diagnoses are defined as those health problems that have the *potential* for resolution by means of *nursing* actions. Patients' nursing prob-

lems are defined in terms of nursing diagnoses. They are *not* medical diagnoses, medical treatments, or diagnostic studies. They may not be the problems that a nurse experiences while delivering patient care. They are clinical judgments of those problems that have the potential to be resolved by means of nursing intervention.

From a legal aspect, many nurse practice acts do not address the matter of nurses making such diagnoses. Those that do often fail to define what the term means. For example, the Pennsylvania Nurse Practice Act defines the practice of professional nursing as: "diagnosing and treating human responses to actual or potential health problems. . . . [The] foregoing shall not be deemed to include acts of medical diagnosis or prescription of medical therapy".

Nursing diagnosis is a term that has come into use in recent years through nursing education. It has physicians confused and some health care attorneys concerned. For the most part, making a diagnosis is an act of medical judgment that may be done only by a licensed physician. From the risk management standpoint, it may be wise not to use the term. There are some types of diagnosis that a nurse may do independently—for example, wound care. A nurse does not need the authorization of a physician to diagnose a superficial abrasion of the knee. The nurse is doing the same thing a physician would be doing, and it is not necessary to qualify the term as a nursing diagnosis.

The term and the concept of nursing diagnosis have no place in an outpatient medical record. Typically, chart entries are made by physicians and nurses in the same set of progress notes. Any use of the term *diagnosis* will be perceived as a true diagnosis in the medical sense. A nurse making a diagnosis must be working under strict protocol or direct supervision of a physician. Any other diagnosis made by a nurse constitutes the unauthorized practice of medicine.

The term *nursing diagnosis* is often used as the title of a nursing care plan. This is confusing but legally acceptable if the nurse is not making a diagnosis or ordering care. Problems arise when the nurse fails to understand the difference and writes a medical diagnosis on a patient. (Richards and Rathbun 1993, 433)

From the perspective of many in the nursing profession, nursing diagnoses have been described as redundant terminology that clouds communication; as statements of the obvious; as so much doublespeak to describe medical clinical symptoms and diagnoses. Anything is acceptable as long as it is not used by physicians. This is perceived by many nurses as creating pretentious barriers with others in the health care profession and as just another way to confuse the patient.

Telenursing presents a particular dilemma for the champions of nursing diagnoses.

> The challenge to nursing is to organize this material in terms of ease of access, confidentiality of usage, accuracy and contextual relevance, and ease of comprehension. . . . Telenursing, because of its communicative nature, is forced to use modern idiom, if not the vernacular, to communicate effectively. This disallows much of the specious nursing jargon and private use of language to which nursing has been exposed in recent years [nursing diagnoses]. The bottom line seems to be that if one wishes to make oneself understood, one had better use language that can be understood. (Yensen 1996, 213)

DOCUMENTING DISCHARGE TEACHING AND PLANNING

Changes in the health care delivery system and increased efforts at cost control have resulted in increasingly abbreviated hospital stays. It is inevitable that an increasing number of lawsuits alleging premature discharge as a cause of injury or even death will be initiated. This is an area of litigation that will present entirely new issues and challenges for the professional nurse charged with preparing patients and families for a physician-ordered discharge that the nurse may consider inappropriate.

It will be the patient's physician who will ultimately be responsible for documenting in the medical record that the patient's status and prognosis warranted discharge at that time. The patient's nurses will be the ones assigned the task of preparing the patient and the family for the event and documenting their teaching and supportive efforts in detail. Proper discharge planning and teaching may play a critical role in the recovery process. Deficiencies in this professional responsibility can leave the practitioner open to liability.

Discharge Teaching Guidelines

There are a number of guidelines and suggestions for the nurse involved in discharging a patient who may be relatively ill and for relatives who may be ill-prepared. These are shown in Table 9.2.

Table 9.2
Discharge Teaching Guidelines

- Ascertain the needs and knowledge of the parties before beginning.
- Do not assume that the patient or the family can "manage", or take them for granted.

- Begin with the simplest instructions and basic ideas and gradually introduce more complicated procedures and concepts. They may be overwhelmed at this time.
- Proceed very slowly. Teach in several short sessions, or, if appropriate, arrange for at-home follow-up teaching when they are settled in.
- Provide as much written material as possible—preprinted brochures, pamphlets, instruction sheets, videotapes, or any other instructional material. Ask that these be prepared if they are not available. Prepare them if necessary. Have the patient or family member sign a list of all materials provided to confirm receipt.
- Include this list in the progress notes.
- Explain everything in terms that they can understand. Confirm their understanding. Ask questions. Answer questions.
- Provide opportunities for return demonstrations of all procedures.
- Document in detail who was taught, what was taught, how it was taught, and by whom it was taught.
- Document the degree of understanding and how this was determined.
- Confirm availability for any further questions or ongoing support.

INCIDENT REPORTS

"An incident report is a written description, factual and nonjudgmental, of an event that caused an injury (or had the potential to cause an injury). It doesn't belong in the patient's medical record, nor does any mention that it's been filled out" (Cournoyer 1995, 21). The incident report, the "unusual occurrence report", or whatever it may be called, is the proper place to document untoward events or compromised care. Any extraordinary event (one that is a *marked deviation* from the routine) usually requires the filing of a report *whether or not there has been any injury* involved.

The departure from the routine may be any occurrence that is considered inconsistent with the institution's normal operation or with the care of patients in the institution—including the incompetence of any caregiver. This would always describe any occurrence that could possibly impute liability on the part of the institution. A report may outline the circumstances of an incident that caused an injury or it may present factors *predictive* of a possible injury. The preferred and widely used format is a check-off list arranged by categories of circumstances or factors. This (by design) may present limited space for any personal narrative description of the circumstances of the event.

Purpose of the Incident Report

To maintain accreditation, a hospital is required by the JCAHO to set up and maintain some internal system of incident reporting according to de-

fined standards and guidelines. Such a system functions as an integral part of the total risk management and quality assurance program maintained by every hospital. The primary purpose is to provide the institution with a means to review and evaluate patient care in order to effect improvements in the overall quality of that care and to forewarn appropriate administrative staff of potential exposure to liability. By tracking specific facts and circumstances surrounding all untoward events, the institution can identify patterns and develop strategies of identification and prevention that will serve to decrease the risk of similar incidents or injuries reoccurring. Ultimately such a system should protect patients, staff, and the institution itself.

In addition to identifying actual and potential problems, the incident report may identitfy potential litigants and assist the institution's counsel in preparing for a possible or likely lawsuit. With the knowledge of those events that might precipitate a suit, the hospital's attorney can begin planning defense strategies or proposals for a settlement offer in lieu of a trial. An incident report may also serve in apportioning blame. See Table 9.3 for guidelines for preparing this report.

Table 9.3
Guidelines for Preparing an Incident Report

- Prepare only one copy.
- Prepare it as soon as possible.
- The person preparing the report should be the one who actually saw what happened or who has complete and accurate knowledge of the facts.
- Do not describe other than what you have seen or what you have been told by *reliable*, impartial witnesses.
- If you include the statements of witnesses, confirm that they are not merely hearsay. Name the source and indicate how they know of the circumstances. Quote them.
- Describe precisely what transpired, what actions were taken at the time, and by whom.
- Be accurate, concise, and, above all, *objective*.
- Be honest. Tell the *truth* as best you know it even if this could compromise you or another. Regardless of your involvement, document completely and factually. This could eventually prove to be your best defense.
- Present *facts only*. No conclusions, assumptions, opinions, or unfounded statements of any kind should be offered.
- Do not include any recommendations, suggestions, or advice—this will be done by the staff member who will investigate the incident.

- You can and should name names. Include the addresses of family, visitors, or any other such witnesses. The names of all parties involved, including staff, must be included in the incident report but *never* in the chart.
- *Never* admit liability, culpability, or error. Be very careful of your choice of words. Avoid words that might convey the slightest suggestion of fault or blame.
- Do not attempt to assign blame, or suggest, or infer who is or could have been responsible.
- Include the patient's statements and his or her version of the events. Quote or paraphrase the patient's statements.
- If equipment malfunction is involved, describe the failure. Note the specific type of device, the manufacturer, the product number and any serial number, the name of the technician who last inspected it, and the date. Ideally such items should be secured as is until proper documentation of any defects can be done.
- If a medication error is involved, include all details.

In the event of an incident involving injury to a patient, the appropriate physician should be advised as soon as possible. If the patient and/or family is not already aware, they also should be informed. It can be argued that this should be done in any incident regardless of whether or not the patient has suffered any harm. Should the patient and/or family discover the facts on their own, it could set up a climate of suspicion, mistrust, and anger—the usual motivating factors of a lawsuit. "If the result of an injury is unexpected or a complication has occurred, whether a lawsuit follows often depends on the perception of events and the degree of rapport between the health care provider and the patient" (Fiesta 1994, 5). Competency is the first malpractice preventive measure in nursing practice. Honesty follows close behind.

Discoverability of the Incident Report

An incident report should *never* be mentioned in a nurse's notes. If this is done, the legal doctrine of "incorporation by reference" can be claimed by the plaintiff's attorney. If a nurse states in his or her notes that an incident report has been prepared and filed, this reference incorporates that report into the medical record and thus makes it discoverable. The events involving compromised patient care should be documented but not identified as "incidents". Any information in the chart can be included in the incident report. However, do not include something in a note just because it is in the incident report—for example, names of staff or witnesses.

In many states an incident report is considered to be confidential—a privileged communication between the institution and its counsel. As

noted, however, any reference to the report in the record can strip away this veil of secrecy and provide the plaintiff's lawyer with a view of a potentially damaging piece of evidence.

The courts in various states have examined the matter of the discoverability of the incident report and its admissibility as evidence in malpractice litigation. Rulings have varied, and there have been no consistent decisions. There has been an increasing number of rulings that permit plaintiffs the right of discovery provided they can demonstrate a licit need. More and more courts are opening incident reports to discovery and scrutiny. Many insurance companies and agencies of federal and state government are exercising rights to secure and review them in their fiduciary and regulatory capacities.

An incident report may pass through many hands and be seen by many eyes—some appropriate, some just curious, inquisitive staff, whether they were involved or not. Incident reports are likely to be reviewed by nursing supervisors and administrators, the hospital's administration, counsel, and its insurance carrier. Various governmental agencies including the JCAHO may examine them. And, eventually, the attorney for the plaintiff may succeed in obtaining the report and presenting it in open court for public scrutiny.

A nurse should always prepare an incident report as if it were discoverable. But prepare it without any inordinate fear of its being discovered. If the report is complete, accurate, and truthful, it should hold no peril for the preparer. If it is riddled with inconsistencies, hearsay, accusations, unfounded conclusions, or any implication of culpability, it may become a valuable weapon in the hands of a prosecuting attorney.

COMPUTERIZED CHARTING

As more and more hospitals adopt systems of computerized documentation, nurses have reacted with varying attitudes and degrees of enthusiasm and acceptance. Ideally, computerized charting will provide a medium for more complete, accurate, and timely charting. It will facilitate immediate access to clinical data together with interpretations and implications of that data for patient care. All members of the health care team will have the means for comprehensive review, analysis, consultation, and communication of data on the patient's status, prognosis, and needs. All such information will be instantly retrievable, manageable, and legible. And all such information will be worthless (if not dangerous) unless it was complete and accurate when entered into the database.

It will be every nurse's responsibility to assure the accuracy of each datum they enter. The same responsibility is involved in reviewing all data retrieved and presented on the screen or in a printout. Even if the individual nurse was not responsible for an input error, he or she could be held liable for failure to detect and correct the error. Checking the accuracy of a computer printout, detecting errors, and comparing the information to that already in the chart will be an area of increasing potential liability for nurses. Another area of risk is the ease with which patient files might be retrieved and copied, altered, or even deleted from data banks. Computerized charting may make an onerous task easier, but it will not remove the onus of complete, accurate, and timely documentation. It is a technology that will present new challenges and liability risks for nurses.

Confidentiality in Computerized Medical Records

In addition to generating and managing information, computerized charting presents another major concern for nurses—that of confidentiality and the breach of it through inadvertent or deliberate disclosure of information to unauthorized persons. Nurses who are careless with their access code or password, allowing it to be revealed to unauthorized persons or sharing it indiscriminately, place themselves at serious risk for liability if patient confidentiality is breached as a result. After a patient record has been displayed on a monitor and the required information noted, the record should be removed from the screen and not left available for unauthorized viewing.

> The quantity and sophistication of information contained in computerized patient records—quick access to data, the ability to combine and cross-match information from divergent sources, and the ease of transmitting large amounts of data—pose increased patient confidentiality risks and raise the stakes for hospitals and nurses in case of breach. Moreover, because the legal status of computerized medical records still is ill-defined, these records are vulnerable to legal challenge, especially regarding their admissibility in court. (Gobis 1994, 15)

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10

The Medical Record As Evidence in Nursing Malpractice

THE MEDICAL RECORD

The medical record, in its entirety, is a written chronicle of the medical and nursing care that a patient has received, or is expected to receive, over a period of time, and a record of those who provided that care. This includes care prior to admission to an institution, care while in the institution, or an anticipated course of treatment after discharge. It is first and foremost a medical document and second a legal document. As a legal document it will provide evidence of the type and quality of care that a patient received at the hands of those caregivers whose orders, progress notes, and various reports are included in it (Sharpe 1999).

Standards and Purposes of the Medical Record

In the *Accreditation Manual for Hospitals*, the JCAHO defines the standards and purposes of a medical record. These are applicable in all patient care settings.

Standards

- The record will confirm that the patient has been properly identified, assessed, and admitted to the institution

- The record will reflect timely and proper medical and nursing intervention and treatment based on medical diagnoses
- Such intervention and treatment will be completely and accurately documented
- The documentation in the medical record will conform to the standards defined by the JCAHO and the U.S. Department of Health and Human Services
- All such documentation will be retained and protected by the institution for the prescribed period of time

Purposes

- Directs and documents the medical regimen
- Directs and documents the nursing process
- Documents patient care management and the patient's response to, and effectiveness of, medical and nursing interventions
- Provides a central repository of data to be communicated to all members of the health care team
- Provides a business record for the institution
- Establishes a legal record to protect the rights and interests of the patient, the institution, and the providers of care
- Contributes data for scientific research and continuing education in relevant fields

The principal function of the record is to facilitate continuity in patient care. It is the primary means of communication among all members of the health care team. Thorough documentation demonstrates thorough care. Deficient documentation may demonstrate deficient care. The nursing staff's record of the nursing process must be as exact as the process itself. Complete and accurate documentation is an inherent part of competent care.

Legal Significance of the Medical Record

The significance of the contents of a medical record in a malpractice lawsuit is of paramount importance. The adequacy of the record can make or break a case. If it demonstrates deficiencies in care—breach of duty—it will severely hinder a defense to charges of malpractice. If it is complete, accurate, and factual, it may serve to repudiate allegations of negligence.

The patient-plaintiff's medical record provides his or her attorney with the single most effective weapon in assailing the defendant's credibility and competency. It will be the primary source of the facts and circumstances

surrounding the incident at issue and will invariably be presented in the courtroom as evidence in a malpractice trial. When presented as evidence at a trial the content of the record is presumed to be true. If any significant element in the record can be shown to be missing, inaccurate, or untruthful, the credibility of the entire record could be compromised. The attorney for each side will scrutinize the record to weigh its merits and its utility in supporting his or her respective cases. If the record is tight, the plaintiff's case may not be. "[A]s many as one out of four malpractice suits are decided from the patient's chart" (Edelstein 1990, 40).

Ownership of the Medical Record

"It is generally held that the hospital or medical provider generating the record is the owner of the original document. However, all states recognize the right of patients to have access to the information contained in their medical record and to make copies at their expense" (Appleby and Tarver 1994, 128). The institution maintains legal ownership of a patient's medical record, and physicians own patients' records that are maintained in their offices. In each setting, these are business records that are necessary to the proper administration of the institution or conduct of a practice.

Although the institution or physician has control over the physical record, the question of ownership of the information contained in it is debatable. "The plain fact is that patients have a proprietary interest in their own medical records. At the very least the *information* contained in medical records is the property of the patient. But for the patient, the information would not exist! To require the assistance of counsel to get such records unfairly and unnecessarily burdens a patient who is trying to obtain what is rightfully his" (Wecht 1978, 9).

The American Medical Association considers the content of the record to be the property of the physician. The AMA has stated that: "[N]otes made in treating a patient are primarily for the physician's own use and constitute his personal property. . . . [O]n request of the patient a physician should provide a copy or a summary of the record to the patient . . . an attorney or other person designated by the patient" (AMA 1992, 32).

Access to the Medical Record

As noted previously, the collection of documents is the property of the institution. The collected data belongs to the patient. The right of physical possession, of ownership, does not mean that access to the content of the record can be completely denied to any one outside the institution. As a gen-

eral rule, under common law, a patient has the right to review the content of his or her record and submit appropriate additions and corrections for inclusion. An individual may not alter or remove any document. At the time of this writing, one-half of the states have laws in effect that grant patients access to their medical records in the possession of hospitals or physicians. The laws vary considerably by state (Johnson and Wolfe 1995, 35, 39). Most define the criteria and procedures for access. Even those states that grant access may impose a variety of restrictive limitations. For example:

- The law may apply differently to hospitals, physicians, or mental health institutions.
- The individual(s) granted access may specify the patient only and/or the patient's attorney or other legal representative.
- The nature of access may permit only a review of the record or also the right to have a copy of it.
- The patient may be permitted access to the entire record or only a summary.
- Release of the record may be only at the custodian's discretion.
- In a number of states, attending physicians may retain the right to withhold or release a record.
- There may be certain predefined conditions such as demonstrated relevancy to litigation. A court order may be required. "Good cause" may have to be shown. (For a listing of access laws by state, see appendix I.)

Certain documents contained in a medical record may not, by law, be released without proper authority. These usually include records relating to psychiatric diagnoses and treatment, and certain information that would be considered privileged and confidential. Twenty-seven states and the District of Columbia do permit patients direct access to their mental health records (Johnson and Wolfe 1995, 39).

In 1977, the Privacy Protection Study Commission, which had been created under the 1974 Federal Privacy Act, prepared a report that defined a number of recommendations regarding the rights of patients to access their medical records. In the report, the commission recommended that both federal and state statutes be implemented or adapted to provide an individual who is the subject of a medical record maintained by a health care provider the right to access the record, including the right to read and copy its contents (Privacy Protection Study Commission 1977, 298).

The various state statutes may include specific disclosure laws that permit access without the consent or the knowledge of the patient. It is incumbent upon the institution to identify those individuals or agencies that have a

legitimate need to know this information. A competent person can authorize access to his or her medical record by an attorney, a third-party payer, or any other legal representative on his or her behalf. If the individual lacks the legal capacity for such authorization, a parent or a legal guardian may represent the rights to access. A court subpoena will open any record to legally sanctioned inquiry.

Any individual, in any jurisdiction, can request a subpoena to gain access to his or her records. Several states provide a right of direct access; a patient does not have to initiate a formal legal procedure, or a lawsuit, to obtain his or her records. In some jurisdictions, there may be a requirement that only the patient's attorney can initiate such a request. Frequently, the procedure involved is daunting—this to discourage frivolous inquiries. There is no evidence to support contentions that providing a patient with access to his or her medical record will give impetus to a lawsuit.

The institution may reserve the right to define the time, place, participants, and supervision of the patient's examination of his or her file. The patient is entitled to a copy of this record, and the institution should provide it for a reasonable processing fee. There have been recent incidents of institutions assessing unreasonable, exorbitant fees to provide copies of medical records to patients and attorneys involved in cases of malpractice. Several states have now outlawed these excesses by imposing a maximum per-page charge.

Some statutes may require that the record be complete before it may be released and define a period of time within which this must be accomplished. This may be several weeks following the patient's discharge or demise—if the latter occurs during his or her hospital stay.

Access laws should be the concern of the nurse. A staff nurse or a nurse manager should not routinely provide a file to a patient or to any one not authorized to see the medical record. All such requests should be directed to the appropriate administrative staff. If a patient persists in requesting to see his or her record, the nurse must refer the demand to the nursing supervisor for further action. If the nurse is given permission to release the record or any part of it, he or she should request that this approval be in writing. Ideally the institution's policies and procedures should forbid the staff nurse any direct involvement in these matters.

A patient's medical record is open to any member of the health care team involved in that patient's care. Quality assurance and risk management staff routinely review charts as part of their role. Insurance company representatives will visit nursing units or medical records departments and examine the charts of those patients who are their business clients. Representatives

of governmental agencies and programs such as Medicare or Medicaid also have access.

Appropriate staff members of the institution usually have free access. Student nurses are permitted to examine charts in preparation for and during clinical assignments; the consent of the patient is usually not required in these instances. Records can be the source of research data. A request by an outside individual or agency is normally submitted to a review panel for evaluation of the merits of the proposed research and a guarantee of patient-subject confidentiality.

When the medical records department of a hospital receives a letter from an attorney (or a subpoena) requesting the records of a patient, this is usually a red flag. The risk management department and the institution's counsel are alerted to the request and the possibility of a lawsuit. The attorney representing the institution will call for a medical record at the first hint of a lawsuit. The original record is usually secured to eliminate the possibility of tampering. A copy will be prepared and forwarded to the patient's attorney making the request.

The request may set in motion a review of the record by the hospital's quality assurance, risk management, and legal counsel to predetermine the likely cause of a claim of negligence and preevaluate the merits of any potential claim. An effort will be made to define the degree of exposure to liability, the possible damages to be claimed, and the strengths and weakness of their position. Contingent on the findings of the review, strategies for a possible defense in an anticipated lawsuit may be defined and implemented. Terms of a settlement proposal may be formulated.

LEGAL IMPLICATIONS OF TAMPERING WITH THE MEDICAL RECORD

A corrected note is an altered note. However, an altered note is not necessarily a corrected note. The writer's intent may not be to amend and clarify but to deceive and conceal. Any attempt at deliberate falsification of a record can be evidence in law of the concept of "consciousness of negligence." The inference that could be drawn is that the individual who altered the record was fully aware of his or her own negligence, and this action was an attempt to conceal it. In such instances, a judge may instruct a jury that negligence on the part of the defendant can be assumed from the defendant's apparent attempt to cloak it—even though no other evidence of negligence is apparent. Tampering is illicit altering. It is wrongfully adding to or changing information or data that is already contained in a medical record. Additions might be made to complete or clarify. But no matter the intent,

any such alterations could be interpreted as tampering unless fully documented reasons accompany the changes.

The deliberate *omission* of significant facts is another form of tampering. A nurse should never succumb to temptation, suggestion, or pressure to delete relevant and crucial facts no matter how potentially damaging these might be. Unsanctioned removal and/or destruction of any documents in the record is equally reckless. If a document must be rewritten the original must not be discarded. A jury might suspect that the document that was destroyed could have been incriminating and might consider such an action to have been an attempt to conceal evidence. If this was in fact the intent, the individual has perpetrated a fraud.

A physician or a nurse should never arbitrarily add to, change, or rewrite another's notes. If a nurse determines that this has occurred he or she should refer the matter to nursing administration. Inevitably alterations to a medical record must be made. These can be as routine as correcting spelling, grammar, or mistranscribed data; or they can involve substantive errors such as missing orders, omitted assessments, or absent progress notes. If any *significant* alteration must be made in a patient's record, the practitioner must advise the institution's administration in writing of the need and intent. When and if approved, the physician or nurse must proceed with the addendum according to the direction of the institution's risk management department and/or counsel. Any other person who might have relied on the original record must be advised of the revision.

Under no circumstances should a nurse retrieve a record from the medical record department files and attempt to make any significant alterations on his or her own. It must be remembered that long before a lawsuit is actually filed the plaintiff's attorney may have already obtained a copy of the complete record, and this has been reviewed in detail by the attorney and/or a nurse litigation consultant. Any discrepancies that are later identified (especially before a skeptical jury) may impeach the entire record and certainly the credibility of the defendant.

"When key records are altered or destroyed, the plaintiff's ability to make a prima facie case for negligence is greatly hampered or disappears altogether" (Appleby and Tarver 1997, 66). If the plaintiff's attorney can demonstrate that the patient-plaintiff's record was tampered with, he or she can claim fraud and conspiracy to commit fraud. The accused nurse might face additional charges of aggravated and outrageous conduct. Any attempt to conceal or manipulate facts with a deliberate, willful intent to impede a legitimate inquiry, evade blame, misinform, mislead, or deceive constitutes fraud. Under such circumstances it is a *criminal* offense—a *felony*. Other-

wise, inappropriate alteration of a medical record may be treated as misdemeanor crime in most states.

A nurse, or any one else, should *never* attempt to tamper with a medical record. Any competent forensic document examiner will be able to detect an effort to subvert a record. Any compromised record will be the *kiss of death* for the defendant's case and perhaps for the career of the party responsible. Inevitably the consequences of misguided efforts to conceal or mislead can be far more devastating that a frank admission of the truth.

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11

Legal Implications of Informed Consent

CONSENT

In 1914, Justice Benjamin Cardozo opined: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." (*Schloendorff v. Society of New York Hospital*, 105 N.E. 92 [1914], 17). The patient's act of consent imparts to a health care provider the right to treat and demands of that practitioner the right treatment. There are two fundamental moral and ethical principles inherent in this process. First is the right of free choice affirmed by Justice Cardozo, and second is the concept of nonmaleficence embodied in the Hippocratic Oath, which demands that the practitioner swear that: "[T]he regimen I adopt shall be for the benefit of my patients according to my ability and judgment and not for their hurt or for any wrong."

Forms of Consent

There are two forms of consent: (1) expressed and (2) implied.

Expressed Consent

Expressed consent may be written or oral. Either is considered valid in most jurisdictions. However, in the event of a lawsuit where consent, or al-

leged lack of it, becomes an issue in dispute, proving oral (or implied) consent could be a challenge for the defense. Obviously, written consent is the most desirable form from a risk management view. If at all possible, a witness should be present for an oral consent. In all situations, the circumstances should be documented in detail.

Implied Consent

Consent may also be implied. It is that consent that may be inferred from a patient's actions such as a nod of the head, a wave of a hand, or other gesture to express assent, or by the patient's inaction or inability to act. In an emergency situation where a person is unable to give consent for treatment the law presumes implied consent.

CONSENT IN NURSING PRACTICE

Clinical nursing practice may involve either form of consent, and a nurse must actively and routinely affirm a patient's consent by informing the patient of and explaining an intended action and confirming the patient's understanding and agreement. For the nurse, consent is usually verbal, but a patient's resigned shrug of the shoulders or the absence of any words or actions of protest can signify implied consent. If a competent patient offers no apparent objection, this can be interpreted as implied consent. When in doubt as to the patient's intent, the nurse should document what was actually involved in the exchange, including both the patient's verbal and/or body language.

In the event that a consent must be obtained by telephone, it is advisable that the practitioner accept the consent while another person listening confirms that it has been given and by whom. If an interpreter is needed, it is important to confirm that the interpreter is fluent in the patient's language, fully understands the information being presented, can accurately convey the information, and can verify the patient's understanding and approval. The interpreter's name and relationship to the patient should be documented.

The patient's permission for routine, basic, nursing and medical procedures is implied by his or her admission to, and very presence in, the hospital. During the admission process each patient is routinely asked to sign a consent form that is applicable to those procedures required to provide basic assessments and the initiation and continuation of routine care. Subsequently, the individual's ongoing cooperation in the medical and nursing regimen attests to consent. For other than such routine procedures and treatments, *informed* consent is required for those involving a higher degree of

risk for injury, serious complications and side effects, or death. The patient participating in any experimental treatment or medical trials must give informed consent, which, under federal laws and regulations, has specific and rigid guidelines. A person may not be tested for certain diseases or conditions without his or her knowledge and consent—HIV/AIDS is an example.

Any medical or nursing intervention or attempts at such intervention without a competent patient's expressed or implied consent, informed or otherwise, could result in a claim of battery or of negligence in failure to obtain such consent. Battery is normally a tort but can also escalate to a criminal charge. Malpractice litigation, which may include a claim of lack of consent, is most likely to revolve around a principal issue of professional negligence rather than a minor issue of battery.

"Technical battery" occurs when a nurse, physician, or other health care provider exceeds the scope of the consent given by a patient. Should the patient rescind his or her consent and the practitioner proceeds in disregard of this recision, a lawsuit for battery could be initiated. The exception could be that such a withdrawal of consent constitutes an immediate and unwarranted risk to the patient's health, well-being, or very life. Otherwise, the legal right to refuse, and that decision by the patient, must be respected. Should a patient refuse or revoke a consent, particularly an informed, signed consent, the nurse must advise the physician immediately and document the event fully. The patient or the patient's legal representative should be apprised by the *physician* of the consequences of that decision.

The right to refuse or to revoke includes a competent patient's election to leave the institution at any time, for whatever reason, against medical advice (AMA). The nurse dealing with this patient must follow the policies and procedures of the institution. If possible, the patient should be persuaded to sign the appropriate release form indicating discharge AMA. However, the right of self-discharge AMA is not absolute. If such an individual is deemed to be incompetent or a threat to society or to him- or herself, he or she can be legally detained by the use of such reasonable force as is necessary to prevent elopement.

In addition to direct implications for the person's health, a decision to withdraw consent could have economic repercussions. The individual's health insurance carrier may refuse reimbursement or rescind coverage to the client who refuses to accept a course of treatment that is considered appropriate and essential to prevention, diagnosis, and management of his or her illness—routine or catastrophic. What a patient may perceive as a reasonable, personal choice, an insurance company may construe as the unilat-

eral imposition or continuance of an unreasonable insurance risk that warrants the cancellation of a policy.

INFORMED CONSENT

Informed consent is that permission, given freely and willingly, by a person, or by that person's legally appointed surrogate, which enables a provider of health care, in mutual agreement, to render service to that person as his or her patient. Such mutual consent imparts to a practitioner the right to treat a patient: to do something, which is intended to be therapeutic, to or for that person.

There have been an increasing number of malpractice cases in which the patient-plaintiff has alleged that his or her "informed" consent was not given for the procedure or course of treatment that caused the injury claimed. It is very likely that, at some time in the course of clinical practice, a nurse will become involved in obtaining and/or witnessing a patient's informed consent for surgery or some other treatment or procedure where this is required. The nurse should be aware of his or her responsibilities in these instances and the legal implications of participating in this process. Informed consent, or lack thereof, is primarily a liability risk for physicians, dentists, or other autonomous health care providers, such as nurse practitioners. Various states have enacted both substantive and procedural laws that provide definitions of informed consent, define claims and defenses that will be allowable, and specify the elements of a claim for a tort of negligent nondisclosure.

REQUIRED ELEMENTS OF INFORMED CONSENT

There are two intrinsic elements required to validate informed consent: (1) the patient must have the legal capacity to give such consent, and (2) the duty of full disclosure. These are the legal elements that are defined by virtually all states. However, what a plaintiff may be required to demonstrate in a claim of malpractice may differ from jurisdiction to jurisdiction.

Legal Capacity

The law recognizes that only that person who has legal capacity can consent to or refuse medical treatment. Capacity is defined as the person's ability to comprehend all of the significant implications and consequences of his or her actions or a refusal to act. A basic concept in the law is that of the "reasonable person" test. Should a plaintiff in a lawsuit claim a lack of in-

formed consent, he or she must prove that a reasonable person under the same or similar circumstances would not have given consent on the basis of the information that he or she had been given.

Only a patient deemed fully capacitated may give valid informed consent. A capacitated patient is one who fully comprehends the facts being presented and realizes the implications of whatever choice he or she makes based on those facts. The individual who is unconscious, severely impaired as a result of drugs or alcohol, insane, mentally retarded, or otherwise mentally impaired cannot acquiesce in an act of informed consent. Any alert, fully oriented adult is normally viewed as manifesting legal capacity.

In obtaining informed consent, the patient's *physician* is legally responsible for confirming that the patient is competent and has the legal capacity to give it. For that person who has been adjudicated as incompetent, a court-appointed surrogate or guardian can act in his or her behalf. If such a guardian has not been named, the circumstances may require a petition to a court to appoint one immediately.

In some jurisdictions, designated members of an incompetent or incapacitated patient's family or even a friend may give consent. In the order of priority, and contingent on availability, the patient's spouse would normally be consulted first, then adult children, and last, parents. Virtually all states now empower their citizens to formalize such designations by documents such as living wills, powers of attorney, or other legally appropriate directives. These will be discussed in chapter 12.

Another essential element is that the consent must be *freely given* by the patient. There can be no coercion or duress of any kind. This includes physical force or psychological pressure in the form of intimidation or threats. Once given, consent may be withdrawn at any time. The right of refusal is not necessarily an absolute right. The state may supersede that right in several instances. These might include:

- the refusal of consent by a parent or guardian that jeopardizes the life or well-being of a minor (including a fetus);
- the individual, by their refusal, is unjustifiably jeopardizing his or her own life; in such instances, honoring the refusal could be viewed as participation in an assisted suicide; and
- preservation and protection of public health and safety is involved.

Full Disclosure

A duty to disclose goes to the very heart of informed consent. That duty is the mandated requirement that *all significant and material facts* be pre-

sented to a patient, in language that the patient can fully understand, in order that the individual may make what can be accurately construed as an informed decision to accept or refuse a proposed course of action. *Not every conceivable risk* or side effect need be included. This presentation must also include *all possible alternative courses of action*—including taking no action at all—and the consequences of these.

Two standards have evolved from court decisions that are recognized as guidelines for the quantity and quality of information to be included. The first is that of the "reasonable physician" who must include all of those facts that any other reasonable medical practitioner would provide under the same or similar circumstances. The second standard is that of the "reasonable patient" who is entitled to information which, in content and format, is necessary for any reasonable person to make a rational choice. The patient must be given a quantity and a quality of information such that he or she can make an intelligent, judicious decision in accepting or rejecting the treatment or procedure proposed. In most jurisdictions, an objective test will be applied that will attempt to confirm whether or not the risks presented would be considered material to any reasonable individual in the same or similar circumstances; and would such an individual consider those material risks of such significance as to prompt him or her to refuse consent.

A malpractice lawsuit might not involve any claim by a plaintiff that he or she did not give an informed consent for the treatment rendered, or such an assertion can be a peripheral issue. If the lawsuit has its basis in an asserted lack of informed consent, the plaintiff must demonstrate that the physician or other health care professional—by a failure in full disclosure—breached his or her duty to the plaintiff and in so doing caused the plaintiff to decide on a course of action that he or she would not have elected otherwise. In effect, the patient must prove that the alleged breach of duty was the cause of the injury claimed.

Required Elements in Full Disclosure

There is continuing debate on what constitutes "material risk". However, it is generally agreed that full disclosure must include certain essential components. These are:

- the patient's present clinical status and/or current prognosis;
- pertinent details regarding the proposed treatment or procedure—*in a layperson's language*;
- inherent, *significant* risks and usually expected adverse side effects;
- anticipated therapeutic outcomes as they can best be defined;

- alternative treatments or procedures, if any, and their risks and benefits;
- the patient's right to refuse and right to retract consent at any time; and
- possible or expected developments should the patient refuse.

A practitioner's inadvertent deficiency in the requirements of full disclosure may not invalidate the patient's informed consent, but it may become a factor in sustaining a liability claim for negligence. The multitude of laws and the infinite subtleties in interpretation of constituent disclosure factors in informed consent have given rise to many lawsuits.

Exceptions to the Duty of Full Disclosure

There are several exceptions to the duty of full disclosure.

- Emergency: Life-saving intervention is required immediately. The patient's condition precludes obtaining informed consent. Consent is implied. There may be a state statute defining procedures for obtaining consent and who may give it. In some instances, a court order may be required.
- Waiver: Any competent adult can refuse consent or waive consent. A patient can waive his or her right to full disclosure yet still consent to the proposed treatment or procedure.
- Obvious risk: The inherent risks of the treatment or procedure are apparent to any reasonable person. They have been widely publicized and are known to the population-at-large. Or the patient knows the risks because he or she had previously undergone the same course of treatment for which informed consent had been given.
- Therapeutic privilege: The practitioner who intends to perform the procedure may assert that certain information that he or she considers potentially detrimental to the patient's health or well-being can and should be withheld in obtaining the patient's informed consent. The practitioner may deem that full disclosure could jeopardize the patient's physical or mental status, interfere with treatment, impede recovery, or impair prognosis. When invoking therapeutic privilege, the practitioner is required to justify the decision by complete documentation of the rationale.

Related to exceptions to full disclosure is the "extension doctrine" that permits a practitioner to initiate a course of action not specifically discussed or consented to previously, but that is now required by exigencies arising during the procedure. In effect, a life-threatening situation arises that warrants an extension of the scope of the patient's consent and at that instance, the patient is not able to concur. An example would be more extended sur-

gery determined to be immediately necessary for the unconscious patient present on the operating table.

MINORS AND CONSENT

The statutes of each state generally prohibit any health care practitioner from providing services to a minor without the consent of a parent or legal guardian. The exception to this is an emergency where the minor's well-being or life may be at risk. In the case of an unemancipated minor, consent would normally be given by a parent or a legal guardian. Where the parents are divorced or separated, the parent with primary custody would usually be responsible. The adoptive parents of a child enjoy the same rights as natural parents. A stepmother or stepfather may not have the right of consent. The prerogatives of foster parents will be determined by applicable statutes and regulations governing the placement agency involved. With few exceptions, a court-appointed guardian is endowed with such a legal right.

According to the statutes in any given state, a minor who is self-supporting and living in a residence that he or she maintains, or a minor on active duty in the armed services, may be considered an emancipated minor and, therefore, has the legal capacity for informed consent and to enter into certain contracts. As a general rule, however, an unemancipated minor is considered to be lacking in the legal capacity for informed consent. There are a number of exceptions that various state laws may allow or that define specific guidelines.

- Treatment for substance abuse or addiction
- Treatment for mental health problems
- Care and management of specified communicable diseases, including sexually transmitted diseases
- Reproductive health services including birth control and abortion

CONSENT FORMS

The standard consent form that patients are asked to sign upon admission to a hospital is usually adequate for routine procedures. However, presenting a patient with a preprinted form that he or she is asked to read and sign does not constitute true, legal informed consent. Informed consent is a process of instruction, education, and revelation. It is not a cursory reading and signing of a document. To be legally acceptable, informed consent should incorporate the elements described previously.

If the statutes of a state define the content of a consent form, and if the language of the form that a patient signs conforms to the statutes, there can be a presumption in law that informed consent was, in fact, given. In the event of a malpractice lawsuit in which informed consent becomes an issue, a signed form that is couched in very general terms or that merely affirms that the content has been presented to the patient may not suffice. In several states a signed consent form may provide a defendant with strong, but not conclusive, incontrovertible evidence. A plaintiff may still be permitted to challenge the document in court and claim its inadequacy of content, his or her lack of understanding, incapacity, duress, or irrationality under stress.

Many state statutes do not define a requirement for a signed consent form. If a physician has thoroughly documented that he or she has verbally presented to the patient all of the required elements of full disclosure, and that the patient understood and assented, the progress notes of the practitioner may serve as evidence in lieu of a signed form. The physician may also have obtained the patient's signed consent in the office at some time before an actual admission date. This form may be forwarded to the hospital, and, assuming no significant change in the patient's medical status or contraindications for the proposed procedure, could be legally acceptable. Such authorization forms should be examined for an expiration date.

A consent form may not include any language that precludes the patient from revoking authorization at any time. Unless withdrawn, a signed form remains in effect until such time as a change in the patient's status introduces a significant alteration in the parameters of risk and intervention that mandate review, revision, or recision—or until a specified expiration date has passed. In this event, the process of full disclosure in informed consent must be repeated as necessary. A periodic review and renewal, regardless of the patient's condition, may also be required by the policies and procedures of the institution as defined by the JCAHO.

RESPONSIBILITY FOR OBTAINING INFORMED CONSENT

It is the primary, legal responsibility of the *practitioner* (usually a physician) who has ordered, or who will perform, a procedure or administer a treatment to affirm to his or her satisfaction that the information they presented to their patient was completely understood, and to obtain that patient's informed consent. The staff nurse, in the usual course of his or her duties, should have no direct responsibility in providing full disclosure or obtaining informed consent. A practitioner may legally delegate this responsibility to a nurse, but assumes the inherent risks of this action. This in-

cludes a risk of joint liability for a claim of negligent nondisclosure. A nurse may then act as the agent of the practitioner and assumes the role of the delegator—and the liability. If a nurse assumes this role, the institution also incurs increased exposure to liability under the doctrine of *respondeat superior.*

Informed consent obtained by a nurse has been considered acceptable in a case in which the court ruled that the information which the nurse provided was within that particular nurse's scope of practice. A nurse practitioner may be allowed and/or required to obtain informed consent before carrying out certain procedures. Generally, the law directs that a nurse is permitted to attempt full disclosure only if that responsibility has been delegated to him or her by a physician and in accordance with the policies and procedures of the employing institution. Regardless of the source, the information must be provided to the patient by the individual most qualified by education and experience to do so.

If the practitioner fails to or refuses to carry out full disclosure, a nurse must report this to a nursing supervisor for further action. If the nurse is reasonably certain that any requisite element of the full disclosure process has been omitted, he or she must present his or her concerns to the physician; and, if not satisfied, refer the matter to nursing administration for further action. The nurse's failure to do so could present a risk of liability. If a patient has not been fully informed for any reason, the nurse must document the circumstances in detail, including attempts to resolve the matter.

THE NURSE AS A WITNESS TO INFORMED CONSENT

Depending on the jurisdiction, a witness may not be required to validate informed consent. A nurse's signature as a witness could provide some degree of additional protection from liability for the physician. Some institutions have a policy that requires a nurse witness a consent form. The primary function of the nurse who witnesses this document is to attest that the patient was competent and had the legal capacity to sign, signed voluntarily, and the signature affixed is, in fact, authentic—it is that of the person giving the consent. The signature of the witness should not attest to the degree of comprehension by the patient of the information that he or she has been given by the physician.

The nurse who signs as a witness is not obtaining the patient's informed consent. Ideally, the signature of the nurse-witness should come after he or she actually *heard* the verbal exchange between the physician and the patient—the physician informing the patient and requesting the patient's sig-

nature. Legally, if the nurse is reasonably certain that full disclosure has taken place, he or she can request that the patient sign the consent form and also witness the signature. Otherwise, unless the nurse is actually present to observe and hear the physician's presentation of information, he or she cannot verify the content of the discussion. Know and follow the applicable policies and procedures of the institution.

Signing the form only as a witness does not present the nurse with any liability for failure to obtain informed consent. However, he or she should confirm the fact of informed consent before witnessing the signature of the patient. If the patient, or perhaps a family member, states to the nurse that he or she (the patient) does not understand any portion of the information presented, the nurse should instruct the patient not to sign the form and notify the physician. If the nurse permits such a patient to sign the form without taking appropriate action, he or she could be held liable.

The nurse should not attempt to answer a patient's questions regarding the medical aspects of the treatment or procedure after the physician has provided the disclosure information. Any such questions should be referred to the physician. The nurse has no professional duty or authority to answer such questions. In electing to act as witness, the nurse incurs no responsibility for providing information or clarification. A nurse may elect to reinforce selected information previously given, but is cautioned not to usurp the practitioner's legal duty to inform. Should the nurse choose to answer questions or provide clarification on any matter, he or she must address only those aspects of the procedure that are clearly within the scope of nursing practice. Should he or she step beyond this line, he or she may incur the risk of an accusation of practicing medicine.

WITNESSING OTHER LEGAL DOCUMENTS

In witnessing a document such as a will, power of attorney, or bill of sale, the nurse simply attests to the authenticity of the signature that he or she actually saw being affixed to the document. The nurse should examine the document to confirm that what he or she is signing is, in fact, what it is purported to be. Each time a nurse agrees to participate is such nonprofessional business, he or she should note the details in any personal anecdotal records. *Before* a patient signs any legal document, the nurse, as witness, should do an assessment of the patient's mental status and later note this in the chart.

If the nurse has any reservations as to the competency or the legal capacity of the person signing, he or she should not witness the person's signature. The nurse should refuse to participate if he or she suspects or observes

any evidence of coercion, fraud, or undue influence. The nurse could be held liable if he or she witnesses a document knowing, or having reasonable cause to suspect, that the person who is signing it is legally incapable of doing so.

What a nurse elects to do in these circumstances can have very serious legal implications. In the event of litigation revolving around the document in question, the nurse could be subpoenaed and required to recount the circumstances of the event and his or her impressions of the participants' behaviors. Under no circumstances should a nurse request or accept compensation of any kind for acting as a witness while on duty.

There may be a time when a nurse could be witness to statements made by a patient in anticipation of impending death. It is very common for a patient to elect to dictate a last will and testament after admission to a hospital. Many institutions have standardized forms available that have been prepared by their legal departments. When the request is made, the staff nurse should refer it to a nursing supervisor for appropriate action. If the urgency of the situation requires immediate action, and an oral will is expressed by the patient as testator, ideally two persons should be present for the dictation and transcription, and to witness the patient's signature on the transcription—if he or she is able to sign. In some jurisdictions, witnesses are not required. The provisions of this oral last will and testament should be recorded in the medical record and the notation signed by both witnesses. If such an oral will is valid under the state's statutes, it is a legally binding document. A declaration such as deathbed confession of a past crime should be taken down verbatim and placed in the medical record. The appropriate law enforcement authorities should be notified immediately; it could be a critical element in criminal proceedings—including exoneration of another.

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Legal Implications of Advance Directives and No-Code Orders

ADVANCE DIRECTIVES

"Advances in medical knowledge and the development of life-sustaining technologies have changed the very nature of death. No longer a 'moment', dying may now be viewed as a process or continuum, the duration of which can be prolonged indefinitely. This technological potential has given rise to an unprecedented array of professional, moral, and legal questions within the health care delivery system" (Schwarz 1992, 92). The nursing profession has now become intimately involved in the protocols of death. There is even a nursing diagnosis for it: "Dying Process".

The rights of a terminally ill person to refuse medical intervention of any kind have not always been clear. Two legal landmark cases (*Quinlan* in 1976 and *Cruzan* in 1990) focused widespread interest on the legal and ethical implications of the "right to die" issue. On December 1, 1991, the Patient Self-Determination Act of 1990 (PSDA, the Act) went into effect in the United States. This statute confirmed the immemorial common law principle that every competent human being who has reached majority has an inherent right to accept or refuse medical treatment—the concept affirmed by Justice Cardozo over eight decades ago. It is in dealing with the incapacitated or incompetent adult in need of medical intervention that at

times confounds the courts. Who will make the decision when the person whose sole prerogative it may have been, can no longer do so? The PSDA did not address this question and, in effect, relinquished such decisions to courts of the various states.

> In 1990 the U.S. Supreme Court [in deciding the *Cruzan* case] . . . acknowledged that a competent adult has a constitutionally protected right to refuse unwanted medical treatment. However, it found that for an incompetent patient, in order to protect the state's interests, the court may require 'clear and convincing' evidence of what the patient, if competent, would want. The Court did not define 'clear and convincing' but it did acknowledge that a proper living will, a legal document stating what health care a patient will accept or refuse, would have satisfied this higher standard. (Aiken and Catalano 1994, 108)

The Court prescribed that such clear and convincing evidence of an individual's desires regarding medical treatment be present before a decision can be made to withhold life-sustaining interventions. It was left to the individual states to determine the quality of proof required. Clarification and affirmation of these desires is the objective of advance directives.

Each state now has differing laws on its books that permit any adult having legal capacity to effect some form of legal document prescribing the desired course and preferences of his or her medical care in the event that the adult becomes unable to define his or her wishes. These enactments are variously called "right-to die", "natural death", or "living will" laws. They incorporate the self-determination concept presented previously, and recognize a person's right to decline any and all extraordinary, heroic, life-saving measures when there is no reasonable expectation of survival. Certain elements are seen in most of the statutes. There is usually a requirement that the patient has been determined to be incompetent or incapacitated before the advance directive is implemented. The statute may also require that a terminal illness with no possibility of recovery be evident, that the patient be in an intractable coma, persistent vegetative state, or so profoundly debilitated as to show no promise of response to treatment. The language of several statutes is sufficiently broad as to include those individuals in a state of dementia, including those with Alzheimer's disease.

Generally, the laws prescribe that the advance directive will go into effect only when a physician makes a determination of one or more of the above conditions. In some instances the statutes require that a second physician concur in this determination. Such a diagnosis and decision may have to be made only after the individual is actually admitted to a hospital.

A potential problem exists with the "portability" of advance directives—the situation that arises should an individual relocate or travel to another state whose statutes may not recognize certain provisions of an advance directive created in another jurisdiction. In some states, a directive is valid only if it complies with the statutes of the state in which it was created. In others, the document is valid only if it is in compliance with the statutes of the state in which it is to be implemented. In the event of establishing permanent residence in another state, an attorney should be consulted in that state to review the documents and bring them into compliance.

Advance directives generally are binding on all health care providers. They are drawn up while the actor is capacitated and go into effect only when he or she is incapacitated. "The term *incapacity* should not be confused with the term *incompetence*, although they are frequently used interchangeably in the clinical setting. Incompetency requires a judicial determination; it is a finding by a court that an individual lacks the ability to make *all* decisions, including health care decisions" (Schwarz 1992, 94). Since the Act affirms that a particular state's law will control any such directives permitted under an enacted statute, the language of a directive must conform to the prerequisites of that statute. Health care providers must know the provisions of the law in their locale.

TYPES OF ADVANCE DIRECTIVES

There are three principal types of advance directives: (1) the living will, (2) medical directives, and (3) durable power of attorney.

Living Will

The living will is a written, witnessed declaration of a person's specific desires and intentions concerning the nature and extent of medical care he or she wishes to receive—or not receive—in the event that he or she is personally unable to affirm such desires or intentions. It is an expression of a person's hope that the terminally ill patient will be allowed to die a natural, dignified death when that is the only, final option. It will direct decisions regarding the course of treatment when a terminally ill patient, with no reasonable possibility of recovery, can no longer make such decisions.

Unfortunately living wills are often couched in very broad, vague, comparatively simple terms that deal primarily with extraordinary interventions—when there is "no hope". They may include such language as no "heroic" or "extraordinary" efforts, but fail to address such basic measures of life support as nutrition and hydration. Despite a consensus among medi-

cal, ethics, and legal experts that hydration and nutrition, via one route or another, are recognized as medical interventions and should be recognized as such in an advance directive, there is still much controversy surrounding decisions to withhold such efforts.

With few exceptions, each state provides a different written format for a living will. In some, patients are required to use the prescribed form; in others, they are not. However, the language of any form utilized, particularly on "standard" forms, must conform to the state's law. This may leave wide latitude for a variety of individual interpretation and selective implementation. Frequently a preprinted form for a living will may incorporate specific patient directives that may not be allowed under the statute of a particular state. Such forms are readily available in various publications and on many Web sites. An attorney who is knowledgeable regarding the provisions of the state of jurisdiction should be retained to prepare a living will that will not only be a "legal" document but a legally binding document.

Oral living wills are usually not legally binding; although, it must be remembered that a patient's statements regarding his or her election to refuse treatment are binding. If a patient expresses his or her wishes to a nurse about the course of treatment, the nurse should record such statements in the progress notes, quoting the patient as accurately as possible. An oral living will should, however, be respected; any documented living will, written or oral, will likely be accepted by a court as definitive evidence of a patient's wishes. More specific medical directives can supplement or replace such deficient documents.

Medical Directives

Medical directives may also be called "physician directives"; they are a more specific and comprehensive embodiment of the living will. An array of specific clinical circumstances is presented together with the patient's election in each situation. The patient defines the medical regimen he or she desires and expects in each scenario. These attempt to provide specific guidelines for the provision of or withholding of life-sustaining medical intervention. They cannot possibly include an option for every conceivable scenario.

Durable Power of Attorney

A durable power of attorney, also called a "medical power of attorney" or a "durable power of attorney for health care" is an instrument which appoints a surrogate—an individual who, by proxy, is charged with making decisions relevant to an incompetent grantor's medical care, treatment, and

termination of care and treatment when appropriate. A durable power of attorney takes effect immediately if the principal or grantor has legal capacity. The grantor can revoke the power of the attorney at any time. This power of attorney is "durable" in that it survives the grantor's incapacity; it does not survive the grantor. It terminates upon the death of the grantor. Many state laws now assume that any power of attorney may be durable unless stated otherwise. Durable powers of attorney can be recorded with the appropriate officer of a court. The process of recording such legal documents can make them (and their private details) a part of the public record. In some states, the individual must have both a terminal illness and a lack of legal capacity for a durable power of attorney for health care to be effected.

INFORMING THE PATIENT REGARDING ADVANCE DIRECTIVES

The PSDA requires hospitals and nursing homes that receive federal funds such as from Medicare and/or Medicaid to inform each patient of his or her right, under the applicable state statute, to forego medical intervention should he or she become incapacitated. These institutions are required to determine, and document, if the patient has prepared any advance directives. They are mandated to provide *written* information about them to every patient at the time of admission. The admissions office of the institution usually presents each patient and/or family members with a brochure or pamphlet that summarizes the provisions of the state law, and defines and explains the patient's rights and the various forms of advance directives permitted under their state's statute. It was the original intent of the PSDA to encourage every individual to prepare advance directives in anticipation of a time when incapacity or terminal illness precipitates a need—a time when the individual is unable to do so.

NURSES' ROLES IN ADVANCE DIRECTIVES

Nurses are expected to assume an active, supportive, and key role based on a thorough understanding of the statutes applicable in their state and the implications of the provisions of those laws for nursing practice. As patient advocates, nurses are charged with a degree of professional responsibility in educating the health care consumer regarding informed consent and decision making—including advance directives. In 1992, the American Nurses Association recommended that the subject of advance directives be included routinely in every nurse's admission assessment.

The PSDA requires that each institution have a policy and procedure in place regarding advance directives. Nurses should become educated in the

appropriate procedures, timing, and techniques to be used in eliciting this information. "For patients (and proxies or surrogates) who wish to complete advance directives, nurses have a responsibility to ensure that patients: (1) have access to the knowledge on which to base a treatment decision, (2) have clearly expressed their decision and desires, and (3) receive treatment in accord with their expressed preferences. . . . There is evidence that nurses are the health care providers most likely to implement the PSDA" (Mezey et al. 1994, 31).

A nurse may be the first health care provider to become aware of the existence of a directive. This may be elicited during the course of the admission assessment of the patient. When this is determined, the information should be documented in the nurse's assessment notes and confirmed to the physician and all others involved in the patient's care as directed by the institution's policies and procedures.

As a result of intimate and ongoing involvement with the patient, a nurse may ascertain facts that could warrant a revision, or even recision, of a directive. The patient may express uncertainty, lack of conviction, or reluctance to let a directive stand; the nurse may be the first and only one privy to such confidences. When such sentiments are expressed or suggested, the nurse should discuss the matter with the patient's physician who may then confirm the patient's feelings and intentions and mutually reevaluate the course of action. Nurses should encourage patients to express their concerns, misgivings, and intentions, and, in a continuing process of support, assist them in confirming and defining these most personal decisions—this while validating the individual's decision-making capacity and using all appropriate procedures and personnel.

DOCUMENTING ADVANCE DIRECTIVES IN THE MEDICAL RECORD

The Patient Self-Determination Act also mandates that a notation regarding a patient's written directive be entered into his or her medical record. The Act does not require that a copy of the document be included. If the patient has not brought the documents with him or her at the time of admission, the nurse should ask an individual who has access to them to send valid copies of them to the institution as soon as possible for review, validation, inclusion into the record, and communication to all appropriate personnel. Should the patient decide to execute or revise an advance directive after admission, the nurse is advised not to become directly involved in the procedure. He or she should refer the matter to a supervisor who may request that a social services or risk management staff member assist the patient. Nurses

are not required (or even allowed in some states) to witness the patient's signature on these documents. Should they do so, they could ultimately be called on to defend their assessment of the patient's legal capacity at that time.

COMPLIANCE WITH ADVANCE DIRECTIVES

The patient's *physician* will be primarily responsible for the interpretation and implementation of an advance directive since it deals with the medical regimen and the course of medical intervention. The physician, nurse, or other health care provider who makes every reasonable effort to carry out a directive should, as a general rule, be immune from civil or criminal liability.

The laws of each state have not only sanctioned advance directives, but have also established legal procedures to guarantee that these will be carried out by those health care professionals charged with that duty. It may not be a physician's sole and final prerogative to elect not to honor an advance directive. Such a decision is the sole and final prerogative of a court. If a physician decides not to honor a directive on the basis of personal, religious, ethical, or moral convictions, he or she must initiate a transfer of the patient to another physician or institution that is willing to do so. If the physician or the institution persists in providing intervention clearly contraindicated by a legitimate advance directive, the patient's family or a legally appointed designate may seek a court order to force compliance with the patient's wishes.

Conflicts are bound to arise with persons who have a direct interest in the patient's welfare (or estate). There usually are criminal penalties imposed on individuals for any attempt to tamper with an advance directive or make false statements regarding one's existence or nonexistence without the knowledge or consent of the grantor. These can apply no matter how well intentioned their efforts may be. Many physicians fear a lawsuit from family members who insist on compliance or, conversely, demand noncompliance. Many state statutes do provide immunity from liability for physicians who make good-faith decisions about life-sustaining interventions initiated in some circumstances.

Several articles of the ANA Code for Nurses (ANA 1985) affirm that nurses have a moral and professional responsibility to act as patient advocates, especially in those instances where a professional colleague is perceived to be in violation of the standards of practice—medical or nursing. When a nurse suspects or confirms that an advance directive is being disre-

garded, he or she has a legal and professional duty, as patient advocate, to intervene. Failure to do so could expose the nurse to a share of liability.

ORGAN DONATION AND ADVANCE DIRECTIVES

In the event that the patient has been properly identified as an organ donor, life-sustaining measures may be initiated despite the existence of an advance directive that contraindicates them. This may be done in order to maintain the designated organs in a viable state until they can be harvested. There can be a number of complex issues introduced in such situations. Anyone who intends to be an organ donor should consult with both their physician and an attorney regarding the relevant provisions of any advance directive they may have signed or intend to prepare. The eventual, complying act of euthanasia to recover the donated organs at the most opportune time is, in effect, a deferred compliance with the directive and would not appear to contravene the expressed or implied wishes of the dying or clinically dead donor.

NO-CODE ORDERS

In the absence of a written appropriate advance directive, any competent individual has the right to request that his or her physician write a "no-code" order when circumstances warrant it. This affirms the patient's personal decision that neither medical nor nursing staff attempt resuscitation in the event of cardiac and/or respiratory failure. The patient may also elect to refuse other life-sustaining procedures and define the criteria to be considered. All discussions with the patient or appropriate family members regarding the decision should be documented thoroughly by the physician involved. Any patient or family discussions with a nurse regarding the matter must also be documented and referred to the physician so that he or she can evaluate the patient's intentions and write the order accordingly. A nurse should never agree to an inappropriate request from a family member or any other person, unless the individual is acting under a documented advance directive that has been implemented based on the patient's status.

This so-called slow code is *the* order that most often does not appear in the physician's written orders or notes but is most frequently given orally. A verbal "do not resuscitate" (DNR) order presents an unacceptable risk to the nursing staff. As a general rule, nurses should not accept and/or act on a verbal DNR order. Should there be any question of the propriety of a nurse's action in the event of a code, a physician could disclaim a verbal order by denying he or she gave it or by refusing to countersign it. If a nurse is re-

quired by the urgency or mitigating circumstances of the situation to accept a verbal DNR order, it is advisable to have a witness who can confirm the subject, date, time, originator, and the verbatim content of the order.

In the absence of a written DNR order (or physician-activated advance directive) a nurse must initiate full-code protocols and begin resuscitative efforts immediately—even if the patient is terminally ill. If a DNR order has in fact been written, the nurse should, of course, not call a code. To do so could expose the nurse to a charge of insubordination, breach of duty, battery, or even criminal negligence. Failure to take appropriate action, with or without a written order, could be construed as an independent medical judgment, tantamount to practicing medicine without a license. Such an action could expose a nurse to censure and possible loss of licensure. Without a documented no-code order, the nurse must behave as if the order simply does not exist. Failure to take what a court might eventually deem appropriate action may be cause for a claim of malpractice. Defending such a claim could be very difficult in the absence of a written DNR order.

Every hospital accredited by the JCAHO is required to have a written policy regarding withholding or termination of life-sustaining measures. Every staff nurse must know what that policy prescribes and act accordingly. A typical directive on this matter states that any no-code order must be *written*—by the appropriate physician—in the patient's medical record. It is a legal and professional responsibility of the physician. The policy may include a procedure for periodic review of a DNR order and criteria for continuance or cessation contingent on the patient's status.

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Malpractice Insurance

PROFESSIONAL RESPONSIBILITY FOR COVERAGE

Anyone involved in the provision of health care in any capacity should have professional liability insurance. It is every nurse's professional duty to be responsible in all matters of practice. This includes competency in nursing skills and also fiscal accountability. Although there may be no legal requirement for a nurse to have malpractice insurance coverage, there is a moral and ethical imperative in this responsibility. It is a reasonable expectation on the part of every patient that a nurse will provide safe and therapeutic care; and, in the event that the nurse fails in this duty, that a financial remedy will be available to compensate the patient for any injuries. The injured patient can seek this remedy in restitution from an insurance company and/or in seizure and conversion of the nurse-defendant's personal assets and future wages. Malpractice insurance is a logical requirement in our litigious society. It should be a practice requirement in the professional community. It has been suggested that proof of such coverage be a criterion for professional licensure.

THE NEED FOR MALPRACTICE INSURANCE

Any nurse, in any practice setting, at any time, can be named in a nursing malpractice claim or lawsuit. This includes the student aspiring to the pro-

fession, the staff nurse or administrator in active practice, the nurse who is temporarily away from practice, or the individual who has enjoyed active retirement for some time. None is exempt from potential litigation or immune from the risk. If any one of these does not now have, or has never had, the appropriate type of malpractice insurance coverage, this risk could perpetuate itself. Know the type of coverage you have, and take immediate remedial steps if it is deficient in any way.

The days when a nurse did not have to worry about or even need malpractice insurance are long gone. In the litigious climate of today's health care, the nurse who does not recognize the constant peril of being sued, and who does not take appropriate steps to mitigate such risk, is naïve, reckless, and fiscally and professionally irresponsible. It is the foolish nurse who does not appreciate the reality that he or she can be the victim of a lawsuit by any one at any time (even long after his or her retirement from active practice) and that the suit may be based on the flimsiest pretext or the remotest connection to a long-passed event.

Malpractice, as defined previously, is professional negligence. It is not synonymous with incompetence. Even the most competent nurse can be sued for an action or omission that harms a patient. Insurance coverage will not eliminate the risk of being sued; but it will go a long way in easing the fear of being sued and provide a reasonable sense of security and some degree of peace of mind. It will never provide immunity for the incompetent.

A nurse's malpractice insurance policy should not be another liability, an additional risk to manage, in his or her practice. It could be argued that it has no actual relevancy to clinical practice. It cannot enhance a practitioner's skills or prevent negligence. It does not directly protect the hospital, a clinical nursing instructor, an academic institution employing that instructor, or the nurse's fellow staff or supervisors. It certainly does not protect the patient. Essentially, it protects only the policy holder.

GOING NAKED

A reasonable question then is: If a nurse has no substantial assets that could be taken in an adverse judgment, why incur the expense, why incur the cost of coverage? Why not "go naked"? If the individual has no material wealth, what is at risk? They do not have the deep pockets of a physician or the deeper pockets of the hospital. Without significant resources, they may think they are, in effect, "lawsuit-proof" or "judgment-proof". There is a very serious flaw in this logic. The laws applicable to damages awarded in judgments vary according to the jurisdiction. In many jurisdictions the

judgment remains open, or the plaintiff can file, and refile it, until it is satisfied or until they elect to forego it. During the time the judgment remains open, liens may be placed on property. Any assets that the defendant might acquire, including inheritances, could be seized in satisfaction. Wages could be garnisheed. His or her estate could be sued.

State laws vary on the nature and amount of personal assets that can be seized in satisfaction of a judgment. However, in most states, jointly owned assets are not subject to attachment. In the event that a nursing malpractice lawsuit actually goes to trial, an adverse judgment awarded by a jury could force a defendant into bankruptcy and an ongoing state of insolvency. A negotiated settlement could have equally devastating financial consequences. This can happen to the nurse who is insured when the amount of damages exceeds the policy limits, or to the nurse who is uninsured—where there is no policy and no limits.

A legal defense must be mounted against a malpractice action. Every nurse should carry a personal policy if for no other reason than it will provide, and compensate, an attorney to defend the nurse in any malpractice claim. Damage awards aside, attorney's fees could bankrupt a defendant without coverage. This alone dictates a personal policy as a sound investment at modest expense. Once a complaint or lawsuit has been filed against a defendant, he or she will not be able to obtain insurance coverage after-the-fact. Efforts to protect assets will likely be to no avail.

MISTAKEN PERCEPTIONS OF MALPRACTICE INSURANCE

A prevalent and mistaken belief is that malpractice coverage actually invites lawsuits against nurses and physicians or markedly increases the risk of malpractice litigation. Research shows that there is no substantive evidence for this notion. Neither the plaintiff nor his or her attorney can verify a prospective defendant's insurance coverage until a lawsuit has actually been filed and the discovery process is initiated.

Another fallacy is that a sympathetic jury will be more inclined to award damages, or to be more generous in such awards, when they believe that a bountiful supply of an insurance company's money is available for distribution to the injured victim. In fact, the jury is likely to be ignorant of existing coverage, let alone the amount. In some jurisdictions this knowledge is forbidden to a jury by law. Of course, it would be a reasonable supposition by a patient-plaintiff and by any or all members of a jury, that an intelligent and prudent practitioner would carry malpractice insurance and that the coverage involves substantial sums.

TYPES OF MALPRACTICE INSURANCE POLICIES

There are two types of malpractice insurance policies. It is absolutely necessary for every nursing student, for every nurse in clinical practice of any kind, and for the nurse who is no longer practicing—even long retired—to know which type of policy he or she now carries or *has ever carried.* The two types of policies are "occurrence" and "claims-made". They cover either medical or nursing malpractice.

Occurrence

An occurrence malpractice insurance policy covers all events (injuries or alleged injuries) that occur *during the period in which the policy was in effect. This would include all claims that might be made after the policy has expired or been terminated.* Most personal policies are occurrence, and it is the most advantageous type to have, even though premiums might be higher. The advantage lies in the fact that once the policy goes into effect, *a suit arising from any incident while it is in effect will be covered regardless of how long afterward it may be brought.* Because of the vagaries in the statutes of limitations, the occurrence policy offers the best and most long-lasting protection. Look for language in the policy such as "any injury arising out of . . . during the period of coverage of this policy"—this denotes an occurrence-based policy.

Claims-made

A claims-made policy *covers any claims made while the policy is actually in effect.* Under this type of coverage, even if the alleged injury occurs during the policy period, but the lawsuit is not filed until after the policy has lapsed, the insurer has no obligation. *If this policy is terminated or is allowed to expire, all coverage ceases.* The *claim must be made within the policy period* and must be promptly reported to the insurance carrier during the policy period or during the "tail". Once this type of policy is purchased, *it must be maintained continuously and uninterrupted in order to provide adequate protection. Under such a policy, the individual is also covered for any claim that might arise from an event that occurred before the policy went into effect.*

The majority of institutional coverage is claims-made. Since these policies cover only claims filed while the policy is actually in effect, the nurse who has left the employment of the institution, and does not have, or has never had, appropriate personal coverage, could incur the sole responsibil-

ity for defending himself or herself against a claim for malpractice arising many years after terminating employment by a particular institution. The individual who changes jobs frequently or has several different employers (such as agencies) at one time, can lose track of malpractice insurance status and create potentially dangerous deficiencies in coverage. Acquisition and maintenance of an appropriate personal policy substantially reduces such risks.

"Tail" Coverage

"Tail" coverage is added coverage that provides an uninterrupted extension of a policy period. It is also known as an "extending reporting endorsement". It extends the coverage provided under a claims-made policy and provides protection to a health care provider against any claims filed for events that might have occurred during the period of the preexisting claims-made policy, which is no longer in force. The availability of such supplemental coverage may be limited. It can be an expensive option for the purchaser of a claims-made policy.

READING AND UNDERSTANDING A POLICY

A malpractice insurance policy that practitioners purchase represents a business contract between them and the insurance company. The promotional materials that they may have received will not contain every detail and provision of the policy. In deciding if a policy is adequate or appropriate for their circumstances, they should review the various terms and conditions of the proposal with a representative of the carrier. Prospective purchasers should be prepared to ask pertinent questions and insist on clear, intelligible answers. If they have already acquired coverage, they should examine their policy in detail to confirm their understanding of the language and terms.

Every policy will contain certain sections and provisions. These elements are common to all policies but may vary in the degree of comprehension allowed the reader. If the language of the policy is not clear, the insured should contact a representative of the insurance company, preferably the agent who sold the policy, and ask for an explanation. If not satisfied, he or she should write directly to the company's chief executive officer and state a complaint politely, firmly, and succinctly.

Elements of a Policy

The elements in any given malpractice insurance policy may vary by arrangement within the body of the policy but generally include the following.

Insuring Agreement

This is the part of the contract that defines the rights and obligations of each party. The insurer promises to provide, and pay for, legal representation to defend the policy holder against a lawuit for malpractice regardless of the merits of the claim. In return, the insured agrees to pay the premiums (the "consideration" of the contract) and agrees to accept and abide by the terms of the policy—*each and every one of them*! The insured is required (possibly under oath) to provide complete and accurate information on an insurance application form. It must be remembered that a falsified application, if discovered by the carrier, can nullify the policy at *any* time.

Of particular significance to a defendant will be any statement regarding the insurance company's right to settle any and all claims against them *without* their prior consent or knowledge. A policy may or may not require the insured's consent before a settlement agreement can be reached. If the insured withholds such consent without reasonable cause, the carrier could rescind coverage. The insured should know and understand what, if any, part he or she will play in discussions or agreements regarding a settlement of the claim. It must be remembered that *a settlement is not an admission of liability*; however, it denies a defendant the opportunity to present his or her side of the story to a jury and it could leave him or her with a feeling of betrayal. Settlement does not provide vindication.

Generally, a malpractice insurance policy will prohibit the insured from incurring any expenses or obligations, or making any payments, unless these are voluntary, and at the personal expense of the insured. The terms of the contract may also provide that unless the insured has fully complied with each of the terms of the policy, he or she cannot initiate an action against the carrier.

If a nurse elects for ADR in any claim of malpractice, he or she may be required to retain an attorney personally. Malpractice insurance carriers, as a general rule, do not provide legal counsel for a client in the event of ADR proceedings unless a *lawsuit* has actually been *filed*.

You must notify your insurance carrier that you intend to use ADR in a lawsuit. Although the company may be amenable to the less costly alternative to litigation, it may still retain the right to decide how the claim against you (and, in effect—them) will be disposed of. If the insured fails to notify the carrier that he or she has elected ADR, the insured could risk forfeiture of coverage for any settlement of the suit agreed on without the carrier's consent or knowledge.

Coverage Agreement

This section will specify the particular individual insured and define those areas of nursing practice that are covered by the policy. This will usually be an individually named practitioner, properly licensed by a state board, who provides professional services within the scope of nursing practice defined by a state's nurse practice act. The term "professional services" may have different meanings to the parties, and a dispute could arise in the event of a suit.

There may be language in this portion of the policy that refers to "such professional services that may be personally provided by the individual named as the insured". This covers the individual nurse in the course of his or her own personal nursing duties and actions. Any nurse whose duties might routinely include supervision of other nurses, ancillary staff, nursing students, or any one providing patient care should examine the policy for language referring to "services which are provided by any individual acting under the personal supervision, control, or direction of the insured". Inclusion of this statement offers protection for the nurse, as a supervisor, in the event that a claim based on improper supervision would arise. As previously discussed, the Supreme Court has recently expanded the definition of "supervisor".

Conditions

This section of the policy bears close scrutiny and thorough understanding. It is here that the obligations of the insured and the insurer in the event of a claim or lawsuit are set forth. The rights of the insurer to cancel the policy and the applicable criteria will be defined here. There will be a requirement that the insured notify the carrier within a specified time period in the event of any claim or suit that could give rise to a payment of damages. The method of notification may or may not be specified. The insured may be required to forward certain relevant documents to the insurer. The insured must follow these conditions exactly. Any failure in following the defined notification procedures could be cause for *immediate voiding* of the policy. An employer's policy may also specify precise procedures for notification of the employer in the event that a nurse becomes aware of a possible claim or suit. Failure here could result in selective voiding of that nurse's coverage under the employer's policy.

In the event of litigation, the insured defendant will be obliged to cooperate with and to assist the attorney assigned by the insurance company in every possible way in the preparation of a defense. This includes a full and truthful disclosure of all relevant facts. Any attempts to withhold or falsify

pertinent information could be cause for the carrier to void coverage and withdraw the assigned attorney's services. The now uninsured individual would be obliged to retain an attorney at his or her own expense.

The defendant will be expected to appear and testify at depositions and at a trial. Failure to cooperate with the insurance company or its representatives could cause cancellation of the policy. If during the course of the lawsuit, the attorney retained by the carrier determines that the insured has attempted a cover-up, is not cooperating, or has violated any of the terms and conditions of the policy, the attorney is obliged to report the circumstances to the insurance company that has retained his or her services. The company could then elect to refuse to further defend the insured, leaving the insured to his or her own devices.

An insurance company may permit policy holders to select counsel of their choice in the event of a suit for nursing malpractice. Usually the carrier will provide a defense attorney to represent the insured. The nurse has a right to know and evaluate the credentials and experience of any attorney retained on his or her behalf and should demand a trial lawyer who has extensive experience in litigation involving medical and/or nursing malpractice.

Exclusions

Exclusions are the specified actions or circumstance that are *not covered* under the terms of the policy. Under a "reservation of rights", the carrier reserves the right to deny coverage if it determines that the claim involves any alleged action or circumstance that is defined as excluded. The company will not pay the costs of defending a nurse in these circumstances. If it were to be determined at some future time that a defense had been provided for an action which, in fact, was excluded, the insurer may demand and/or sue for reimbursement from the insured (to include attorney's fees and any damages paid out!). There are some carriers who might require that the defendant be responsible for a certain portion of expenses involved in the litigation until such time as it is demonstrated that an activity was *not* excluded.

An individual liability policy usually provides rather broad coverage, and for purposes of exclusion, would focus on those actions that would be usually defined as beyond a practitioner's scope of practice. The scope of nursing practice includes any and all skills, procedures, and knowledge included in any curriculum of nursing education and/or defined and authorized by a state's nurse practice act. Nurses employed in advanced practice and expanded roles such as midwives, practitioners, consultants, or as en-

trepreneurs should confirm any exclusionary provisions of their policy applicable to their positions, practice, and professional services.

Other specific exclusions may include any claims resulting from actions of a nurse on duty while he or she was impaired as a result of substance abuse. *Criminal acts are universally excluded.* These include fraud and various forms of patient abuse, including assault and battery. Actions considered to be gross negligence may be listed. A more recent exclusion is the transmission of HIV/AIDS by a nurse to a patient. *Punitive damages* that might be awarded by a court are *virtually always excluded.* The costs of legal representation required in a hearing before a state board of nursing are generally not covered.

Subrogation

In an institution's policy, the conditions may also include the insurance company's statement of subrogation of rights. In a situation where the institution is named as the sole defendant in a malpractice lawsuit in which a practitioner (physician or nurse) was directly involved but not named as a co-defendant, the insurance company will pay damages in a settlement or in an awarded judgment. The insurer could retain the right to sue (cross-file against) that practitioner deemed negligent in the original action and, therefore, responsible for the loss. Under the common law of some states, the nurse or physician could be held liable. Without a personal malpractice policy, the individual would incur all costs of defending the suit and any damages awarded.

Policy Limits

"Limits" is a policy's predetermined maximum amount that the insurance carrier will pay out in the event of a settlement or judgment in a lawsuit. The "double limits" of coverage specify the amount that will be paid for each individual claim and an aggregate amount. The first is identified as the "per incident" or "per occurrence" limit. This delimits the monetary amount that the insurance company will pay out for a *single* claim. The second, the "aggregate" limit, is the total amount the insurer will pay out *in any given policy year.* The aggregate of claims that might arise from a single occurrence are treated as a single claim for the purposes of coverage under the policy.

The amount of coverage that a practitioner decides to commit for may be determined by the cost. The largest amount for the least cost is the ideal. The individual should shop for malpractice insurance and explore the market as he or she would for life, health, or property insurance. A practitioner's particular specialty area of practice and the nature of that practice should be a

factor in determining the appropriate amount of coverage. Self-employed, advanced practice nurses, and those practicing in high-risk nursing specialties should commit for the maximum amount available and affordable. Staff nurses should also acquire maximum coverage that is usually available for a modest investment.

Supplementary Payments

Certain policies may provide for stipends to the insured to supplement reduced earnings resulting from their involvement in litigation. There may also be reimbursement for reasonable expenses relating to the suit. This optional additional coverage is usually available at a modest cost. It is worth the added expense. An employer's policy is not likely to provide for such supplementary coverage, and the individual who does not have this provision in a personal policy runs the risk of any financial losses incurred as a result of missed work and incidental expenses related to the lawsuit.

EMPLOYER COVERAGE

A recurring question for nurses is whether or not they should purchase individual malpractice insurance or practice under their employer's policy. A prevalent delusion is that they are fully covered under the employer's policy. An employer's policy may not provide blanket protection. There may be limits to the scope, length, and amount of coverage provided. Typically, the employee will be covered under a group contract, but not as an individual. The nurse who believes that he or she is covered under such a policy (which is usually quite comprehensive) may elect to forego the purchase of a personal policy. As far as the institution's coverage goes, it should benefit an employee to some degree. However, it goes only as far as the limits of the premises—while the nurse is actually on duty, as an employee—and only when acting within the scope of nursing practice.

The nurse-employee may not be covered for any actions that are not defined in the job description, not in conformance with the institution's policies and procedures, or in violation of the state's nurse practice act. In the event of a lawsuit, if the employer can demonstrate that the nurse's action was, in fact, outside of the scope of his or her practice, the individual without a personal policy may find it necessary to retain a defense attorney at his or her *own expense*. Even if covered personally, it is likely that his or her own insurer would refuse defense under the conditions of the policy relating to such actions. Most employer policies do not include any form of supplementary payments for an employee's lost wages or other expenses

incurred during a lawsuit. These will be the employee's personal responsibility.

If a nurse and the employer are named as co-defendants in a lawsuit and found liable for damages, the employer will take priority in coverage, the nurse secondary. If the limits of the policy are expended on behalf of the institution, the nurse will be on his or her own unless he or she has a personal malpractice policy. It must remembered that the insurance carrier's obligation is first and foremost to protect the interests of its institutional client—whose employees may be secondary. The policy coverage will be structured to meet the needs of the institution and not necessarily those of its employees.

A second deficiency in employer coverage could be in the legal representation provided to the nurse by the institution's insurance carrier. As noted, the institution is the attorney's primary client, and the interests of that client may take precedence. The institution may elect to settle a lawsuit in order to avoid the expense and adverse publicity that a trial might engender. The nurse will likely have no say in this decision—a decision that could have a more adverse effect than a trial that might ultimately have been to the nurse's advantage. For this reason, every prudent nurse is encouraged to acquire and maintain a personal policy to protect his or her personal interests. With such a policy, the carrier's first allegiance will be to the nurse. He or she should be the sole priority of the attorney assigned as defense counsel.

Even when a nurse is covered by an employer's policy, he or she still could be at risk from the insurance company's subrogation rights as previously described or from the employing institution itself. Based on a nurse's proven malpractice, the employer (or former employer) could elect to file an indemnity countersuit against the nurse to recover its costs and any monetary losses incurred in the lawsuit when the amount of damages awarded is in excess of the coverage limit. This is very rare. It can be very demoralizing to staff. It may be prohibited by terms of the institution's policy. Of course, the institution's policy will not cover the nurse in this unlikely instance; a personal policy may or may not. If an individual does not have the benefit of this type of coverage under a personal policy, the costs will be the individual's and the individual's alone.

In the past, institutions paid additional premiums for coverage of nursing staff and other health care providers. There has been a trend identified in which staff nurses are not being included in an institution's blanket liability insurance policy. In an ongoing effort to cut operating costs, many institutions now recommend, or require, that their employees personally contract and pay for coverage. In some instances premiums may be reimbursed as a

part of a benefits package. If the institution remits the premiums for personal policies in a lump sum to a carrier, there is a risk that a nurse could default in his or her personal responsibilities under this arrangement. In the event of a malpractice lawsuit filed against the nurse personally, he or she might assume that the matter will be handled by the institution and fail to take the prompt and direct notification steps required by a personal policy. This failure could result in a forfeiture of coverage.

Learning about Your Employer's Coverage

The nurse is entitled to know the extent of coverage (if any) under an employer's policy. He or she should request an opportunity to meet with an appropriate risk management or human resources administrator to review the provisions of the employer's insurance policy and their implications for that nurse in their particular practice setting. Having done this, the nurse should review his or her own personal policy to identify any deficiencies and needs for augmented coverage. The elements to look for in an employer's policy are shown in Table 13.1.

Table 13.1
What to Look for in an Employer's Policy

- Is the individual specifically named in the institution's policy? This is essential to prove to an insurer that he or she is/ was an employee of the institution.
- Is his or her title, position, or job description listed as covered?
- What language indicates that he or she is, in fact, covered?
- What type of policy is in effect—claims-made or occurrence?
- Does the policy provide the individual with personal liability coverage?
- What are the applicable limits of that coverage? What are the limits of liability? Will the individual share in a specified limit that includes other staff and the hospital itself?
- Is there a subrogation provision?
- Which, if any, exclusionary clauses pertain to the individual?
- Is there a deductible? If so, what is the amount?
- Is the individual covered only while on duty or also off the job?
- Will a copy of the policy be made available to the individual? This is essential. Without it, the individual has no guarantee that he or she is, in fact, covered.

14

The National Practitioner Data Bank

THE CREATION OF THE NATIONAL PRACTITIONER DATA BANK

The National Practitioner Data Bank (NPDB, Data Bank) was established through Title IV of Public Law 99–660, the *Health Care Quality Improvement Act of 1986*, as amended (the Act). The intent of Title IV was to improve the quality of health care by encouraging hospitals, state licensing boards, and other health care entities, including professional societies, to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of previous damaging or incompetent performance. At the same time, it is charged with protecting the rights of the practitioner.

In 1987, Section 5 of the Medicare and Medicaid Patient and Program Protection Act (PL 100–93) expanded certain provisions of the 1986 law. The expanded scope included provisions for licensure actions taken against certain health care practitioners. Final regulations governing the Data Bank were published in the *Federal Register* on October 17, 1989, and are codified at 45 DFR Part 60. On September 1, 1990, the NPDB was formally inaugurated. There were no retroactive reporting requirements for events prior to September 1, 1990. Copies of the Act and the final regulations are provided

in the *National Practitioner Data Bank Guidebook*, which is available through the Data Bank Help Line. (See appendix II for the NPDB's Web site.)

DEFINITION OF "HEALTH CARE PRACTITIONER"

Initially the focus was primarily on the medical and dental professions, but when eventually implemented, and as amended, the scope of the law included all licensed health care practitioners. These other health care practitioners are defined as individuals other than physicians or dentists who are licensed or otherwise authorized (certified or registered) by a state to provide some form of health care services. There is no requirement to query or report on laypersons who are not licensed or otherwise authorized by a state

Table 14.1
Examples of Other Health Care Practitioners

"The following list is provided solely for illustration. The inclusion or exclusion of any health care occupational group should not be interpreted as a mandate or a waiver of compliance to Data Bank reporting requirements, since licensure and certification requirements vary from state to state."

Acupuncturists	Occupational Therapy Assistants
Audiologists	Ocularists
Chiropractors	Opticians
Dental Hygienists	Optometrists
Denturists	Orthotics/Prosthetics Fitters
Dietitians	Pharmacists
Emergency Medical Technicians	Pharmacists, Nuclear
Homeopaths	Physical Therapy Assistants
Medical Assistants	Physical Therapists
Medical Technologists	Physician Assistants
Mental Health Counselors	Professional Counselors
Nuclear Medicine Technologists	Psychiatric Technicians
Nurse's Aides	Radiation Therapy Technologists
Nurse Anesthetists	Radiologic Technologists
Nurse Midwives	Rehabilitation Therapists
Nurse Practitioners	Respiratory Therapists
Nurse, Registered	Respiratory Therapy Technician
Nutritionists	Social Workers, Clinical
Occupational Therapists	Speech/Language Pathologists

Source: National Practitioner Data Bank 1996, C-2.

to provide their legitimate services. Examples of these practitioners are shown in Table 14.1.

CONFIDENTIALITY OF DATA BANK INFORMATION

Information reported to the Data Bank is considered confidential and can not be disclosed except as specified in the regulations at 45 CFR Part 60. A comprehensive security system has been designed to prevent access to and manipulation of the data by any unauthorized persons. Persons or entities that receive information from the NPDB either directly or indirectly are subject to the confidentiality provisions and the imposition of a penalty if they violate those provisions. Federal statutes subject individuals or entities who knowingly and willfully report to or query the Data Bank under false pretenses, or who fraudulently access the Data Bank computer databases, to criminal penalties, including fines and imprisonment.

The Privacy Act of 1974

The *Privacy Act*, 5 USC, Section 552a, protects the contents of federal systems of records on individuals, such as those contained in the Data Bank, from disclosure without the subject's consent, unless the disclosure is for a routine use of the system of records as published annually in the *Federal Register*. The published routine uses of Data Bank information do not allow disclosure to the general public. The limited access provision of the *Health Care Quality Improvement Act of 1986*, as amended, supersedes the disclosure requirements of the *Freedom of Information Act* (FOIA), 5 USC Section 552, as amended.

WHAT MUST BE REPORTED TO THE DATA BANK

The NPDB is charged with collecting and maintaining three types of information:

- Reports of medical or nursing malpractice payments of damages resulting from:
  1. a *written* claim;
  2. a negotiated settlement of a claim;
  3. the awarding of a judgment in a court; or
  4. any decision in formal arbitration.
- Reports of adverse licensure actions taken by state boards of medicine or nursing.

- Reports of professional review actions taken by hospitals and other health care entities that adversely affect clinical privileges for a period longer than thirty days; or the voluntary surrender or restriction of clinical privileges while under, or in return for not conducting, an investigation relating to possible incompetence or improper professional conduct; and reports of review actions taken by professional societies that adversely affect the subject's membership in the society.

Payments of Claims

Only those payments made for the benefit of a named practitioner as a result of suits or claims are reportable. The subject of the report may be any health care practitioner. The fact that such an individual may not have been named as a defendant is not material.

Any health care entity or insurance company that pays out money on behalf of a licensed practitioner as a result of a *written* malpractice claim or action in law is required to report such payment within thirty days. If the party making the payment fails to report any such disbursement, the statues provide for civil penalties, including a fine of up to $10,000 for each act of omission in reporting.

The payment can be one resulting from a negotiated settlement of a claim, the awarding of a judgment in a court, or any decision in formal arbitration. Any and all such payments, *regardless of the amount*, made as a result of a written claim, or a lawsuit for malpractice, which names an individual health care provider, and which demanded monetary compensation, whether such payment is made as an award in a judgment or in a negotiated settlement, must be reported. These payments include all those the terms of which may have been stipulated as confidential by a court. If a claim, lawsuit, settlement, or trial does not involve or require cash disbursements for other than legal expenses, no report is necessary.

Reports must be submitted to the Data Bank when medical malpractice payments are made for the benefit of residents or interns. Medical malpractice payments made for the benefit of house staff insured by their employers are also reportable.

Payments made for the benefit of medical, dental, or nursing students are *not* reportable. Unlicensed student providers provide health care services exclusively under the supervision of licensed health care professionals in a training environment, for example, a clinical nursing instructor. Students do not fall into the "other health care practitioner" category. These latter are licensed by a state and/or meet state registration or certification requirements.

The filing of a lawsuit or claim is *not*, in itself, reportable. *There is no requirement that the claim actually be filed in any court of law.* The NPDB makes no evaluations or presumptions as to the merits of any claims of malpractice upon which a payment may have been based. The NPDB is primarily concerned with the accuracy of the data reported and its mandate under the federal laws in the compilation and proper dissemination of the data.

Report Format

The report must include the name of the practitioner, and other specific data regarding him or her, the amount of the payment made, and all relevant details surrounding the circumstances of the claim—*including the name of the claimant.* Reporting entities are required to provide a detailed narrative that describes the acts or omissions and the injuries upon which the medical malpractice action or claim was based.

Narrative descriptions must include seven general categories of information:

1. Age: The patient's age at the time of the initial event.
2. Sex: Male, female, and disputed; disputed may be used in claims involving individuals whose sex has been physically altered or who are physically one sex but live outwardly as the other.
3. Patient Type: Generally an indication of inpatient or outpatient status. This category is useful when the event might occur in a variety of clinical settings.
4. Initial Event (Procedure/Diagnosis): Usually the event on which the claim is predicated. It should reflect a generic diagnosis and procedure, if applicable.
5. Subsequent Event: Usually an occurrence that precipitated the claim. The time sequence in relation to the initial event is relevant.
6. Damages (Medical and/or Legal): A description of damages resulting from the initial and subsequent events.
7. Standard of Care Determination: If a determination was made by the payer whether or not standards of care were met, the determination is to be included. (National Practitioner Data Bank 1996, E–7)

WHO MUST REPORT TO THE DATA BANK

The federal statute prescribed mandatory reporting of specified data on selected health care professionals and defines those entities that are required to report. These entities are shown in Table 14.2.

Table 14.2
Reporting Requirements Affecting Physicians, Dentists, and Other Health Care Practitioners

Entity	Reporting to the Data Bank
Hospitals and other health care entities:	*Must* report: (1) professional review actions related to professional competence or conduct that adversely affect clinical privileges of a physician or dentist for more than thirty days; (2) a physician's or dentist's voluntary surrender or restriction of clinical privileges while under investigation for professional competence or conduct or in return for not conducting an investigation; and (3) revisions to such actions. May report on other health care practitioners.
State medical and dental boards:	*Must* report certain adverse licensure actions related to professional competence or professional conduct and revisions to such actions for physicians and dentists.
Professional societies:	*Must* report professional review actions that adversely affect professional memberships and revisions to such actions for physicians and dentists. May report on other health care practitioners.
Medical malpractice insurers:	*Must* report payments made on behalf of physicians. dentists, and other health care practitioners in settlement of or in satisfaction in whole or in part of a claim or judgment against such practitioner.
Health care practitioners:	Are not required to report on their own behalf.

Source: National Practitioner Data Bank 1996, C–1.

WHO CAN AND WHO MUST QUERY THE DATA BANK

An entity may be required by law to query the NPDB in certain instances, and in others, may have an option to do so. Only health care institutions and entities, professional organizations, and state licensing boards have access to the database. Any individual practitioner may access the data bank only on his or her own behalf. State boards of medicine and nursing have access.

Insurance companies offering medical malpractice policies are prohibited access even though they are required to report payments.

Information in the files of the NPDB is prohibited to the public-at-large. There have been several bills introduced in Congress to permit public access, but these have been vehemently objected to by the American Medical Association and failed to become law. A plaintiff or a plaintiff's attorney who has actually filed a claim or suit for malpractice against a hospital may have limited access. Attorney access is discussed in detail in a following section. A *Fact Sheet for the General Public* and a *Fact Sheet for Attorneys* is available from the NPDB. Query requirements are shown in Table 14.3.

Table 14.3
Title IV Querying Requirements

Entity	Requirement
Hospitals: Screening applicants for medical staff appointment or granting of clinical privileges; every two years for physicians, dentists, or other health care practitioners on the medical staff or granted clinical privileges	*Must* query
At such times as they deem necessary	May query
Other health care entities: Screening applicants for medical staff appointments or granting of clinical privileges; supporting professional review activities	May query
State licensing boards: At such times as they deem necessary	May query
Professional societies: Screening applicants for membership or affiliation; supporting professional review activities	May query
Plaintiffs' attorneys: Plaintiff's attorney or plaintiff representing himself or herself who has filed a medical malpractice action or claim in a state or federal court or other adjudicative body against	May query

a hospital when evidence is submitted which reveals the hospital failed to make a required query of the Data Bank on the practitioner(s) also named in the action or claim	
Physicians, dentists, or other health care practitioners:	
Regarding their own files	May query
Medical malpractice insurers:	May *not* query

Source: National Practitioner Data Bank 1996, D–4.

Health care facilities other than hospitals may submit a request for information on any licensed practitioner who is employed or being considered for employment. A hospital is not required to query more than once every two years regarding a practitioner who is continuously on staff. Hospitals with annual reappointment are not required to query annually. Hospitals *may* query at any time in conjunction with professional review procedures.

Hospitals are not required to query the Data Bank regarding medical and dental residents, interns, or staff fellows even though these may be licensed. They are considered trainees in a structured program of supervised graduate medical education rather than members of the medical staff. A hospital is required to query the Data Bank regarding residents or interns when such individuals are appointed to the medical staff or granted clinical privileges to practice outside the parameters of the formal educational education program (e.g., moonlighting in an ICU or emergency room).

Queries Regarding Staff Nurses

A hospital has the *option* to query the data bank regarding a registered, professional nurse who is being considered for a *staff* nursing position that does not involve the granting of clinical privileges. However, the regulations refer to a health care practitioner as an individual "on the medical staff"; therefore, most nurses would be excluded. Such privileges usually are granted only to advanced practice nurses such as nurse practitioners, clinical nurse specialists, nurse midwives, or nurse anesthetists. In any instances where clinical privileges are being granted to a nurse, a query is mandatory.

LEGAL IMPLICATIONS OF A HOSPITAL'S FAILURE TO QUERY THE DATA BANK

As shown in Table 14.3, *hospitals are the only health care entities with mandatory requirements for querying* the Data Bank. If a hospital fails in

the inquiry protocol, as mandated by law, which could have revealed information that would have given cause for the hospital to deny or revoke clinical privileges, the hospital could be held liable in a malpractice claim against the practitioner. It could be presumed that the hospital might have had knowledge of any information reported to the Data Bank concerning that individual and was aware of what the Data Bank could have revealed about the practitioner who is the subject of a malpractice claim.

What the attorney for the plaintiff will attempt to prove is that the hospital was negligent in:

1. hiring and granting clinical privileges to the defendant practitioner;
2. failing to adequately investigate the practitioner's background by accessing the NPDB as required by law;
3. failing to verify the truth and accuracy of the practitioner's professional education and experience as shown on an application before employment and granting of clinical privileges; and
4. failing to establish and/or follow written policies and procedures regarding employment and the granting of clinical privileges.

ATTORNEY ACCESS TO THE DATA BANK

A plaintiff's attorney who has actually filed a claim or suit for malpractice against a hospital may have limited access. He or she is permitted to obtain information from the NPDB only under certain conditions (National Practitioner Data Bank 1996, D5–D6.)

If a hospital is named as a defendant together with individual practitioners, the plaintiff's attorney must demonstrate that the hospital failed in its statutory obligation to query the Data Bank as described previously. If this can be proven, the NPDB may disclose the information; however, the attorney can utilize any information derived only in that specific case and involving only that specific hospital. *It may not be used to assail the individual practitioner.*

The conditions and limitations for attorney access are defined in the Act and in the Rules and Regulations as follows:

§60.11 Requesting information from the National Practitioner Data Bank.

(a) *Who may request information and what information may be available.* Information in the Data Bank will be available, upon request, to the persons or entities, or their authorized agents, as described below:

. . .

(5) An attorney, or individual representing himself or herself, who has filed a medical malpractice action or claim in a State or Federal court or other adjudicative body against a hospital, and who requests information regarding a specific physician, dentist, or other health care practitioner who is also named in the action or claim. Provided, that this information will be disclosed only upon the submission of evidence that the hospital failed to request information from the Data Bank as required by § 60.10(a), and may be used solely with respect to litigation resulting from the action or claim against the hospital. (Federal Register 1989, 13)

Defense Attorney Access

Defense attorneys are *not* permitted to access the Data Bank under Title IV because the defendant practitioner is permitted to self-query the Data Bank. If the attorney is representing the practitioner as defendant, the easiest and most direct way to access the Data Bank is, of course, to assist the client in making the request directly on his or her own behalf.

OTHER DATA BANKS

The NPDB database is the latest of its kind but certainly not the only one. What is unique is that it was established and functions under federal laws that provide for mandatory reporting and inquiry. The scope of information required, and now retained, exceeds that of all other data banks; however, there was no provision for retroactive inclusion of the data that had been amassed by its predecessors. These include:

- The American Medical Association: The AMA has maintained a file on each of its members since 1905. AMA Physician Select Information, including the AMA Physician Masterfile, is available through the AMA Website. (See appendix II.)
- State boards of licensure—medical and nursing: These have long maintained data on individual practitioners licensed in their jurisdiction. Generally, any adverse action taken against a licensee is a matter of public record. This may not include complaints filed or investigations in process. Some states require reporting of any claims, settlements, or judgments based on malpractice.
- The National Council of State Boards of Nursing (NCSBN): The NCSBN has maintained a data bank since 1980. Participation by each state is discretionary. Access to this data bank can be through a state board only.
- The Federation of State Medical Boards: A central repository for data gathered from the various state medical boards on physicians whom they have disciplined.

- The National Nurses Claims Data Base: Created by professional nursing organizations to monitor liability claims and incidents for the entire profession and provide a resource for nurses involved in lawsuits. Insurance companies and employers do not have access. Nurses are expected to provide information *voluntarily*.

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15

Disciplinary Actions by State Boards of Nursing under Nurse Practice Acts

HISTORY OF NURSE PRACTICE ACTS

By the end of the first two decades of the twentieth century, a number of states had enacted laws requiring that nurses register with an appropriate state agency in order to be permitted to practice. These states included New Jersey, New York, North Carolina, and Virginia. By 1923, each state had enacted a registration act. It is from these requirements that the designation "registered" nurse derives. Any nurse who filed the proper forms and paid the required fee was registered—no license per se was issued. However, it is from these early laws that mandatory licensing in each state also derives.

The first state to require that nurses be licensed as well as registered was New York, which passed the first licensing act in 1938. This represented the first formal amalgamation of law and nursing which recognized nursing, as a profession with concomitant legal rights and privileges granted, obligations and liabilities imposed, and sanctions and penalties prescribed. The stature of nursing was now enhanced by a statute of law. By 1952, every state had enacted a nurse practice act.

CONTENT AND PURPOSE OF A NURSE PRACTICE ACT

The nurse practice act of each state defines the practice of nursing and, in varying detail, the standards of that practice. The act itself, together with the various rules and regulations promulgated under the act that effect the implementation and enforcement of the statute, constitute the primary regulatory mechanism for nursing practice in any state. The structure, content, and scope of an act will vary by state. In very broad language, the acts define nursing, the scope of nursing practice, the prerequisites of nursing licensure, and the requisites of continuing licensure. The various acts are embodied in such a way as to provide nursing practice with maximum latitude as the profession evolves and grows. Many of the preexisting state nurse practice acts embody a model act proposed by the American Nurses Association in 1980.

An act usually empowers a state's board of nursing to draft and publish various rules and regulations. It is in these specific directives that nurses will learn the details of the law as it affects day-to-day practice. These are not laws per se, but are recognized as having the force of law. These are the mechanisms by which the general provisions of the statute are implemented and enforced. A state board, in response to formal inquiries, may also issue rulings relevant to the scope of nursing practice. These do not carry the force of law. From time to time, as circumstances dictate, a board may seek an opinion from other state agencies, particularly the office of the attorney general. These opinions, although not law, will carry great weight in a court of law.

Content of an Act

The content of a typical state nurse practice act includes the following:

- a definition of nursing;
- a statement of the scope of nursing practice;
- the basic requirements for the issuance of a license to practice as a registered nurse;
- standards for curricula of nursing education and for examination for licensure;
- a description of matters that must be reported to the board;
- policies and procedures regarding disciplinary actions to be taken against a license; and
- the organization of the state's board of nursing—the composition of its governing body, bylaws, responsibilities, and duties.

Purpose of an Act

The paramount objective of every nurse practice act is to protect the public-at-large—the consumer of health care. It does this by defining the scope and standards of nursing practice and the credentials required of those permitted to that practice. The board of nursing is charged with the responsibility of fully investigating any and all charges against a licensed practitioner and, where indicated, taking appropriate disciplinary action. This regulatory effort is essential for the protection of the health, welfare, and safety of society. It is the duty of each state's board of nursing to carry out this mandate. It is the professional duty of each licensed, registered nurse to know and understand the applicable act and its implications for professional practice.

DEFINING NURSING

Virtually every state nurse practice act defines "nursing". The ANA prepared a model definition in 1955, which was to act as a guideline for each state. This was revised in 1970 when nursing diagnoses began widespread use, and again in 1979 to include the expanding roles of nurses. These definitions have generally been broad enough to include nurses practicing in various clinical settings and roles. It would be very difficult, if not impossible, to formulate a precise yet comprehensive definition that would satisfy all state regulators (and all nurses). Any definition need be acceptable as a reasonably comprehensive guideline for competent practice by any nurse in a variety of clinical settings.

The constantly changing and evolving role of the professional nurse, together with advances in practice and increased autonomy, continually challenge traditional definitions of nursing. States have been required to redefine this element of their nurse practice acts to accommodate the increasing numbers of advanced practice nurses including clinical nurse specialists, nurse practitioners, and nurse midwives.

SCOPE OF NURSING PRACTICE

The scope of practice embodies the permitted actions and duties of a profession. It is a legal demarcation of the boundaries of nursing practice drawn according to the nurse practice act and all subsequent rules and regulations evolving from the act. As nurses have expanded their roles and attained semi-independence in certain clinical procedures and settings, challenges to the propriety, to the legality, of these roles have inevitably followed.

Where nurses have been permitted to practice in expanded roles, new issues in standards of care have concomitantly arisen. When nurses assume clinical duties and procedures traditionally reserved to physicians, courts may impart higher standards and a more rigorous duty. Nurses must be willing and able to accept these implications for practice and realize that with increased autonomy comes increased accountability and liability. To provide the maximum protection from liability for the nurse in an expanded role, nurse practice acts must include language that is as broad as possible yet as specific in intent as attainable.

The policies and procedures of an institution define the scope of nursing practice in that institution. This definition may or may not agree with that presented in an applicable state nurse practice act. It may be more restrictive and definitive, but it cannot be more comprehensive. The institution cannot arbitrarily expand the definition of a state's nurse practice act by developing and implementing policies and procedures proscribed by law. The statute will always take precedent. Every nurse is legally bound to act within the scope of practice as defined by statute and will incur sanctions if he or she ventures beyond those boundaries.

THE BOARD OF NURSING

Each state licensing board is charged under the applicable act with all aspects of licensure and nursing practice. Any given state board of nursing is usually composed of nurses (including LPNs) from various areas of a state. This provides not only geographical diversity but also professional, social, and cultural variety. A board may also have one or more representatives from the public-at-large; these may come from a variety of backgrounds not involved with health care. The governor of a state may have the prerogative of appointing a given number of members of the board for terms of three to six years. (See appendix III for a list of state boards of nursing.)

LICENSURE

A license is a formal permission granted by a legally constituted authority to an individual that gives that individual authoritative permission to do something or to practice some profession which, without such legal permit, would otherwise be considered unlawful. Licensure is the process by which a governmental agency grants such authority under law. The authority of the state to draft and enforce various professional practice acts derives from common law, which charges the state with protection of the health and well-being (the "commonweal") of its citizens.

Licensure defines the standards expected, and the credentials demanded, for admission to a profession, and the criteria for continuance in that profession. It identifies the individual professional's scope of practice and predicts the consequences of failure in compliance to be imposed by appropriate disciplinary action.

Types of Licensure

There are two types of licensure. The first is "permissive", which concerns the use of a specific title conveyed to an individual by the license. If the individual intends to display this title and present it as a credential in professional practice, he or she is required to comply with the applicable statute.

The second type is "mandatory", which involves the selected profession itself. If an individual intends to practice in medicine or nursing, for example, he or she must meet all of the requirements for admission to the profession and to engage in its practice as these are defined by the profession itself and the state licensing authority.

VIOLATIONS OF A NURSE PRACTICE ACT

A formal complaint against a nurse can be filed with a board of nursing by a patient, a nursing colleague, a physician, a professional organization, an administrator of an institution, by the state board itself—by anyone. Many acts require that nurses report violations that they *themselves* have committed as well as violations that they have identified on the part of other health care providers. These actions include any "unprofessional" conduct, including negligence, malpractice, moral turpitude, fraud, various criminal acts, incompetence, and any actions considered outside the defined scope of practice. Unprofessional conduct is the prevailing basis for such actions. Application of the statutes in accusations of it can be challenging to a board of review that will consider each case individually The term *unprofessional conduct* is somewhat vague and can encompass a great number of actions or omissions on the part of a nurse.

Unprofessional conduct includes a failure to report, within a reasonable time, any violations of the nurse practice act, including any of the rules and regulations that have been promulgated under the act. Failure to report such violations is in itself a breach of the law. Every effort should be made to protect the rights of the individual making the disclosure. This includes not revealing his or her identity and some provision for immunity from retaliation. If the individual who files the report does so in good faith and

without malicious intent, he or she will not likely incur liability for a charge of defamation in any eventual lawsuit.

Should the violation alleged have occurred in an institution, the reporting process would begin there. The policies and procedures of the institution will direct the process and define the protocol. Typically these would require that a report be in writing; that it be factual, complete, and accurate in all assertions; that it include the names of all parties involved; and that it be made in good faith. If the nurse who initiates a report determines that the institution has failed to take what would be considered appropriate action, he or she is required to report the situation to the state board, which may pursue the matter further.

BASES FOR DISCIPLINARY ACTIONS BY A STATE BOARD

As noted previously, unprofessional conduct is the most common allegation involved in disciplinary actions under the various nurse practice acts. This conduct includes, but is not limited to:

- negligence, even in the absence of injury to a patient;
- incompetence;
- moral turpitude;
- substance abuse;
- conviction for a criminal act—a felony or certain misdemeanors;
- fraudulent application for licensure;
- failure to report the denial, suspension, or revocation of a license in another jurisdiction;
- failure to report a physical or mental impairment that could render a nurse unable or unfit to practice and that might require intervention by the board;
- violations of any specific provision of the act and/or any of the rules and regulations promulgated under the act; and
- aiding or abetting another in any violation of the act.

TYPES OF DISCIPLINARY ACTIONS BY A STATE BOARD

Not every claim or incident of nursing malpractice will be grounds for adverse action against a nurse's professional license. The action of the state board will depend on the circumstances of the alleged incident, the degree of injury to the patient, and the nurse's professional record. Even that nurse who has been found liable for malpractice by a jury will emerge from the courtroom with his or her license intact. The courts have no jurisdiction in

initiating actions against licensure. This is the sole prerogative of the state board. A nurse may have entered the courtroom already deprived of his or her license as a consequence of prior action by the board's "court"—the disciplinary review panel.

Following the required procedures, a state board may initiate one or more adverse actions against the nurse named in a complaint. These include:

- Censure: A statement of disapproval recorded in the official minutes of the board. This then becomes a matter of public record.
- Reprimand: This written advisory is usually given to the individual personally and becomes part of his or her file. It may also be disseminated publicly, usually in the board's official publications.
- Probation: This may be for a period of varying duration.
- Suspension of a license: This may be for a prescribed period of time.
- Revocation of license: This can preclude issuance of a license to practice by any other state.

A board may demand that certain conditions be met before an action of probation or suspension be lifted and the nurse's license is reinstated. He or she may be obliged to undergo a period of supervised clinical experience during which he or she may be required to demonstrate clinical competency in selected areas. There may be a requirement for attendance at selected seminars, inservice presentations, or successful completion of specific educational programs or academic courses. Retesting and recertification in certain relevant competencies and skills may be ordered.

Substance abuse has become *the* major cause of disciplinary actions against nurses, and more and more state boards are reporting proceedings involving impaired nurses. If impairment due to substance abuse has been identified, participation in a counseling or rehabilitation program may be required; and reinstatement will be contingent on successful completion of the program. Any other form of counseling or intervention considered appropriate to the circumstances may also be directed. The nurse's reinstatement to professional practice will be determined to a great degree by the nurse's personal commitment and cooperation.

DISCIPLINARY PROCEEDINGS

A number of states require that a report be filed with the board of nursing whenever a nurse is named as a defendant in a malpractice lawsuit. This does not necessarily initiate any disciplinary proceedings by a state board.

The report may merely be received and reviewed by the board and filed in the nurse's dossier. There may be no action against the practitioner's license at that time. Such action could be considered and effected as the circumstances of the plaintiff's complaint are fully presented or in the event that an adverse judgment is decided in court—after the nurse-defendant has been found liable. A number of states require reporting of any amounts paid out in damages awarded against a physician or nurse.

If the nurse's file contains previous substantiated records of negligence or criminal behavior, the board may elect to initiate action against the defendant's license, and set the disciplinary proceedings in motion immediately—compounding the defendant's problem of civil litigation. Each state board has outlined the process involved in handling disciplinary actions initiated under the act. These generally follow the same format as shown in Table 15.1.

Table 15.1
State Board Disciplinary Proceedings

- Formal filing of a complaint according to the policies and procedures defined by the board
- Written notification of the complaint sent to the health care provider who is named in the report
- Preliminary review and evaluation of the complaint by a panel
- Preliminary investigation of the allegations by a state attorney
- Preliminary conference to discuss findings of the investigation
- Formal hearing before the full board
- Board review of the testimony in the hearing
- A decision on the form of disciplinary action proposed
- An appeal, to a court of proper jurisdiction, of any adverse action taken by the board

The Preliminary Investigation

Investigators for the board will contact all possible witnesses to obtain facts and statements regarding the complaint. Relevant medical records will be subpoenaed and the institution's policy and procedures will be obtained. When the board's investigation is completed, the attorney for the state will schedule a conference to include the subject of the complaint and his or her attorney. At this conference, the state's attorney, or possibly a panel of board members, will review the report of the investigation and advise the nurse of what formal charges could be filed with the board. A consent agreement may be offered after this preliminary conference. This usually provides for

sanctions that are less severe than those that *could* be imposed at a full hearing. If this is declined, the matter proceeds to the full hearing.

The Formal Hearing before the Board

When the board decides to hold a hearing on the allegations presented in the preliminary report, the subject of that report will be notified. He or she will receive a letter that will define the specific allegations that have been made. The subject will be advised of the hearing date, the time, and the place in which it will be held. This notice will also include various procedural instructions for the recipient. When the nurse receives such notice, he or she should immediately retain the services of an attorney who is familiar with such licensure proceedings. A professional malpractice liability insurance policy does *not* cover the nurse in responding to actions by a state board.

The purpose of the hearing is to ascertain the validity of the complaint and determine what formal action, if any, the board might be required to take. Witnesses may be presented. Attorneys should be present. The nurse who has been called should not expect the same dynamics that take place in a deposition or trial. This is a formal fact-finding effort and not necessarily an adversarial confrontation. The interests of the individual nurse and those of the profession are of prime concern.

The proceedings will be transcribed by a stenographer (in the event of a court appeal a transcript will be necessary). The findings of the investigation will be presented. The nurse will be questioned by the attorney representing the board (usually an assistant state attorney general) and his or her own attorney regarding the allegations. Members of the hearing panel may also pose questions. When all testimony has been heard, the members of the board will consider its content and deliberate as to what action will be taken. Their decision may be announced immediately, but is more likely to come down at a later date. The subject of the hearing will be sent a formal written advice of the findings and the board's decision.

In the event that the decision is adverse, the nurse may initiate an appeal to an appropriate civil court within the time period defined—usually two to three weeks. The court will consider only the propriety of the action and decision of the board and *not* the merits of the nurse's conduct that gave cause to that action and decision. The court may affirm the decision, reverse it, remand it, or modify it in some way. Where indicated, continuing appeals to higher courts may be pursued. An appeal process can be a very tedious and very expensive endeavor. By the time the appeal wends its way through the

jural maze, sufficient time may elapse for the nurse to reapply for licensure or reinstatement under any applicable provisions of the nurse practice act or other state laws.

CYBERCARE

Telemedicine

There has been increasing discussion in both the general and professional media about telecommunications technology and its applications to the rapidly developing concept of "telemedicine". This term, which is used most frequently, actually refers to a subset of the more inclusive "telehealth", which is becoming the preferred terminology because it more accurately represents the current model of health care delivery with its focus on health maintenance, wellness, and disease prevention. As a health care mode, telehealth has been available in one form or another since the 1960s. The more comprehensive "telehealth" also incorporates the concept of "telenursing".

Telehealth

[A]s telecommunications technology becomes more accessible and more widely used by different health care professionals, "telehealth" is a more inclusive and descriptive term for what is being done and what is possible. . . . Telehealth is a broader, more inclusive term and is more reflective of current views that health care is more than treatment of illness or injury; that it involves teaching, learning, lifestyle alterations, understanding of the impact of culture, ethnicity and other factors on the individual and the health care professional. . . . Different terms may lead to confusion among the public, promote an impression of divisiveness and competition among users of telehealth. (Milholland 1995, 13)

Telehealth is the linking of two or more discrete end-users by any interactive electronic means for the purpose of transmission and/or exchange of information and data in any health-related application. It is remote, electronic, clinical consultation, assessment, and monitoring of consumers of any form of health care. Telehealth is the utilization of telecommunications technology in the dissemination of health information, expertise, and intervention across varying distances to a disparate population most often in greastest need of such access.

Telenursing

Telenursing is defined as the practice of nursing over distance using telecommunications technology. The nurse engages in the practice of nursing by interacting with the client at a remote site to electronically receive the client's health status data, initiate and transmit therapeutic interventions and regimens, and monitor and record the client's response and nursing care outcomes. The value of telenursing to the client is increased access to skilled, empathetic and effective nursing delivered by means of telecommunications technology. (National Council of State Boards of Nursing 1997, 1)

As noted previously, telenursing is merely another subset of telehealth. It is the application of the art and science of nursing mediated in whole or part through any electronic means. The two key dimensions of telenursing are distance and electronic mediation. It is the nurse's electronic presence at a patient's bedside providing personal care by means of an impersonal medium.

Technology in one form or another has always been viewed with discomfort, disdain, or dread, by a large number of nurses (the "nurseosaurus"). Telenursing is no exception. "Many fear that rapid implementation of computerized telecommunications in managed care health plans and in home health agencies will lead to replacement of direct in-person registered nurse care, weakening the therapeutic nurse-patient relationship" (Helmlinger and Milholland 1997, 61). The ANA has affirmed that telenursing will not replace the direct, hands-on interventions of a nurse; rather it will serve to enhance both the nursing process and the profession (American Nurses Association 1996, 2). The emerging role of nurses presents unique professional and economic opportunities as well as unique questions and problems. "Telecommunications is advancing at such a rapid rate that its application to health care delivery and nursing practice will continue to emerge and evolve" (National Council of State Boards of Nursing 1997, 2).

Telenursing is now being utilized in all four fields of professional nursing: (1) clinical practice, (2) education, (3) administration, and (4) research. It is to its applications in clinical practice that the focus of policy makers, regulators, HMOs and other payers, health care institutions, and nursing and medical practitioners has been primarily directed. Telenursing enhances the roles of advanced practice nurses in the initiation and management of both nursing and medical regimens by electronic implementation of standing orders, protocols, and guidelines.

Telenursing has been in existence in one form or another for quite some time. However, a review of the nursing literature derives relatively few ref-

erences. Despite the growing interest in telecommunications as a health care delivery medium, research on the actual and potential contributions of the nursing profession has been markedly absent. In fact, little to no information—with the exception of brief anecdotal comments—has been available on the role of nurses in telehealth (Horton 1997, 1).

Virtually all nurses in advanced practice, and many nurses in any clinical setting, will inevitably be required to utilize this next wave in the provision of health care. The electronic age has changed the ways in which health care is being delivered—by whom—and to whom. Nurses in the most distant clinical settings can now collaborate with other providers—nurses and physicians—in real-time, interactive video consultation. The patient can be seen, heard, assessed, and treated by a team of experts dispersed among many sites.

"The challenge to nursing is to organize this material in terms of ease of access, confidentiality of usage, accuracy and contextual relevance, and ease of comprehension. . . . Telenursing, because of its communicative nature, is forced to use modern idiom, if not the vernacular, to communicate effectively. This disallows much of the specious nursing jargon and private use of language to which nursing has been exposed in recent years. The bottom line seems to be that if one wishes to make oneself understood, one had better use language that can be understood" (Yensen 1996, 213).

Legal Issues in Telehealth

The problem that telehealth presents is that the revolution in science and technology has run ahead of the devolution of law. The legal system has not yet caught up. A key issue that has just begun to be addressed by state boards of medicine and nursing is of the legality of providing health care across state lines, an inherent aspect of telemedicine and telenursing. Are nurses and physicians practicing "modem medicine" violating the laws of the states in which they are licensed to practice by, in effect, practicing across state lines? Are they violating the laws of those states in which their remote patients reside—and in which they are not licensed? (Gobis 1996; Kjervik 1997)?

Telecommunications has created, and certainly will continue to create, new questions, problems, and challenges to the nursing profession and its regulators. The most germane question is: Is telenursing nursing practice? The consensus is that if nursing services are delivered by any means, it constitutes nursing practice. This has been affirmed by the National Council of State Boards of Nursing and the American Nurses Association.

There are many more issues involved in telenursing, including patient confidentiality, informed consent, and the relinquishment of personal, physical contact with the patient. The concept and all of its professional and legal implications are the subjects of much further legal and nursing research.

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Roles of the Professional Nurse in the Legal Process

NURSES' ROLES IN THE LEGAL PROCESS

In the course of his or her nursing career, a nurse may find him- or herself on one side of the law as defendant, on another side as plaintiff, or amidst the law—between either side as a nurse attorney, a testifying expert (TE), or as a consulting expert (CE). These last two roles represent relatively new, emerging, and very rewarding alternative careers for the professional nurse. In these expanded roles, the nurse is not confined to cases of malpractice only, but can become involved in other forms of personal injury, toxic torts and environmental issues, product liability, workers' compensation; and even criminal actions as a forensic witness in such cases as rape or child and elder abuse. Opportunities for nurses are limited only by their knowledge, their creativity, and their initiative in persuading the legal community of their valuable contributions and cost saving effectiveness.

WHY NURSES ELECT TO FUNCTION IN THESE ROLES

A nurse may be motivated to undertake these roles for several reasons.

- He or she can enhance the image and status of nursing by presenting nurses in a legitimate role in the legal arena

- The roles present an opportunity for the professional nurse to define and maintain the standards of nursing care
- A nurse can be instrumental in identifying unsafe practitioners and removing them from clinical practice, thus protecting the public as consumers of health care
- The roles provide an opportunity to protect and defend peers from unjust accusations and nonmeritorious suits that can impugn the individual nurse and the profession
- A nurse seeks the challenges and learning experiences these new and expanding roles present
- He or she enjoys independence and autonomy in an entrepreneurial role
- A nurse recognizes and appreciates the monetary rewards that his or her efforts will bring

THE NURSE ATTORNEY

The nurse attorney is yet another distinguished role for the professional nurse. He or she may function in independent practice, as a member of a law firm, on the staff of an insurance company, or as nursing-legal scholar and author.

THE NURSE AS A TESTIFYING EXPERT

Since the landmark decision in 1985 in *Tripp v. Humana* (474, So.2d 88, 1985) more courts have been directing that nurse experts testify in trials involving nurses and standards of nursing care. This acknowledgment that nursing, as a profession, involves a distinct body of scientific knowledge has been a hard-won concession from the legal system that has traditionally failed to recognize and accept this concept, and has consistently called upon physicians to testify to the propriety of nursing care. This has long served only to denigrate the nursing profession, and engender and sustain the misconception that nurses lack professional status, autonomy, responsibility, and credibility.

As a general rule, a physician may be permitted to testify in the courts of every state regarding the standards of nursing care. Conversely, it is highly unlikely, and equally inappropriate, that a nurse would be allowed to address the standards of the practice of medicine except in those instances where certain skills and procedures might be shared by each discipline. The roles of the nurse practitioner or the nurse anesthetist are examples. In other matters not exclusively within the scope of professional nursing, the courts

have permitted physicians or other appropriate health care providers to testify in cases of nursing malpractice.

Typically, a physician has no knowledge of nursing practice other than that derived from transient and cursory observation, confirmation that his or her orders have been carried out, and critical interrogation when a nurse is seen to have failed in "subservient" duties. A physician's education in medicine provides little, if any, knowledge of the formal standards, policies, and procedures that define and direct nursing care. The physician is trained in the science of medicine, the nurse in the art and science of nursing. It is appropriate that this academic dichotomy be sustained in the setting of litigation, but not maintained in collaborative efforts in patient care. Neither profession is served well when one usurps the prerogatives of the other—in court or in clinic.

The TE is not what is known in law as a "witness to the facts". The fact witness will testify from the perspective of one who actually saw the alleged incident or participated in the event directly or indirectly. The TE does not attest to the occurrence of facts, but rather provides opinions and interpretations of the alleged facts. The role of the expert witness is to define what would have been the reasonable care that would have been appropriate and expected under the circumstances surrounding the event of alleged nursing malpractice. The TE will be called upon to address two primary issues: (1) the standards of nursing care and (2) any deviations from the standards of care as a causative factor in the plaintiff's alleged injury.

Presentation of the testimony of a TE constitutes the principal difference between a suit for ordinary negligence and one of malpractice. During the deposition, and in the event of a trial, the nurse expert witness will define the standards of nursing care, and present his or her own (and other) expert opinions on the perceived deviations from those standards. A TE does not establish them. His or her duty is to educate the court regarding standards already defined, established, and accepted by the nursing profession.

He or she may be asked to provide answers to a number of hypothetical questions posed by either side. However, testimony will address one fundamental question: What would any reasonable nurse with the same education, knowledge, skills, and experience have done under the same or similar circumstances? Therefore, much of what an expert witness will be expected to provide will be his or her own opinions and judgments on the issues at hand. These opinions and judgments will be derived from his or her personal credentials, including education, experience, and recognized expertise.

An expert witness' testimony presented in a court of law, incorporated in a transcript of the legal proceedings, and possibly available through citation of the case, could conceivably serve to establish legal and nursing precedents and further define the standards and practice of professional nursing.

The nurse as expert witness will be well advised to confine his or her opinions on the issues exclusively to nursing practice. Opposing attorneys will announce vigorous objections in court if a nurse presumes to stray over the line. A favorite tactic of the attorney is to propose a series of questions, hypothetical or otherwise, which might elicit from the nurse opinions or comments on matters that are exclusively in the realm of medical practice. If a TE falls into the lawyer's trap, his or her "expertise" in such matters will be challenged, professionalism ridiculed, and credibility called into question.

In accepting nurses as expert witnesses, the courts have come to acknowledge that much of what constitutes the present scope of nursing practice is now beyond the knowledge of the average layperson who might sit in judgment. In matters of highly technical, complex, or specialized skills, procedures, and language, the advanced education, training, informed opinions, and critical judgments of the expert nurse are essential. It is the TE who presents the definitive standards to the jury who must then decide if those standards were breached. When the opinions of the experts conflict or contradict, the jury will be left to decide the credibility of one or the other. In those instances where the issues and evidence are not too esoteric, the jurors may be left to their own instincts, knowledge, and common sense in deciding the case, and expert witnesses may not be permitted by the court.

The TE may also be consulted by the client or employing attorney during the trial preparation phase of the suit. As a witness for the plaintiff, he or she may be asked to participate in defining the complaint to be filed. As a witness for the defense, the TE may assist in preparing refutations to the complaint. He or she will also review the transcripts of depositions given by his or her counterparts. Frequently the opinions of the expert will be a determining factor in a negotiated settlement. Ideally, the TE (and the CE) approach their assignments as impartial professionals. Inevitably, the attorney who engages their services expects that their findings will corroborate the allegations and claims of his or her client exclusively. Questions put to one's own expert witness will attempt to elicit answers that refute the position of the opposition. Questions put to the opposing side's witness will attempt to elicit those positions and opinions that might eventually be presented in court and that may suggest possible strategies of the opposition and appropriate countermeasures.

Qualifications of the Testifying Expert

The TE is a professional, expert nurse—not a professional, expert witness. As a nurse, the first duty is to serve the profession. Providing a service to the legal system is secondary. Any nurse who is considering this role must be able to demonstrate the expertise and integrity demanded of both masters.

Inevitably, there will be the same conflict and disagreement between the parties in a lawsuit as to what constitutes an "expert" witness and over the credibility and merits of each expert's testimony and opinions. There is invariably a scenario of dueling experts, some of dubious merit. The courts are filled with experts who propound educated guesses as profound opinions. The most highly qualified are often reluctant to enter into the adversarial, confrontational, and demeaning arena of trial testimony where an attorney will likely attempt to discredit the credentials of the opposition's TE by disparaging his or her education, experience, expertise, or motives. A common innuendo is that the individual is a "hired gun", a "professional witness", a mercenary with opinions for sale.

The nurse may be questioned extensively regarding his or her prior services as a TE, the time that is devoted to providing this service, and the total amount of remuneration received in the past and expect to receive in the present case. In this instance, the witness will be challenged to assert that he or she is being compensated appropriately for his or her expertise and valuable time in testifying and not being "paid" to testify. The objective of this whole demeaning exercise is to demonstrate that the individual is not an expert, and is, therefore, not suitable to serve as such in the matters at issue and should be disqualified. In addition to the qualifications listed, the person who intends this career must have a very thick hide.

The TE cannot have any direct relationship or connection with any of the parties in the case. There can be no hint of conflict of interest; otherwise, the TE's credibility could be impeached. In accepting a case, the expert witness must be willing to determine, and judge, the merits of the case, and withdraw or continue according to his or her convictions. Agreeing to testify is tantamount to endorsement of the case and the client's position.

An attorney, in a misguided effort to promote the best case for a client, may assume that any nurse should know all there is about nursing and attempt to exert some pressure or offer an attractive incentive to a prospective expert witness. The nurse in this situation would be obliged to refuse any case involving issues beyond his or her area of expertise. However, he or she can still serve the attorney and the profession effectively by assisting the attorney in locating a suitable nurse expert. Many nurses (and physicians)

elect to reject cases in their immediate geographical area when they are asked to testify for a plaintiff. Testifying for a defendant in their own locale is usually more palatable.

The credentials of a testifying expert must be at least equal to, if not superior to, those of the nurse against whom he or she is testifying. Ultimately a judge may determine if a TE is qualified to testify in court.

The qualifications of a nurse expert witness are:

- Appropriate nursing education—an attorney, or a judge, may require a BSN as a minimum level of academic preparation. Many demand a master's degree. (The higher the degree, the more impressed the jury might be!)
- Sufficient clinical experience, past and current—this could be a minimum of five years in the specialty area that the TE or CE is addressing in the case.
- Certification in a specialty area of nursing—a clinical nurse specialist (CNS), nurse practitioner (NP), or other advanced practice nurse is a most suitable expert witness.
- Other professional credentials—these might include faculty in nursing education, publication, public speaking, honors and awards, and membership in appropriate professional organizations.
- Understanding of the legal system and the legal issues in nursing practice—many TEs and CEs are also paralegals.
- He or she should have a reasonably thorough familiarity of the state nurse practice act and its rules and regulations.

THE NURSE AS A CONSULTING EXPERT

The nurse as litigation consultant provides support services to an attorney throughout the trial preparation process and during a trial. As a consulting expert to either plaintiff or defense attorney, he or she acts as a collaborator and strategist. Utilization of a nurse CE represents a very cost effective way for a lawyer to prepare a well-organized and effective case and anticipate the strategies of the opposition. Since fewer than 10 percent of all malpractice lawsuits ever go to trial, the CE's value is in helping to prepare a sound case, the merits of which could induce an offer of prompt and reasonable settlement by the opposition and thus reduce the costs of a prolonged suit.

Comparison of the Roles of the Testifying and Consulting Expert

Unlike the TE, the CE *does not testify*, he or she only consults, as the title indicates. This service may be provided for either side in a lawsuit. The tes-

tifying expert may have a high and visible profile while presenting testimony during a deposition or a trial. The consulting expert is "invisible", working behind the scenes in a "clandestine" collaboration with the attorney from the initial phases of the case right on through any eventual trial where, if the client-attorney is amenable, he or she might be allowed to sit at the table in the courtroom. This could be the first time that the opposition becomes aware of this covert collaborator.

Any report generated by the CE is considered "attorney's work product", and as such is considered privileged and confidential. Unless a TE incorporates any or all of a report generated by a CE into his or her own discoverable testimony, a CE's work is generally not discoverable. The CE's thoughts and opinions are protected from scrutiny by the cloak of anonymity that the role imparts.

The focus of the nurse expert witness is much narrower, and his or her testimony will be confined to the area of his or her nursing expertise or clinical specialty. He or she may be provided only limited access to the medical record. The nurse litigation consultant can take a much broader approach to a case and should have unlimited access to the medical record and all other pertinent materials. In this capacity, the CE can review and assess the actions of any health care provider (including physicians) involved in the patient's care and address any one of a large number of cogent and peripheral issues. The CE's approach to a case is global rather than regional.

Services Provided by the Consulting Expert

Among the services that the CE may provide are:

- liaison between parties, physicians, and attorneys;
- identify and locate potential witnesses and defendants;
- interview clients, witnesses, and other parties;
- assist in the preparation of witnesses;
- aid in preparing questions and responses in depositions and trial;
- assist in the preparation of interrogatories, complaints, and other documents, and responses to them;
- assessment of plaintiff's alleged injuries;
- identify and obtain all pertinent records and documents;
- organize, review, and analyze medical records;
- prepare summaries, chronologies, and reports;
- review, analyze, and summarize transcripts of depositions;

- identify and evaluate expert witnesses and negotiate for their services;
- prepare or obtain exhibits and/or demonstrative evidence;
- educate attorneys and other parties on facts and issues relating to nursing care or validate their knowledge;
- define standards of nursing care and any deviations from them;
- research—locate, obtain, and summarize pertinent literature;
- present the client with the most current information available; and
- assist the client in setting up or improving his or her medical/nursing reference library.

Advantages in Using the Consulting Expert

Nurses as consultants bring several advantages to the prosecution or defense of a case of nursing malpractice:

- they are experts in nursing practice;
- they know the standards of nursing care; and
- they have the superior advantage of hindsight.

Qualifications of the Consulting Expert

Like the expert witness, the litigation consultant's credentials, ethical standards, and integrity must be above reproach for the sake both plaintiff and defendant in a case. However, the CE may work on any type of case regardless of the nursing specialty involved, performing a variety of services. The issues may involve injury, illness, or health. In reviewing the medical records, the nurse can draw on his or her own knowledge, skills, experience and education in identifying and reporting the issues involved. However, nurse experts in any given specialty should be consulted as the need arises. It would be reckless and presumptuous for any nurse to present him- or herself as an expert in all areas of nursing practice. No one can know, or credibly pretend to know, everything about the profession and all of its specialties and subspecialties.

BECOMING A TESTIFYING EXPERT AND/OR A CONSULTING EXPERT

The nurse who is considering either or both of the challenging roles of becoming a testifying agent and/or a consulting expert may elect to focus on only one side—plaintiff or defense. It is recommended, however, that accepting assignments from either plaintiff or defense attorneys will provide

valuable insights into how opposing parties think and plan. Any nurse considering these roles should first examine his or her own credentials—personal and professional. As an expert witness, can he or she legitimately claim to be an expert, or is he or she merely a dilettante who will attempt to convince an attorney-client that a nurse is a nurse is a nurse? Is he or she primarily motivated by monetary rewards in what can be a very lucrative occupation, or is he or she committed to maintaining and improving the standards and image of the nursing profession? Does he or she have the work habits, communication skills, and the physical and emotional stamina that these high-stress roles demand?

IMPLICATIONS FOR THE NURSING PROFESSION

It is likely that the number of malpractice suits against nurses will continue to increase, and, concomitantly, the opportunities and the need for nurses to participate in such litigation as expert witnesses or as consultants. Nurses in these roles can enhance the understanding of all parties regarding professional nursing and its essential involvement in the health care delivery system. They can present a comprehensive view of the entire spectrum of health care, including current and future needs and a definition of how nursing expertise can and will respond to those needs.

Nurses have the right to demand that only members of their own profession be allowed to testify in matters of nursing malpractice and that this be a consistent convention. Nursing has a right and a duty to participate in the legal process. It is incumbent upon the appropriate members of the profession to assert this right and make every effort to educate the members of the legal profession and the public-at-large regarding the unique and valuable contributions that the nursing profession can make in a litigious society. Nursing must become politically active in initiating and pressing for enactment of statutes prescribing that nurses be permitted the prerogative in testifying in those malpractice lawsuits naming nurses as defendants.

Remember, however, that in the unlikely event that you are sued for nursing malpractice, a professional *nurse—one of your peers—might be at work on the case for you—or against you.* A plaintiff or an attorney may be naïve or uninformed about nursing practice, but the nurse testifying experts and consulting experts who will collaborate with him or her in preparing a lawsuit are not. These nurses will be the true "jury of your peers" who may condemn you or acquit you long before you encounter the other in a courtroom.

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Appendix I

State Laws on Patient Access to Medical Records

State	Physician	Hospital	Mental Health Records
Alabama	No	No	No[1]
Alaska	Yes	Yes	Yes
Arizona	Yes	No	Yes
Arkansas	Yes[2]	Yes[2]	No
California	Yes	Yes	Yes
Colorado	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes
Delaware	No	No	No[3]
Dist. of Columbia	No	No	Yes
Florida	Yes	Yes	No[4]
Georgia	Yes	Yes	Yes
Hawaii	Yes	Yes	Yes
Idaho	No	No	Yes
Illinois	No[3]	Yes	Yes
Indiana	Yes	Yes	Yes

State	Physician	Hospital	Mental Health Records
Iowa	No	No	No
Kansas	No	No	No[5]
Kentucky	No	No	Yes
Louisiana	Yes	Yes	No[3]
Maine	No[6]	Yes	No
Maryland	Yes	Yes	Yes
Massachusetts	No[6]	Yes	No[3]
Michigan	Yes	Yes	Yes
Minnesota	Yes	Yes	Yes
Mississippi	No	No[7]	Yes
Missouri	Yes	No	No[3]
Montana	Yes	Yes	Yes
Nebraska	No	Yes	No[8]
Nevada	Yes	Yes	Yes
New Hampshire	Yes	Yes	Yes
New Jersey	Yes	Yes	No[3]
New Mexico	No	No	No
New York	Yes	Yes	Yes
North Carolina	No	No	No[9]
North Dakota	No	No	No[3]
Ohio	No	Yes	Yes
Oklahoma	Yes	Yes	No[10]
Oregon	No[11]	No[11]	Yes
Pennsylvania	No	Yes	No
Rhode Island	No	No	No
South Carolina	Yes	No	Yes
South Dakota	Yes	Yes	Yes
Tennessee	No	No[7]	No[3]
Texas	No[6]	No[6]	Yes
Utah	No[3]	No[3]	No
Vermont	No	No	No
Virginia	Yes	Yes	Yes
Washington	Yes	Yes	Yes

State	Physician	Hospital	Mental Health Records
West Virginia	Yes	Yes	No[3]
Wisconsin	Yes	Yes	Yes
Wyoming	No	Yes	No

Source: Johnson and Wolfe, 1995. Used with permission.

NOTES

1. Records may be released by a court order only.
2. Records may be released to the subject patient if a lawsuit is being prepared or has been filed.
3. Records will be released to the subject's attorney only.
4. The physician may provide a summary report of the record in lieu of the record itself.
5. Records may be released to patients in community or state mental health institutions.
6. The physician is required to provide either a summary of the record or the record itself.
7. "Good cause" must be demonstrated by a patient in order to obtain his or her record.
8. Records can be released to patients in state mental institutions.
9. Access is permitted to any individual who is or has been a patient of a mental health, substance abuse, or developmental disability treatment center.
10. Records may be released by court order, or with consent of the treating physician(s).
11. State, community, or other nonprivate institutions are required to release records. Private institutions and physicians are not required, but are encouraged to do so.

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Appendix II

List of Web Sites

American Bar Association
http://www.abanet.org/

American Institute of Medical Law (The)
http://www.aimlaw.com/

American Medical Association
http://www.ama-assn.org/

American Nurses Association
http://www.nursingworld.org/

CounselQuest
http://www.counselquest.com/index.html

Emory University Law Library: Reference
http://www.law.emory.edu/LAW/refdesk/toc.html

FindLaw
http://www.findlaw.com/

Galaxy
http://www.einet.net/

Hardin MetaDirectory of Internet Health Sources: Nursing
http://www.arcade.uiowa.edu/hardin-www/md-nurs.html

Internet Legal Resource Guide
http://www.ilrg.com/

Internet Resources in Health Law
http://lawlib.slu.edu/centers/HLTHLAW/HLTHLINK.htm

Internet's Nursing Index
http://www.wwnurse.com/

Law Links: Legal Resources
http://lawlinks.com/

'Lectric Law Library's Medicine and Law (The)
http://www.lectlaw.com/tmed.html

'Lectric Law Library: Reference
http://www.lectlaw.com/ref.html

Legal Information Institute
http://www.law.cornell.edu/

Medical and Public Health Law Site (The)
Online: Richards, Edward, and Katharine Rathbun, *Law and the Physician: A Practical Guide*
http://www.plague.law.umkc.edu/

Medical Law: Martindale
http://www-scilib.uci.edu/HSG/Legal.html

Medical Malpractice Resource Page
http://www.helpquick.com/medmal.htm

Mining Co. (The): Nursing
http://azlist.miningco.com/

Multimedia Medical Reference Library
http://www.med-library.com/medlibrary/

National Council of State Boards of Nursing (NCSBN)
http://www.ncsbn.org/

National League for Nursing
http://www.nln.org/

National Library of Medicine: MEDLINE search
http://www.ncbi.nlm.nih.gov/PubMed/

National Practitioner Data Bank
http://www.npdb.com/

Nightingale: Nursing information and links
http://nightingale.con.utk.edu/

Nursing Internet Resources
http://www.slackinc.com/allied/allnet.html

NursingNet
http://www.nursingnet.org/

Nursing Resource (The)
http://www.intersurf.com/~jesse/index.html#medref

Nursing Sites on the WWW
http://ublib.buffalo.edu/libraries/units/hsl/internet/nsgsites.html

Springnet: Nursing
http://www.nursingmanagement.com/

"Virtual" Medical Law Center: Martindale
http://www-sci.lib.uci.edu/HSG/Legal.html

"Virtual" Nursing Center: Martindale
http://www-scilib.uci.edu/~martindale/Nursing.html

WWW Virtual Law Library
http://www.law.indiana.edu/law/v~lib/lawindex.html

WWW Virtual Library: Bioscience
http://milkman.cac.psu.edu/~dxm12/wwwlibng.html

Yahoo: Health: Nursing
http://www.yahoo.com/Health/Nursing/

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Appendix III

List of State Boards of Nursing

ALABAMA
Alabama Board of Nursing
P.O. Box 303900
Montgomery, AL 36130
Phone: (334) 242–4060

ALASKA
Alaska Board of Nursing
Department of Commerce & Economic Development
Division of Occupational Licensing
13601 C Street, Suite 722
Anchorage, AK 99503
Phone: (907) 269–8163, FAX: (907) 269–8156

AMERICAN SAMOA
American Samoa Health Services
Regulatory Board
LBJ Tropical Medical Center
1869 Executive Drive

Pago Pago, AS 96799
Phone: (684) 633–1222

ARIZONA

Arizona State Board of Nursing
1651 E. Morten Avenue, Suite 150
Phoenix, AZ 85020
Phone: (602) 255–5092, FAX: (602) 906–9365

ARKANSAS

Arkansas State Board of Nursing
University Tower Building
1123 S. University, Suite 800
Little Rock, AR 72204
Phone: (501) 686–2700, FAX: (501) 686–2714

CALIFORNIA

California Board of Registered Nursing
P.O. Box 944210
Sacramento, CA 94244
Phone: (916) 322–3350, FAX: (916) 327–4402

California Board of Vocational Nurse and Psychiatric Technician Examiners
2535 Capitol Oaks Drive, Suite 205
Sacramento, CA 95833
Phone: (916) 263–7800, FAX: (916) 263–7859

COLORADO

Colorado Board of Nursing
1560 Broadway, Suite 670
Denver, CO 80202
Phone: (303) 894–2430, FAX: (303) 894–2821

CONNECTICUT

Connecticut Board of Examiners for Nursing
Division of Health Systems Regulation
410 Capitol Avenue, MS# 12HSR
Hartford, CT 06134
Phone: (860) 509–7624, FAX: (860) 509–7286

DELAWARE

Delaware Board of Nursing
Cannon Building, Suite 203
P.O. Box 1401
Dover, DE 19903
Phone: (302) 739–4522, FAX: (302) 739–2711

DISTRICT OF COLUMBIA

District of Columbia Board of Nursing
614 H Street, N.W.
Washington, DC 20001
Phone: (202) 727–7468, FAX: (202) 727–7662

FLORIDA

Florida Board of Nursing
4080 Woodcock Drive, Suite 202
Jacksonville, FL 32207
Phone: (904) 858–6940, FAX: (904) 858–6964

GEORGIA

Georgia Board of Nursing
166 Pryor Street, S.W.
Atlanta, GA 30303
Phone: (404) 656–3943, FAX: (404) 657–7489

Georgia State Board of Licensed Practical Nurses
166 Pryor Street, S.W.
Atlanta, GA 30303
Phone: (404) 656–3921, FAX: (404) 651–9532

GUAM

Guam Board of Nurse Examiners
P.O. Box 2816
Agana, GU 96910
Phone: (671) 475–0251, FAX: (671) 477–4733

HAWAII

Hawaii Board of Nursing
Professional and Vocational Licensing Division
P.O. Box 3469
Honolulu, HI 96801
Phone: (808) 586–2695, FAX: (808) 586–2689

IDAHO

Idaho Board of Nursing
P.O. Box 83720
Boise, ID 83720-0061
Phone: (208) 334–3110, FAX: (208) 334–3262

ILLINOIS

Illinois Department of Professional Regulation
James R. Thompson Center
100 W. Randolph, Suite 9–300
Chicago, IL 60601
Phone: (312) 814–2715, FAX: (312) 814–3145

INDIANA

Indiana State Board of Nursing
Health Professions Bureau
402 W. Washington Street, Suite 041
Indianapolis, IN 46204
Phone: (317) 232–2960, FAX: (317) 233–4236

IOWA

Iowa Board of Nursing
State Capitol Complex
E. Court Avenue
Des Moines, IA 50319
Phone: (515) 281–3255, FAX: (515) 281–4825

KANSAS

Kansas State Board of Nursing
Landon State Office Building
900 S.W. Jackson, Suite 551–S
Topeka, KS 66612
Phone: (913) 296–4929, FAX: (913) 296–3929

KENTUCKY

Kentucky Board of Nursing
312 Whittington Parkway, Suite 300
Louisville, KY 40222
Phone: (502) 329–7006, FAX: (502) 329–7011

LOUISIANA

Louisiana State Board of Nursing
3510 N. Causeway Boulevard, Suite 501
Metairie, LA 70002
Phone: (504) 838–5332, FAX: (504) 838–5349

Louisiana State Board of Practical Nurse Examiners
3421 N. Causeway Boulevard, Suite 203
Metairie, LA 70002
Phone: (504) 838–5791, FAX: (504) 838–5279

MAINE

Maine State Board of Nursing
158 State House Station
Augusta, ME 04333
Phone: (207) 287–1133, FAX: (207) 287–1149

MARYLAND

Maryland Board of Nursing
4140 Patterson Avenue
Baltimore, MD 21215
Phone: (410) 764–5124, FAX: (410) 358–3530

MASSACHUSETTS

Massachusetts Board of Registration in Nursing
Leverett Saltonstall Building
1100 Cambridge Street, Room 1519
Boston, MA 02202
Phone: (617) 727–9961, FAX: (617) 727–2197

MICHIGAN

State of Michigan
CIS/Office of Health Services
Ottawa Towers North
611 W. Ottawa, 4th Floor
Lansing, MI 48933
Phone: (517) 373–9102, FAX: (517) 373–2179

MINNESOTA

Minnesota Board of Nursing
2829 University Avenue S.E., Suite 500

Minneapolis, MN 55414
Phone: (612) 617–2270, FAX: (612) 617–2190

MISSISSIPPI

Mississippi Board of Nursing
239 N. Lamar Street, Suite 401
Jackson, MS 39201
Phone: (601) 359–6170, FAX: (601) 359–6185

MISSOURI

Missouri State Board of Nursing
P.O. Box 656
Jefferson City, MO 65102
Phone: (573) 751–0681, FAX: (573) 751–0075

MONTANA

Montana State Board of Nursing
111 N. Jackson
Helena, MT 59620
Phone: (406) 444–2071, FAX: (406) 444–7759

NEBRASKA

Department of Health and Human Services
Regulation and Licensure Credentialing Division—
Nursing/Nursing Support Section
P.O. Box 94986
Lincoln, NE 68509
Phone: (402) 471–4376, FAX: (402) 471–3577

NEVADA

Nevada State Board of Nursing
1755 E. Plumb Lane, Suite 260
Reno, NV 89502
Phone: (702) 786–2778, FAX: (702) 322–6993

NEW HAMPSHIRE

New Hampshire Board of Nursing
Health & Welfare Building
6 Hazen Drive
Concord, NH 03301
Phone: (603) 271–2323, FAX: (603) 271–6605

NEW JERSEY

New Jersey Board of Nursing
P.O. Box 45010
Newark, NJ 07101
Phone: (201) 504–6586, FAX: (201) 648–3481

NEW MEXICO

New Mexico Board of Nursing
4206 Louisiana Boulevard, N.E., Suite A
Albuquerque, NM 87109
Phone: (505) 841–8340, FAX: (505) 841–8347

NEW YORK

New York State Board of Nursing
State Education Department
Cultural Education Center, Room 3023
Albany, NY 12230
Phone: (518) 474–3845, FAX: (518) 473–0578

NORTH CAROLINA

North Carolina Board of Nursing
3724 National Drive
Raleigh, NC 27602
Phone: (919) 782–3211, FAX: (919) 781–9461

NORTH DAKOTA

North Dakota Board of Nursing
919 S. 7th Street, Suite 504
Bismarck, ND 58504
Phone: (701) 328–9777, FAX: (701) 328–9785

NORTHERN MARIANA ISLANDS

Commonwealth Board of Nurse Examiners
Public Health Center
P.O. Box 1458
Saipan, Marianas Protectorate 96950
Phone: (670) 234–8950, FAX: (670) 234–8930

OHIO

Ohio Board of Nursing
77 S. High Street, 17th Floor

Columbus, OH 43215
Phone: (614) 466–3947, FAX: (614) 466–0388

OKLAHOMA

Oklahoma Board of Nursing
2915 N. Classen Boulevard, Suite 524
Oklahoma City, OK 73106
Phone: (405) 525–2076, FAX: (405) 521–6089

OREGON

Oregon State Board of Nursing
800 NE Oregon Street, Suite 465
Box 25
Portland, OR 97232
Phone: (503) 731–4745, FAX: (503) 731–4755

PENNSYLVANIA

Pennsylvania State Board of Nursing
P.O. Box 2649
Harrisburg, PA 17105
Phone: (717) 783–7142, FAX: (717) 783–0822

PUERTO RICO

Commonwealth of Puerto Rico
Board of Nurse Examiners
Call Box 10200
Santurce, PR 00908
Phone: (787) 725–8161, FAX: (787) 725–7903

RHODE ISLAND

Rhode Island Board of Nurse Registration and Nursing Education
Cannon Health Building
Three Capitol Hill, Room 104
Providence, RI 02908
Phone: (401) 277–2827, FAX: (401) 277–1272

SOUTH CAROLINA

South Carolina State Board of Nursing
110 Centerview Drive, Suite 202
Columbia, SC 29210
Phone: (803) 896–4550, FAX: (803) 896–4525

SOUTH DAKOTA

South Dakota Board of Nursing
3307 S. Lincoln Avenue
Sioux Falls, SD 57105
Phone: (605) 367–5940, FAX: (605) 367–5945

TENNESSEE

Tennessee State Board of Nursing
426 Fifth Avenue North
1st Floor, Cordell Hull Building
Nashville, TN 37247
Phone: (615) 532–5166, FAX: (615) 741–7899

TEXAS

Texas Board of Nurse Examiners
P.O. Box 430
Austin, TX 78767
Phone: (512) 305–7400, FAX: (512) 305–7401

Texas Board of Vocational Nurse Examiners
William P. Hobby Building, Tower 3
333 Guadalupe Street, Suite 3–400
Austin, TX 78701
Phone: (512) 305–8100, FAX: (512) 305–8101

UTAH

Utah State Board of Nursing
Division of Occupational and Professional Licensing
160 E. 300 South, 4th Floor
Salt Lake City, UT 84145
Phone: (801) 530–6628, FAX: (801) 530–6511

VERMONT

Vermont State Board of Nursing
109 State Street
Montpelier, VT 05609
Phone: (802) 828–2396, FAX: (802) 828–2484

VIRGIN ISLANDS

Virgin Islands Board of Nurse Licensure
Veterans Drive Station

St. Thomas, VI 00803
Phone: (340) 776–7397, FAX: (340) 777–4003

VIRGINIA

Virginia Board of Nursing
6606 W. Broad Street, 4th Floor
Richmond, VA 23230
Phone: (804) 662–9909, FAX: (804) 662–9943

WASHINGTON

Washington State Nursing Care Quality Assurance Commission
Department of Health
Olympia, WA 98504
Phone: (360) 753–2686, FAX: (360) 586–2165

WEST VIRGINIA

West Virginia Board of Examiners for Registered Professional Nurses
101 Dee Drive
Charleston, WV 25311
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Glossary

Abandonment: The abrupt, unjustified dissolution by a health care provider of a duty to a patient without the patient's consent or foreknowledge.

Absolute privilege: The protection, granted under law, to the confidentiality of communications between an attorney and the attorney's client.

Action: Lawsuit.

Administrative agency: A department of government that promulgates, administers, and enforces the statutory laws enacted by that government.

Administrative laws: Those rules and regulations created and enforced by administrative agencies in order to enforce statutory laws.

Admissions of fact: Written requests by both sides asking each other to admit to, or deny, certain facts concerning the issues presented in a lawsuit.

Advance directive: A written, signed, legal document that defines a competent individual's wishes regarding life-sustaining medical intervention on his or her behalf in the event that he or she would become incompetent.

Affidavit: A declaration or written statement of facts made voluntarily and while under an oath administered by an officer of a court or by a notary.

Affirmative defense: A challenge by the defendant to the plaintiff's legal right to bring a lawsuit rather than a challenge to the veracity of the plaintiff's claims.

Amended pleadings: Those that in some way alter pleadings previously entered in the lawsuit.

Assault: Any attempt or threat made by one person to use force upon, to inflict injury upon, or to touch another person in an offensive way without his or her consent. It is any willful action or statement that creates fear or apprehension of being touched in an injurious or abhorrent manner. Actual touching need not occur. A threatened battery.

Battery: The intentional, unpermitted, and wrongful touching of another person, or that person's possessions, in an injurious or offensive manner.

Borrowed servant/employee doctrine: Also known as the "captain of the ship doctrine." The temporary assignment of vicarious liability from a principal employer to a designated employer who then becomes legally responsible for any employee who, voluntarily, is "borrowed" from the primary employer.

Breach of duty: Any failure in a defined legal, moral, or ethical duty owed. Negligence in the proper performance or fulfillment of the duties inherent in a position, office, or profession.

Burden of proof (Onus probandi): Under the laws of evidence, this is the requirement that either party in a lawsuit is obligated to prove, by a preponderance of evidence, the allegations he or she makes. This burden usually falls upon the plaintiff.

Capacity: The intellectual capability to understand the nature, the purpose, and the consequences of one's actions.

Captain of the ship doctrine: Synonymous with the borrowed servant doctrine.

Causation: Any antecedent action or situation that can define a consequent effect.

Cause in fact: The specific action or situation that defines a consequent effect and, without which, the effect could not have come about.

Cause of action: Those alleged facts that give an individual sufficient legal right to initiate a claim in law for redress, relief, or other form of judicial remedy in his or her own behalf.

Caveat: Lit. "beware," or "take heed". A caution or warning.

Caveat emptor: "Let the buyer beware".

Caveat lector: "Let the reader beware".

Civil law: That body of law that addresses noncriminal litigation, for example, the rights and duties of parties involved in contracts, torts, and patents.

Civil penalty: Monetary compensation (damages) or other form of retribution prescribed and imposed as a penalty for violation of a civil law.

Claims-made policy: That form of a malpractice insurance policy that provides coverage only for claims made, and reported, to the insurer during the period in which the policy is in effect, or during the "tail".

Comparative negligence: The degree of relative negligence and liability is measured in proportion to the percentage of shared fault for, or relative contribution to, the plaintiff's injuries on the part of the plaintiff and/or one or more defendants. Damages claimed are then apportioned accordingly as determined by the jury.

Compensatory damages: An amount awarded to an injured party to compensate for the injury by indemnification for any loss caused by the injury.

Competency: Legal capacity. An affirmation of competency may be sought from, and declared by, a court.

Complaint: The document in which the plaintiff, under oath, presents allegations of injury and a formal plea to a civil court for relief under the law in a claim for damages. Also called a petition. It is a statement of cause for judicial action against a named defendant.

Consent: A voluntary acquiescence, approval, agreement, or permission conveyed by one person to another and which allows the other to do something to or for the person consenting.

Contributory negligence: A negligent action or omission on the part of a plaintiff which, together with a like action or omission on the part of a defendant, constitutes a proximate cause of the injuries claimed by the plaintiff.

Corporate negligence: Legal principle under which a corporate entity is held liable for the actions or omissions of employees while those employees are on the job and acting within the scope of their job descriptions.

Counterclaim: A claim made by a defendant that disputes, denies, opposes, contradicts, or refutes the claims made by the plaintiff and that attempts to show cause for action in favor of the defendant.

Damage: The injury, harm, or loss sustained by one person as a result of the tortious action of another.

Damages: The amount of money claimed and/or awarded as compensation for damage.

Defamation: The intentional publication of false information that injures the reputation of another; includes slander and libel.

Default judgment: A judgment made by the court in favor of a plaintiff when a defendant fails to respond to a lawsuit or appear at the trial in his or her own defense.

Defendant: The accused; the person or entity who is being sued. The one against whom a lawsuit is brought and who is charged with defending against the allegations and the claims of the plaintiff for relief under the law.

Defense: That which is offered and alleged by the defendant in response to the action or suit by a plaintiff and which attempts to show as a reason in law, or in fact, why the plaintiff should not recover damages.

Deponent: The individual who is called upon to testify under oath to the truth of certain facts presented orally or in writing.

Deposition: The procedure of deriving pretrial testimony from a deponent.

Discovery: The pretrial procedures and methods used to obtain all relevant information from opposing parties in a lawsuit.

Discovery rule: Under this rule, the statute of limitations in malpractice does not commence until the actual date of discovery of the malpractice by the plaintiff, or that date on which any reasonable person could have, or should have, discovered that an injury was the result of malpractice.

Dual servant doctrine: The legal concept that recognizes shared liability on the part of both a principal and a secondary employer for the actions of a shared employee.

Durable power of attorney: A form of an advance directive that appoints another to act as proxy decision maker should the grantor become incompetent. Revocable; it is nullified when the grantor dies.

Duty: A legal or moral obligation owed by one person to another to conform to defined, acceptable standards of conduct in order to protect others from unreasonable risks.

Emancipated minor: Any individual under the legal age of majority who is totally self-supporting, and no longer under the control of, or dependent on, the care of a parent or guardian.

Exclusions: The provisions in any insurance policy that define the conditions, occurrences, or circumstances that are not covered under the terms of the policy.

Expert witness: An individual who, by reason of specialized education, training, and experience, possesses a superior degree of knowledge regarding specific subjects which, ordinarily, another person would not possess.

Fact witness: An individual who has direct knowledge of, and testifies to, the factual circumstances and issues involved in a lawsuit; a material witness.

False imprisonment: The unlawful, unjustified, and intentional restraint, detention, or confinement of a person without consent, and/or without legal warrant, so that the person so confined is conscious of the confinement and threatened or harmed by it.

Foreseeability: The perception and understanding expected of any reasonable and prudent person of the liability for, and the consequences of, his or her actions or omissions—particularly regarding the inherent risks to others.

General damages: Monetary compensation awarded to a plaintiff for pain, suffering, and other abstract injuries caused by the negligence of a defendant.

Gross negligence: The willful failure to perform a manifest duty with reckless disregard for the possible or probable consequences of that failure regarding the well-being of another. It may be an action or an omission.

Guardian-ad-litem: An individual appointed by a court to act as a special and impartial guardian to represent an unborn, an infant, a ward, or any person adjudicated as incompetent. The appointment exists only for the duration of the particular litigation involved.

Guidelines: A defined or recommended course of action or series of procedures which, if followed, will enable effective implementaion of a policy or attainment of a goal.

Hard damages: Monetary compensation awarded to a plaintiff for the specific amounts of expenses and financial losses incurred, and claimed to have resulted, from the defendant's negligence.

Hearsay evidence: That testimony of a witness who presents not what he or she knows directly and personally, but what he or she has heard or been told. A statement made by other than the declarent, which is offered as evidence but not generally admissible.

Incompetence: The lack of legal or professional qualifications, knowledge, ability, or suitability to discharge a duty. A determination of competency may be a matter for a court.

Informed consent: Consent given only after a full disclosure and confirmed understanding of all pertinent facts necessary for the individual to make an intelligent, reasonable, and voluntary choice.

Intent: The desire, design, determination, or resolve with which a person acts to accomplish a given purpose through a deliberate course of action.

Intentional infliction of emotional distress: The egregious and willful invasion of another's peace of mind in a manner that is wanton, outrageous, and beyond all acceptable standards of decency and morality.

Intentional tort: A civil wrong resulting from an intentional act by the tortfeasor and that causes injury or harm to another's person or property.

Interrogatories: A pretrial discovery procedure in which a series of written questions are presented to the opposing parties named in a lawsuit. The answers are presented under oath.

Invasion of privacy: The unwarranted publication of another person's private affairs, or the intrusion into another's private activities in such a way as to violate his or her intrinsic rights and cause personal harm in some way.

Judgment: The adjudicated decision of a court that defines the rights and duties of the parties in a lawsuit.

Judicial law: Rules of law established by courts or the judiciary; decisional law.

Jury: "Twelve persons selected to decide who has the best lawyer." (Robert Frost)

Law: That which is laid down and established as the embodiment of those rules of conduct defined by a legal authority and having binding legal force on the members of a society.

Lay witness: An individual who is called upon to give testimony on matters regarding the lawsuit but who possesses no special knowledge or expertise regarding the issues or facts about which he or she testifies.

Liability: Legal duty, responsibility, or obligation each person is bound to in law or justice to perform. Legal accountability and responsibility for one's personal actions or conduct.

Libel: Defamation that is expressed in writing or pictorially.

Licensure: The procedures by which an agency of government conveys the right, permission, and authority to a person or entity to engage legally in an activity, practice, or professional occupation.

Living will: A form of advance directive. A written, signed, and witnessed legal document that defines a person's wishes regarding life-sustaining measures of medical intervention to be implemented on his or her behalf in the event that the person becomes incompetent.

Locality rule: Refers to those standards of care that prevail in a community or a defined geographical area. National standards have largely displaced these in malpractice lawsuits.

Malice: The state of mind that motivates an individual to willfully commit a wrongful act with the deliberate intent to injure another or with wanton disregard of the likelihood of such injury as a consequence of his or her action.

Malpractice: Negligence or misconduct on the part of a professional while acting in the capacity of a professional. A failure in professional duties or standards that causes harm or injury to another.

Mandatory licensure: A statutory requirement that permits the practice of certain professions or activities only to those who have received a license to engage legally in such practice.

Material risk: An apparent and significant danger that any reasonable person should recognize as a likely consequence of an action or omission.

Motion: A formal application made to a court in order to obtain a ruling or order that directs an action in favor of the applicant.

Motion for a directed verdict: A formal request that a lawsuit be concluded by a verdict in favor of the defendant because the plaintiff has not met the burden of proof, or the defendant has presented a sufficient, irrefutable defense.

Motion to dismiss: Application to the court requesting the court to set aside the case because there is no valid cause of action or form of relief.

Negligence: Ordinary negligence. The failure to act with that degree of care that any ordinary, prudent, and reasonable person would exercise in the same or similar circumstances.

Non compos mentis: Lit. "not of sound mind." Incompetent, insane, afflicted with some form of debilitating mental impairment.

Nonmaleficence: The legal and moral principle that enjoins health care providers to do no harm to a patient—intentionally or otherwise.

Nonsuit: The adverse judgment of the court when the plaintiff fails to properly proceed to a trial, leaving the allegations unresolved, or is unable to sustain the burden of proof during a trial. Also used to indicate a defendant who is discharged from a lawsuit.

Occurrence-basis, occurrence policy: The category of professional liability insurance that protects the insured for acts of malpractice that occur while the policy is in effect, regardless of when a claim is made afterward.

Ordinary negligence: *See* Negligence.

Ostensible authority: The doctrine of law whereby an institution is liable for the negligence of an independent contractor if a patient has a reasonable basis to assume that such a contractor is an employee of the institution. (See Borrowed servant/employee doctrine).

Parens patriae: Lit. "parent of the nation." Refers to the role of the state in its sovereign capacity as legal guardian of an adjudicated incompetent person or a person having some form of legal disability that prevents him or her from acting on his or her own behalf.

Party: A person or entity that is designated in a lawsuit as either a plaintiff or a defendant of record.

Personal liability: The legal and moral doctrine that holds the individual solely responsible, and fully accountable, for his or her own actions or omissions.

Petition: A formal written application to a court requesting judicial intervention in the matter presented, and a presentation of allegations and facts that have given rise to the cause of action. *See* Complaint.

Plaintiff: The party who brings an action, who sues in a civil court, seeking damages or other form of relief under the law for alleged damage, loss, or harm caused by the defendant.

Pleadings: The formal presentation to the court of claims and defenses by the respective parties in a lawsuit. A statement of the plaintiff's cause for action, and the defendant's defense and/or refutation of that cause.

Precedent: A case that has been decided or adjudicated by a court, and which is afterward accepted and cited as authoritative in the adjudication of a similar case or like matters or questions of law. Also known as the doctrine of *stare decisis*.

Prima facie: Lit. "at first sight," on primary appearance, on the face of it. A fact or matter that can be judged at its first disclosure and presumed to be true unless, or until, it can be proven untrue by evidence to the contrary.

Privileged communication: The transmission of information or facts between or among those individuals who, in a professional relationship, are protected by law or custom from compelled divulgence of such confidences.

Procedural law: That body of law that defines the processes, methods, and procedures to be used in enforcing legal rights and obtaining relief or redress when they are violated.

Proximate cause: That continuous sequence of actions or natural happenings which, without any other identifiable intervening factors, produces an effect which, otherwise, would not have occurred.

Prudent patient standard: Takes into consideration the principal risks and the likely consequences that would be apparent to, and understandable by, any reasonable, prudent person in a decision to accept or reject medical treatment.

Punitive damages: Exemplary damages. Those that are awarded, in addition to ordinary or general damages, against a defendant as punishment for the egregious nature of the tort.

Qualified privilege: Defense to a *prima faciae* case of defamation when it can be shown that there was no malicious intent on the part of the defendant. That is, the statements were made in duty or good faith, in a reasonable manner, for a valid reason, and directed to another person with a legitimate right to know.

Question of fact: A disputed fact, claim, or issue that is usually left to the jury to decide and resolve.

Question of law: A disputed legal contention that is usually left to the court or the judge to decide. This involves the application or intepretation of the law itself, and, therefore, is appropriately within the purview of the court rather than a jury.

Release: A statement, written or oral, which declares the maker's intent to discharge another person from an existing or asserted duty, or the abandonment or relinquishment of a present and/or future claim or right.

Requests for production of documents and things: A step in the discovery process. Formal requisition made by parties in a lawsuit to each side for any and all items that might provide discoverable facts pertinent to the issues.

Res ipsa loquitur: Lit. "let the thing speak for itself." The negligence of the defendant can be inferred or presumed, based on proof that the instrumentality that caused the plaintiff's injury was under the exclusive control of the defendant, and that the injury is such that it otherwise could have not have occurred except in negligence.

Respondeat superior: Lit."Let the master answer." The master is responsible for the acts of the servant. An employer is indirectly liable, under certain circumstances, for the wrongful acts of an employee while the employee is acting within the course of employment. This includes negligence that causes harm or injury to another.

Scope of practice: Those limits, duties, and responsibilities of any given profession that are defined by statutes, rules, and regulations.

Service: Service of process, a summons. The delivery of an official notice to the defendant that a lawsuit, claim, or a charge has been filed against him or her.

Settlement: The private agreement and transactions between the parties to a pending lawsuit to effect a resolution of all claims and issues involved.

Slander: Oral defamation.

Soft damages: Monetary compensation awarded to a plaintiff for such things as loss of consortium, pain and suffering, emotional distress, disfigurement.

Special damages: Damages based on the plaintiff's actual or anticipated, direct or indirect, monetary losses or expenses, which are directly attributable to the defendant's negligence.

Standard: An established, authoritative, and generally accepted rule, model, or criterion that serves as a basis of evaluation, comparison, or validation.

Standard of care: In tort law, that average, acceptable degree of skill, care, and diligence that a reasonable and prudent person in the same profession, would, or should, exercise in the same or similar circumstances.

Stare decisis: Lit. "let the decision stand." *See* Precedent.

Statute of limitations: The procedural law that defines the maximum duration of time within which certain legal actions can be brought by a plaintiff.

Substantive law: That body of law that creates, defines, directs, and controls individual rights and duties and that identifies specific causes for action regarding such rights and duties.

Substitute judgment: A subjective assessment or decision by one person as to how another person would decide, if that other person were, in fact, competent to do so.

Supplemental pleadings: *See* Amended pleadings.

Tail: An uninterrupted extension of the coverage period of a malpractice insurance policy; also known as the extended reporting endorsement.

Testimony: Statements of evidence given by a competent witness under oath.

Therapeutic privilege: The legal concept that sanctions the withholding of information by a health care provider when such information is deemed likely to jeopardize the health and well-being of a patient.

Tort: A civil wrong, other than that involved in a contract, that results from a breach of duty, and which produces harm or injury to the person or property of another.

Tortfeasor: One who commits or is guilty of a tort.

Unintentional tort: A civil wrong resulting from an unintentional act by the tortfeasor and that causes injury or harm to another's person or property.

Vicarious liability: The imputing of liability on one person for the wrongful actions of another based on a direct relationship between the two persons. Also known as substituted liability.

Voir dire: A judicial process. A requirement "to speak the truth."

Waiver: Voluntary relinquishment of a right.

Writ of certiorari: A formal written petition to the Supreme Court, made by the losing party, that the Court review the case.

Writ of habeas corpus: Lit. "you have the body." A legal procedure to determine the legality of a individual's custody or confinement by having the person brought before court at his or her request or on order of the court itself (the writ).

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