Nursing Malpractice: Determining Liability Elements for Negligent Acts

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Damages, Duty, Pecuniary Losses, Proximate Causation, Res ipsa loquitor

Nurses must be concerned about malpractice litigation because nurses may now be held accountable for their own negligence. It is important for each nurse to know relevant law and legal doctrines, and incorporate them into everyday practice as a safeguard for the health care provider as well as the health care recipient (Guido, 2006). This article will review each element involved in determining legal liability for negligent acts. When reviewing a nursing malpractice case for merit, the legal nurse consultant (LNC) needs to determine if all liability elements are present. Two case analyses of nursing malpractice are presented as examples for determining nursing liability. This article is not intended to be a substitute for contacting an attorney when questions arise about nursing malpractice litigation.

Despite ongoing efforts to educate nurses on the law and their professional responsibilities through nursing programs and continuing education courses, the number of nurses named as defendants in malpractice actions continues to increase (Croke, 2003; Guido, 2006; National Practitioner Data Bank (NPDB) Annual Report, 2004). In 1986, The Health Care Quality Improvement Act, Title IV of P.L. 99-660, authorized the Secretary of Health and Human Services to establish and monitor a national practitioner data bank (NPDB). The mission of the NPDB is to protect the public by "restricting the ability of unethical or incompetent practitioners to move from State to State without disclosure or discovery of previously damaging or incompetent performance"(NPDB, 2004, p.10).

The NPDB is a central repository receiving information from private and governmental agencies under U.S. jurisdiction. Information received by the NPDB is accessible to registered entities, such as state licensing boards and professional societies, which are eligible to query. Although patients cannot access the NPDB, health care providers listed in the NPDB can access their own information to check for misinformation. The NPDB collects information on physicians, dentists, nurses, and other health care practitioners who, as a result of judgments in malpractice suits, have entered into settlements, had disciplinary action taken against them that resulted in their licenses being revoked or suspended, had their privileges to practice limited, or had to pay monetary awards (Croke, 2003). According to the National Practitioner Data Bank *2004 Annual Report*, since its inception in 1990 and continuing through 2004, there have been approximately 5,001 malpractice claims assessed against all types of registered nurses (RNs). The NPDB established the following malpractice reason categories for reporting numbers of nursing malpractice payments:

1. Anesthesia related
2. Behavioral health related
3. Diagnosis related
4. Equipment or product related
5. IV or blood products related
6. Medication related
7. Monitoring related
8. Obstetrics related
9. Surgery related
10. Treatment related
11. Miscellaneous

The NPDB classifies RNs into five categories: nonspecialized RNs, nurse anesthetists, nurse midwives, nurse practitioners, and clinical nurse specialists/advanced practice nurses. Nonspecialized RNs were responsible for the most malpractice payments (3,131 or 62.7%), followed by nurse anesthetists (1,035 or 20.7%), nurse midwives (459 or 9.2%), nurse practitioners (368 or 7.3%) and clinical nurse specialists/advanced practice nurses (8 or 0.2%). The majority of payments for malpractice claims were based upon monitoring, treatment, and medications problems, as well as obstetrics and surgery-related problems (NPDB, 2004).

Today's health care environment poses even greater liability risks for nurses. Liability risks that have contributed to the increased number of malpractice cases against nurses include: improper supervision/delegation, early patient discharge, nursing shortage, hospital downsizing, increased autonomy, advanced technology, and better-informed consumers (Croke, 2003). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines *negligence* as a "failure to use such care as a reasonably prudent and careful person would use under similar circumstances" and *malpractice* as:

> improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position; often applied to physicians, dentists, lawyers, and public officers to denote negligent or unskillful performance of duties when professional skills are obligatory. Malpractice is a cause of action for which damages are allowed (JCAHO, 2005).

In 2004, the median and mean payments for all types of registered nurses were $100,000 and $302, 737, respectively (NPDB, 2004). Nurses must be concerned about malpractice litigation because nurses may now be held accountable for their own negligence. It is important for each nurse to know relevant law and legal doctrines and incorporate them into everyday practice as a safeguard for the health care provider, as well as the health care recipient (Guido, 2006).

Liability Elements of Malpractice Litigation

For a nurse to become liable in a malpractice action, the law requires that certain elements be proven by the plaintiff before a successful case can be brought against the defendant nurse (Guido, 2006). The elements include duty, breach of duty, foreseeability, causation, injury, and damages, except as noted under doctrine *res ipsa loquitor*. When reviewing a nursing malpractice case for merit, the legal nurse consultant (LNC) needs to determine if all liability elements are present. If any of these elements is missing, the nurse is not liable for malpractice. The LNC must know relevant state laws and definitions applicable for each element of liability. A summary of medical malpractice laws indexed by state is located at **www.mcandl.com/states.html**.

Duty. The duty of care that is owed to a patient is when an individual engages in an activity where that individual is under a legal duty to act as a reasonable and prudent person would act (Guido, 2006). Two aspects are involved in the duty of care. The first aspect that must be shown is that a duty was owed to the patient. This aspect is created by a legal nurse-patient relationship, not just by employment status; a legal nurse-patient relationship must exist before a lawsuit can commence. Examples of such a relationship include instances when the nurse accepts a patient care assignment, receives a report on a patient, or gives telephone advice to a patient. The LNC may be asked by the attorney to research the nature of the relationship between the plaintiff and alleged defendant nurse (Iyer, 2003).

The second aspect of duty that must be proven is the scope of care that was owed to the patient. The standard of care owed to the patient is that exercised by a reasonable and prudent nurse with like training and experience and under the same or similar circumstances. Nurses are held accountable to the standard of care that was in existence at the time the care was rendered. Various sources for standards of care include JCAHO, State Nurse Practice Act (NPA), National League for Nursing (NLN), American Nurses Association (ANA), nursing specialty organizations, institutional policies and procedures (P&P), hospital nursing job descriptions, nursing journals and textbooks, and expert witness testimony.

Breach of Duty. This occurs when a nurse's care falls below the acceptable standard of care owed to the patient. The deviation can occur by an act of omission or commission. For example, a nurse omits giving an ordered insulin dosage to a known diabetic patient, and the patient lapses into a diabetic coma. Or a nurse gives an ordered insulin dosage to a known diabetic patient, fails to monitor his subsequent lack of oral intake, and the patient suffers a debilitating hypoglycemic reaction. Whether a nurse has satisfied or breached the duties of care owed to the patient is determined by the applicable standard of care.

Due to the fact that medical and nursing knowledge is "more technical than the scope of common knowledge," most state laws require the use of expert witness testimony for establishing the standard of care at issue in a medical or nursing malpractice lawsuit (Iyer, 2003). The expert witness must be qualified by reason of education, training, or experience to opine about a given subject matter (Testimony by Experts, 2000). If the negligence action falls within the common knowledge exception, such as when the subject matter is within the ordinary, common knowledge and experience of the layperson, expert testimony may not be required. Together, the attorney and LNC must determine the applicable standard of care owed to the patient in existence at the time the nurse rendered the patient care.

The LNC reviews the entire medical record, "comparing and contrasting care with published standards determining whether or not there was a breach in the standard of care in a given subject matter" (Iyer, 2003, p. 262). The review also facilitates determining case issues and selection of qualified experts.

Foreseeability. In this area, the nurse has a responsibility to foresee harm and take actions to eliminate the risk. The nurse does not need to foresee events that are "merely possible," but only those that are "reasonably foreseeable" (O'Keefe, 2001).

Could the nurse in the preceding example reasonably foresee that not monitoring a patient's lack of oral intake subsequent to receiving insulin would result in a hypoglycemic reaction? "The challenge is to show that one could reasonably foresee a certain result based on the facts as they existed at the time of the occurrence rather than what could be said based on retrospective thinking and results" (Guido, 2006, p. 75).

Causation (proximate cause). This area is more difficult for the plaintiff attorney to prove. Causation builds upon cause-in-fact and foreseeability. In cause-in-fact (also known as the "but-for" test), the plaintiff must show that the nurse's breach in the standard of care actually resulted in the plaintiff's injury and that these injuries were reasonably foreseeable. For example, a nurse may administer a wrong drug dosage to a patient in breach of standard of care, but there was no subsequent injury; therefore, the plaintiff does not have a cause of action.

When determining a nurse's negligent action in relation to the alleged injury, Iyer (2003) recommends that the LNC should ask the following questions:

1. Did the negligence cause the injury?
2. Did the breach cause all or part of the plaintiff injury?
3. Is there any reason why the result would have been the same absent the deviation?

Legal definitions for causation are found in jury instruction guides for the jurisdiction in question. "The jury instruction guide states the precise language that a judge will

read to the jury when instructing them about the information to consider when rendering a verdict. The information that the jury will be asked to consider is what the attorney will have to prove in court" (Iyer, 2003, p. 282). State-by-state jury instructions can be located online at **www.llrx.com/columns/reference38.htm**.

Injury. In malpractice litigation, the plaintiff must prove that the injury claimed was directly related to the negligent act of the professional defendant. Categories of injuries are physical, financial, or emotional, with the later two usually accompanying physical injury. Together, the attorney and LNC must distinguish a "proximately caused injury" from the injury that the plaintiff would or did suffer irrespective of any breach (Iyer, 2003). The LNC reviews, interviews, researches, summarizes, and evaluates all medical documentation relevant to the alleged injury.

Damages. Monetary awards are given to compensate the plaintiff for the injury proximately caused by the negligent action of the defendant. Categories of damages include:

1. **General Damages:** monetary compensation for a loss that cannot be measured in "nominal amounts." Types of losses may include disfigurement, disability, and past, present, and future pain and suffering.
2. **Special Damages:** monetary compensation for losses due to injury. Types of losses may include medical expenses, lost income, and past, present, and future losses due to injury. (General and Special Damages may be grouped together into one category called Compensatory Damages).
3. **Emotional Damages:** monetary compensation for anxiety or emotional distress associated with injury.
4. **Punitive Damages:** monetary compensation for intentional or grossly negligent misconduct. Punitive damages are awarded to "punish" the individual and to deter similar future actions.

Two classification awards for damages are economic and non-economic. Economic damages concern pecuniary losses, such as medical expenses or lost wages, and non-economic damages concern non-pecuniary losses, including pain and suffering, and loss of consortium. State laws vary on awarding damages, with some capping the award amounts. For example, in 1975, California wrote into law the Malpractice Injury and Compensation Reform Act (MICRA), limiting non-economic damages in medical malpractice cases to $250,000. Additionally, 24 states have enacted laws limiting caps on non-economic damages. When an LNC or life care planner is involved in assisting the attorney with calculating economic damages, having knowledge of relevant state laws is a necessity.

Doctrine *Res Ipsa Loquitor*: "The thing stands for itself." Under this doctrine, the plaintiff does not need to prove how the injury occurred or who was responsible. The basic premise is that, without negligence, the injury would not have happened. In most states, the plaintiff does not need the testimony of an expert witness. For the doctrine to apply, the plaintiff must prove the following three elements (Guido, 2006, p. 86):

1. The accident must be the kind that ordinarily does not occur in the absence of someone's negligence;
2. The accident must be caused by an agency or instrumentality within exclusive control of the defendant; and
3. The accident must not have been due to any voluntary action or contribution on the part of the plaintiff.

The following two case analyses of nursing malpractice are examples for determining nursing liability. They are not intended to be a substitute for contacting an attorney when questions arise about nursing malpractice litigation.

#1 Case Analysis

Lunsford v. Board of Nurse Examiners, 648 S.W.2d 391; 1983 Tex. App. LEXIS 4087

Case Scenario: A patient, Donald Floyd, was brought by a friend, Miss Farrell, to Willacy County Hospital with complaints of chest pain accompanied by numbness and pain radiating down his left arm. Miss Farrell left Mr. Floyd in the hospital waiting room and went in search of medical assistance for Mr. Floyd. Within the facility, Miss Farrell spoke with a physician who subsequently referred her to seek help from the registered nurse on duty, Nurse Lunsford. Nurse Lunsford was ordered by the physician to send the patient and his companion to Valley Baptist Hospital, 24 miles away. The hospital had a policy to send all patients to Valley Baptist Hospital unless the patient had a physician on the hospital's staff or unless it was a "life-death situation."

Upon entering the waiting room, Nurse Lunsford found Mr. Floyd lying on a table complaining of chest pain that also had radiated to his arms. After questioning Mr. Floyd, Nurse Lunsford learned that he had not undertaken any strenuous exercise or eaten anything unusual that day that may have influenced the onset of his symptoms. Despite suspecting "cardiac involvement," Nurse Lunsford did not take Mr. Floyd's vital signs. Nurse Lunsford gave the following instructions to Miss Farrell: take Mr. Floyd to Valley Baptist Hospital; speed there; drive with the automobile's emergency flashers on; and use the automobile's citizens' band radio to call for help on the way to Valley Baptist Hospital. Nurse Lunsford also asked Miss Farrell about her knowledge of cardiopulmonary resuscitation (CPR), as there might be a chance that she may need to use it during transport. Mr. Floyd died five miles from Willacy Hospital on the way to Valley Baptist Hospital.

The Texas Board of Nurse Examiners (1983) conducted a hearing on the actions of Nurse Lunsford relating to Mr. Floyd death. The Board, citing Texas Rules of Evidence 4525 (B) (9), found that Nurse Lunsford's conduct had been "unprofessional and dishonorable… likely to injure patients or the public" and suspended Nurse Lunsford's Texas RN license for one year. The District Court of Travis County, 200th Judicial District affirmed the Board's decision. Nurse Lunsford appealed, citing she did not owe a duty to Mr. Floyd because a nurse-patient relationship had not been established between the parties. The Court of Appeals of Texas, Third District, Austin affirmed the judgment of the District Court.

Elements of Liability:

- **Duty.** Nurse Lunsford cited she did not have a nurse-patient relationship with Mr. Floyd, as he had not been

admitted to the hospital and was not a patient of the staff physician. The Courts found that Nurse Lunsford automatically owed a duty to Mr. Floyd through the receipt of her Texas Registered Nurse licensure and that a nurse-patient relationship existed when she met Mr. Floyd in the hospital waiting room in need of life-threatening emergency care. Texas Board of Nurse Examiners Rule 22 T.A.C 217.11(1)(M),(3)(A)(i) requires an RN to assess the health status of each patient and institute appropriate nursing actions that might be required to stabilize the patient's condition and/or prevent further complications.

- **Breach of Duty.** The Board found and Courts affirmed that Nurse Lunsford failed to assess and implement appropriate nursing actions. Specifically, the following breaches in the standards of care were cited:
  1. Failure to assess Mr. Floyd's medical status;
  2. Failure to inform the physician of Mr. Floyd's cardiac condition and potential life-death medical status; and
  3. Failure to institute appropriate nursing actions, such as taking vital signs and placing the patient on electrocardiogram (ECG) machine, to stabilize Mr. Floyd's medical condition and prevent further complications and, ultimately, his demise.
- **Foreseeability.** Nurse Lunsford should have been able to reasonably foresee the potential complications related to Mr. Floyd's complaints, especially since she admitted to have suspected "cardiac involvement." Nurse Lunsford also questioned Miss Farrell about her knowledge of CPR, which demonstrates Nurse Lunsford's forseseeability of a cardiopulmonary arrest.
- **Causation.** Nurse Lunsford's breach in the standards of care proximately caused the injury. If she had assessed the patient, communicated to the physician about the patient's life-threatening condition, and implemented nursing interventions, his death could have been prevented.
- **Injury.** Nurse Lunsford's breach of duty and failures to assess the patient's condition, to communicate his condition to the physician, and to implement nursing interventions to help stabilize his condition resulted in the cardiac event that lead to his death.
- **Damages.** Nurse Lunsford's RN license was suspended for 1 year.

#2 Case Analysis

Muskopf v. Maron, 764 N.Y.S.2d 741; 2003 N.Y. App. LEXIS 10050

Case Scenario: Susan Muskopf, a patient of Dr. Barry Maron, was admitted to Wyoming County Community Hospital for a unilateral hand repair due to carpal tunnel syndrome. At the time of admission, Ms. Muskopf had been diagnosed with bilateral carpal tunnel syndrome, although her left hand was asymptomatic at the time of surgery. Prior to the surgery, Ms. Muskopf questioned the hospital nurse about the location of the surgical procedure, stating that she thought the surgery was to be performed on her right hand. Subsequently, the hospital nurse reviewed all the pre-operative medical documents in the patient's chart, including the physician's records and informed consent form signed by the patient, and all the documents indicated that the surgery was to be performed on the patient's left hand. The hospital nurse did not notify the physician of the patient's concern regarding the site of the surgery and did not document this conversation in the patient's medical record.

The patient brought a medical malpractice action suit against Dr. Maron, the Wyoming County Community Hospital, and the County of Wyoming, seeking damages for injuries she allegedly sustained when the physician operated on her left hand instead of her right hand. The patient also brought an independent negligence cause of action collectively against the hospital and the county for the failure of the hospital nurse to prevent the surgical error despite having been informed by the patient that she thought the surgery was to be done on her right hand. The Supreme Court, Wyoming County, granted a cross motion of the Wyoming County Community Hospital and County of Wyoming defendants for summary judgment, dismissing the complaint against them (765 N.Y.S.2d 537; 2003 N.Y. App. LEXIS 10047). On appeal to the Supreme Court of New York, the plaintiff contended that the Supreme Court, Wyoming County, erred in granting the defendants' cross motion for summary judgment. The defendants maintained the contention that they were shielded from tort liability, based on the fact that the hospital nurse had reviewed and followed the physician's pre-operative orders. On review by the State Supreme Court of New York, it was cited that the defendants had met their initial burden of proof, based, in part, upon affidavit testimony provided by a nurse expert witness, who opined that the nursing care rendered by the hospital nurse met the standard of care: once the hospital nurse was questioned by the patient concerning the surgical site, the hospital nurse reviewed all the preoperative physician records, as well as the informed consent form signed by the patient, and all the records indicated the surgery was to be performed on the patient's left hand.

An issue of fact was raised by the plaintiff through affidavit testimony provided by the physician expert witness, who opined that the hospital had breached "the accepted standards of medical practice by failing to undertake a comprehensive review of the plaintiff's case, including a specific inquiry to the attending physician and documentation of the results of that inquiry, when the hospital nurse learned of plaintiff's doubts concerning the site of the surgery" (Muskopf v. Maron, 2003, p. 2). The plaintiff's physician expert's opinion was based, in part, on the hospital nurse's own deposition testimony: "If a patient had a question concerning the side on which surgery was to be performed, she [the nurse] would document that she [the nurse] had called the doctor and that he would be in to speak to the patient" (Muskopf v. Maron, 2003, p. 2). The Supreme Court of New York found the issue of fact undisputable, in that the hospital nurse did not follow through with notifying the physician of the patient's concern

and denied the defense's motion that they were shielded from tort liability. The judgment was reversed on the law with costs, the cross motion was denied, and the complaint against the Wyoming County Community Hospital and County of Wyoming defendants was reinstated.

Elements of Liability:

- **Duty.** A legal nurse-patient relationship existed between the patient and the hospital nurse. The hospital nurse owed a duty to the patient to ensure that the physician was notified of the patient's concern regarding the surgical site. In the hospital nurse's own deposition testimony, she stated, "If a patient had a question concerning the side on which the surgery was to be performed, she [the nurse] would document that she [the nurse] had called the doctor and that he would be in to speak to the patient" (Muskopf v. Maron, 2003, p. 2).
- **Breach of Duty.** The hospital nurse breached the standard of care with an act of omission by not informing the physician of the patient's concern regarding the surgical site.
- **Forseeability.** The hospital nurse should have been able to reasonably foresee the potential complication of wrong site surgery related to not informing the physician of the patient's stated concern.
- **Causation.** The hospital nurse's breach in the standard of care proximately caused the injury. If the hospital nurse had notified the physician of the patient's concern about the surgical site, the surgical error could have been prevented.
- **Injury.** The patient had surgery on the wrong hand. The left hand was asymptomatic at the time of surgery.
- **Damages.** For the appellants, the Supreme Court of New York unanimously reversed the appealed judgment on the law with costs, the defense's cross motion for summary judgment was denied, and the complaint against the Wyoming County Community Hospital and County of Wyoming defendants was reinstated.

Summary

When evaluating a nursing malpractice case for merit, the LNC must evaluate each liability element for possible negligence. The first element that must be determined is the existence of a legal nurse-patient relationship between the parties and based upon the relationship what was the scope of care owed to the patient by the nurse [defendant]. The LNC must then determine whether or not there was a breach in the standard of care, identify proximate causation and injury. Once the evaluation is complete, the LNC must be able to provide the attorney with a precise report (verbal or written) based upon each liability element.

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are examined. Although these areas are not as frequently cited in medical litigation as some other clinical areas, for an LNC dealing with such, these chapters are a wonderful resource for those individuals with minimal baseline knowledge.

In addition, this section has two chapters that address topics often entangled in the litigation process: the office based medical record and the independent medical examination (IME). The IME chapter delineates the step-by-step process of an IME, culminating with final impressions and professional opinions regarding the IME. The section on office based medical records was very helpful. As many LNCs are aware, office based verbal communication may not be adequately corroborated with written documentation – and may even serve as the wavering domino leading to an unfortunate cascade of events resulting in medical malpractice litigation.

Part III, chapters 21 through 38, deal specifically with clinical specialty areas. This is the "meat and potatoes" for LNCs who are routinely involved in medical malpractice litigation. These chapters address many high-volume, high-risk areas of clinical practice, e.g. critical care, emergency department, intravenous therapy, obstetrics, orthopedics, pediatrics, skin trauma, medication administration, and psychiatric care. The reader will benefit tremendously from the expertise and experience of each contributing author. If an LNC is already clinically experienced in one of these particular fields, it is likely that the information contained within the chapter will reinforce an existing knowledge base. For the LNC without clinical expertise in one or a number of these designated clinical areas, the chapters will provide an excellent starting point to explore pertinent definitions, patient care interventions, treatment complications, and practice standards.

Part IV of the text explores forensic aspects of care. Although any LNC may encounter altered medical records or utilize a forensic document examiner, for those involved in criminal prosecutions, chapter 41 will be highly beneficial. A detailed discussion of forensic evidence from sexual assaults, gunshot wounds, auto accidents, and poisonings provide examples. The final chapter of the book addresses autopsy reports, which may be an integral component of malpractice, product liability, or toxic tort litigation.

The book concludes with an appendix of medical terminology, Internet resources, textbook references, and a glossary. These four subcomponents, as evaluated separately from the main text, are excellent as a stand-alone reference for the practicing legal nurse consultant.

In summary, authors Iyer, Levin, and Shea have provided the legal and nursing community a comprehensive and worthwhile resource for medical record examination. Whatever your level of competence in legal nurse consulting practice, whether novice or seasoned expert, this publication will be as valuable addition to your reference library.

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