LEGAL IMPLICATIONS OF INCREASED AUTONOMY

The emerging awareness by lawyers of the professional yardstick (standards of care) by which the conduct of a professional nurse can be measured, along with a new-found realization on the part of consumers, heralds the arrival of a new legal frontier.

In the not too distant past, malpractice litigation involving healthcare providers was virtually nonexistent. Physicians held an almost deified position among the public.[1] Nurses, in the eyes of consumers, were regarded as symbols of compassionate care, and in matters of health management were also placed on a pedestal of public trust. In days gone by, if a negative outcome occurred in a healthcare setting, it was attributed to an "act of God" rather than to the negligent conduct of a member of the medical team.[1] Seldom was the conduct of a professional in the health field questioned. Rarely were complaints of medical or nursing maltreatment entertained by attorneys, and it was an even more rare occasion that allegations of this nature materialized into a successful lawsuit, Providers found themselves in a rather enviable position - virtually immune from consumer scrutiny and insulated from the realities of legal accountability. In sum, iatrogenic injury was a well-kept secret,[1] buried deeply beneath the protective layers of the healthcare community and further hidden by the ignorance, misconceptions, and in many cases misplaced faith of the public.

During the past two decades, however, a growing number of consumers and attorneys have become aware of the use of malpractice claims both as a vehicle for compensating injured patients who have suffered from the negligence of providers and as a mechanism for regulating quality of health care. Alerted by a flurry of highly publicized "scandals" emphasizing the fact that health professionals are not only capable of negligent behavior, but also of greed, deception, and even intentional acts and omissions constituting foreseeably fatal conduct, the public has begun to question the opinions and actions of the entire healthcare community. Today, it is commonplace for a patient to seek a second or third opinion regarding his or her diagnosis, treatment, and care management.[1] No longer is an explanation such as "this poor outcome was inevitable due to underlying complications" blindly accepted.

In the wake of such widespread concern for quality of care, a large number of attorneys have begun to explore the legal dimensions of healthcare liability. Such effort over the last 20 years has resulted in a plethora of case authority holding that doctors and frequently healthcare institutions can be liable not only for damages arising out of negligence, abandonment, fraud, wrongful birth, and false imprisonment,[2] but also for crimes ranging from tampering with a governmental record, theft by deception, aggravated assault, and even homicide.[3]

During the course of this evolutionary process, nursing has remained in the background, touched only peripherally by this expanding body of law. Legally perceived by the courts as subservient "nonprofessionals, unable to exercise independent judgment and thus dependent upon the physician for all functions of clinical import,[4] and pragmatically viewed by practicing lawyers as judgment-proof [5] due to this absence of

malpractice insurance coupled with a salary too low to support a meaningful verdict for damages, nurses were generally regarded by the legal community as being exempt from malpractice liability.

In recent years, however, as a number of factors have faced the courts and lawyers to reassess their earlier position. The role of the nurses has changed from that of a passive, servile employee to that of an assertive, decisive healthcare provider.[6] Educational standards have been upgraded. Regulations and state statutes pertaining to the practice of nursing have been promulgated setting forth minimally acceptable conduct and defining nursing in terms of "performing professional services."[4] A Nurses have begun to appreciate the void in health care created by medical specialization and to fill that void by assuming responsibilities formerly performed by physicians.[8] And a growing number of practitioners have begun to carry malpractice insurance (from July 1978 to July 1980 the number of nurses insured by one insurance company rose from 284,000 to 501,000).[9]

No longer expected to wait upon and then blindly follow a doctor's orders, the modem nurse has a legally recognized "duty" to participate actively in decision-making processes that impact upon the practice of nursing and affect the resolution of healthcare issues.[10] Violation of this duty resulting in injury to a patient can subject the violator to administrative, civil or even criminal liability.[11]

Indeed, as nurses have expanded their areas of practice and become more autonomous, they have increasingly become targets for malpractice suits.[9] The emerging awareness by lawyers of the professional yardstick (standard of care) by which the conduct of a professional nurses can be measured, along with a new-found realization on the part of consumers that a legal remedy exists for nursing negligence, foretells a rise in the number of nursing malpractice suits and heralds the arrival of a new legal frontier. Like it or not, the nursing profession has forfeited its secondary risk position in the process of moving out of the shadows of medicine, and has become the legal focus of malpractice actions arising from imprudent and deviant nursing behavior. [12]

Accelerated Accountability

Why is this trend particularly relevant to the gerontological nurse? Nowhere are the factors that precipitated the emergence of legal responsibility and independent liability for the professional nurse more pronounced than in the discipline of gerontological nursing. As a consequence, a climate ripe for litigation presently surrounds the care of the geriatric patient.

This climate has been substantially influenced by a successive floor of profoundly disturbing exposes, studies, and investigations dealing with the topic of inadequate care in America's long-term care facilities. Since the first federal study of nursing quality in 1956 revealed that care was "universally poor,"[13] a sustained epidemic of widespread neglect, recurrent physical abuse, and "abysmally poor care"[14] has been chronicled in America's long-term care institutions.[15] Typical of the voluminous findings are those made public in 1974 by the Senate Special Committee on Aging, 93rd Congress, 2nd Session. Following a 15-year study, the committee concluded that at least half of the nation's nursing homes had one or more serious, life-threatening conditions and that residents frequently

encountered abuse and physical mistreatment including negligent and intentional actions by nursing staff, which led to injury or death.[16]

Unfortunately, current studies establish that the problems identified in the past continue to exist. This reality is perhaps best captured by the Institute of Medicine report published in 1986, which issued the following finding:

> Today, nursing homes can be found in every state that provide seriously inadequate quality of care. In many government-certified nursing homes, individuals who are admitted receive very inadequate-sometimes shockingly deficient-care that is likely to hasten the deterioration of their physical, mental and emotional health.[15]

Such reports have caused long-term care facilities to become symbols of abandonment, isolation, and neglect; galvanized public concern for the quality of nursing care provided the aged; and increased the likelihood that consumers, in cases where elder malfeasance is suspected, will seek the advice or legal assistance of an attorney. Awakened to the effects of "nursigenic"[17] behavior by years of publicity, both public and private, attorneys have begun to pay careful attention to allegations of substandard care and devote substantial thought to theories of liability. The result of such heightened sensitivity has led to a burgeoning number of suits filed on behalf of nursing home residents and their families for violations of governmental nursing regulations and professional standards.[18]

In this atmosphere, a second factor relevant to the legal risks of the gerontological nurse becomes evident - the enhanced vulnerability of aged individuals to iatrogenic and nursigenic behavior. Aging is typified by a decreased capacity to respond to stress. Whereas a mature adult, in most cases is resilient enough to enter a provider facility, suffer the vicissitudes of care, and then leave in an improved condition, the disabled and dependent elderly patient is less able physically to cope with or adapt to nursing care that deviates from professionally recognized standards.[19] Given this reality, it is hardly surprising that the magnified vulnerability of an elderly patient to problems induced by the inadvertent, indifferent, or negligent conduct of a professional nurse is directly related to an escalated potential for legal scrutiny.

Further portending the likelihood of expanded liability for the gerontological nurse is a third and final factor. This factor consists of five circumstances relevant to the practice of nursing in a long-term care setting:

1. The marked absence of both leadership and often interest in long-term care facilities by medical professionals;
2. The critical role that professional nurses have assumed in the initiation of care programs and management for geriatric patients with chronic health problems and superimposed acute illness;
3. The emphasis placed by extensive state and federal nursing home regulations (which seek to define the level of care expected by the government) upon compliance with professional nursing standards and adherence to scientific nursing principles;
4. The development of specialty standards that expand upon the generic standards promulgated by the American Nurses' Association and describe

the minimum level of acceptable performance in the specialty area of gerontological nursing;[4] and

5. The frequent number (comparatively speaking)[20] of nursing home inspections and surveys conducted by government agencies to assure compliance with the above regulations and professional standards incorporated therein.

Operating synergistically to influence the probability of legal intervention, these circumstances not only underscore the importance of the gerontological nurse's professional and legal responsibilities, but also created a setting that yields bountiful amounts of quality assurance data and is potentially pregnant with pertinent legal fact. Moreover, when the emphasis on professionalization and the abundance of available proof is combined with the factors discussed above, a litigious environment, increasingly capable of supporting a mushrooming number of lawsuits, evolves.

The Dilemma

Having completed an excursion into those factors accelerating the gerontological nurse's risk for liability, the final question considered by this article is: How should the gerontological nurse (and for that matter the nursing profession as a whole) respond to the emerging nursing malpractice trend? Certainly one response that practitioners might consider is to treat this escalation of legal scrutiny as a threat to professional honor and an encroachment upon nursing action that can only be halted by the erection of protective, impenetrable walls, designed to mystify "outsiders" who seek to evaluate quality.

Charges of recurrent patient neglect and abandonment on the part of nursing home and administrative staff recently evoked this very response from a nursing expert[2l] in a criminal trial in the state of Texas. After months of testimony by nursing personnel (registered nurses, licensed vocational nurses, nurses aides, and other staff) as well as visitors, relatives of residents, inspectors, and numerous nursing and medical experts had revealed a total and prolonged breakdown of the nursing process; a continual and critical shortage of staff and supplies; and a habitual and extensive practice of falsifying clinical records, the nursing expert (referred to above) was called as a witness for the defense. Adamantly refusing to consider the voluminous eyewitness testimony described previously (while at the same time dismissing as meaningless a proliferation of falsified record entries such as documentation indicating that 24 hours after the body of a patient had been removed to a funeral home, medications were still being administered to the corpse), the defense expert absolved the nursing profession of all wrongdoing.

Further opining ??? that breakdowns, such as the failure of nurses (for 40 days) to question an order that called for a 600-calorie diet to be administered to an undernourished resident, were trivial and acceptable, the defense expert steadfastly maintained that care provided was "within nursing norms, probably better." Finally and most important, outraged that the name of nursing had been besmirched by these charged, the nurse for the defense declared that "it was impossible [for her] to discuss the effects of nursigenic behavior because [she] could not possibly conceive of a nurse neglecting or abandoning a patient."

The loud and discordant notes sounded by these words are significant not because of their impact on the aforementioned case or because the opinions enunciated opposed those of nursing experts called by the state, but because these views, no matter how well intentioned, exemplify a rather defensive and visionless attitude, which stubbornly refuses to acknowledge the existence of deviant and substandard conduct within the ranks of nursing and thereby willfully blinds itself to reality. In a society that has become extremely cognizant of the scars left by inadequate care, the manifestation of such an attitude is as detrimental to the nursing profession as conduct violative of professional standards. Not only does it risk the credibility of the profession and the faith of the public, but it also tarnishes the image projected by both the American Nurses' Association and state licensure boards that a nurse is first and foremost a patient advocate.

Moreover, this position calls into question the will of nursing to examine and solve the myriad of quality assurance problems confronting consumers and raises an ethical issue of the highest priority - does the nursing profession, in its continuing struggle to receive the recognition and dignity it deserves, owe primary allegiance to this cause or to its patients? I hope that by asking the question I have answered it. Nursing must never become so preoccupied with the advancement of its own prestige and power that it forgets the basic premise upon which its professional status depends - public protection. Nurses must realize when this foundation vanishes, so does the need for their profession.

Instead of reacting as if this recent upsurge in legal accountability constitutes a doomsday for the nursing profession (activated by a motley crew of ill-informed outsiders who will, if permitted, permanently stain the honor of nursing and dash all hopes of an expanded healthcare role), I hope the profession of nursing will consider another approach - an approach that treats the law not as an invading enemy but as a powerful ally, capable of improving judgment and extending the dimensions of nursing responsibility.

The first step that must be taken in this regard is for practitioners to appreciate at the outset the, ability of the law to limit professional practice, control nursing actions, penalize imprudent conduct, and elevate the status of nursing by redefining provider boundaries and expanding through case precedent the role of the professional nurse. It must further be realized that the legal framework presently in place is subservient to neither hospital nor nursing home policy, doctors' orders, nor physician or colleague direction. Nurses must understand that no more authoritative reference exists than the law. Moreover, in situations involving competing interest, the law takes precedence even though it may run counter to institutional policy, orders of a physician, or professional tradition.

Once the capability of the law to extend or limit nursing action is accepted, nursing then needs to approach the study of this discipline with the same conviction and purpose evidence in the study of physical, biological, and psychological processes related to nursing theory.[5] Inasmuch as the hallmark of the professional nurse is informed judgment resulting from synthesis of ideas, interdisciplinary principles, and constructs, practitioners should expand their knowledge base to include an understanding of legal precedent and principles. In determining, in a given situation, whether to act or withhold actions, they should rely upon the law as a supportive science, automatically integrating into the decisional process an appraisal of all legal variables.

Obviously, the development of this knowledge base will not occur overnight. However, if the law is to become an integral part of the nurse's thinking process, and a significant dimension of the nursing process, an aggressive educational program must be implemented. Until all professional curricula and continuing education programs recognize the law as an essential component of nursing practice, the positive force of the law is missing from the decision-making process and both nurse and patient are the losers.[5]

Once these educational objectives have ripened into reality, a legally aware nurse will emerge capable of operating safely and securely within the healthcare field, and able to advise other providers how to diminish the risk of legal intervention. Armed with this knowledge, nurses can not only exert a positive influence upon the quality of provider care, but also fill the large void existing between the legal and healthcare communities and, in so doing, further expand the role and autonomy of the professional nurse.

Conclusion

As nursing has crossed the professional malpractice threshold and journeyed into the land of legal accountability, it has been confronted with an ethical issue of the highest priority: How should practitioners respond to the growing scrutiny of the legal profession? It has been the goal of this article to bring into sharp focus the escalating relevancy of this question as well as the far-reaching consequences of the decision to be made. It is this writer's belief that the best interest of the public and nursing will be served not by resisting the upsurging tide of consumer and attorney awareness, but rather by embracing the principles of the law and incorporating them into the interdisciplinary decisional process, which is the hallmark of the professional nurse. In making this suggestion the author seeks not to substitute his perception of the world for that of the reader, but rather to provoke thought on the part of those within the nursing profession about different approaches available to them and the effect the selected response will ultimately have on the practice of nursing.

References

1 . Kravis G: Medical Malpractice. Thoughts and Perspective, Vol. 19 of *Trial* pp 50-55, (May 1983).

2. Perdue: The Law of Texas Medical Malpractice 22 Hous. L. Rev 1.285 (2d ed, 1985) at 1-46.

3. See eg. Homicide: Failure to Provide Medical or Surgical Attention, 100 *American Law Reports Annotated* 2d 483 -519.

4. See a Revolution in White - New Approaches in Treating Nurses as Professionals. *30 VandL Rev* 839-879; also see note 2.

5. See Murchingson I, Nichols T, Hanson R: Legal Accountability in the Nursing Process 1, 185 (1978).

6. Nursing Malpractice Litigation: Toward Better Patient Care, 18 *Trial* 78-81 (Oct. 1982).

7. Bullough: The Current Phase in the development of nurse practice acts. 28 *St. Louis L Rev:* 365-395.

8. *Extending the Scope of Nursing Practice: A Report of the Secretary's Committee to Study Extended Roles for Nurses 4-6 See US Dept of Health, Education, and Welfare publication Government Printing Office,* 1971. Also see note 7, where according to Bullough, "medical specialization has resulted in a shortage of medical providers who can treat common episodic and chronic illnesses at a price that ordinary people, the government, and third party payers can afford."

9. Scholin M: The Use of Nurses as Expert Witnesses, 19 *Houston L Rev* 555-578.

10. Walker D: Nursing 1980: New Responsibility, New Liability, 16 *Trial* 43-47.

11. See generally, Fiesta J: The Law and Liability: A Guide for Nurses 1, note 4; and see specifically, *Lundsford v. Board of Nurse Examiners* 648 SW2d 391 (Tx Civ App-Austin 1983 no writ); *Childs v. Greenville Hospital Authority* 479 SW2d 399 (Tex Civ App-Texarkana 1972, writ ref d n re), and *State v Autumn Hills Convalescent Center, Inc. et al;* Cause No. 84-CR-0727-28,29,30,31, and 32, 212th District Court, Galveston County, Texas.

12. The demise of the "captain of the ship" doctrine has forced nurses to become more responsible for their own acts. *Mavullt v. Elshire* 27 Cal App 3d 180, 187, 103 Cal Rptr 461, 465 (Dist Ct. App. 1972) *Sprager v. Worley Hosp Inc.* 547 SW2d 582 (Tex 1977). In the past nurses were viewed as falling under the umbrella of the physician, who was legally regarded as the "captain of the ship." Presently the courts have begun to recognize the nonliability of the physician for a nurse's negligent acts or omissions. See note 10.

13. U. S. Senate 1957; Recommendations of the Commission of Chronic Illness on the Care of the Long-term Patient, in *Studies of the Aged and Aging,* vol.2 Committee on Labor and Public Welfare, U.S. Government Printing Office, 1956.

14. Butler P: Nursing Home Quality of Care Enforcement. *Clearinghouse Review* (special issue) October 1980.

15. *Improving the Quality of Care in Nursing Homes, Appendix A,* 239-253. National Academy of Science, Institute of Medicine, Committee on Nursing Home Regulation, 1986.

16. Subcommittee on Long-Term Care of the Aged. *Senate Special Committee on Aging, Nursing Home Care in the United States; Failure in Public Policy;* No. 93-1420, 93rd Congress, 2nd Session (1974).

17. For a proposed definition see: Miller M: latrogenic and Nursigenic effects of prolonged immobilization of the ill aged, *J AM Geriatr Soc* 1975; 23, pp. 360-369. "...In a variety of dictionary and word sources, terminology identifying a nurse induced abnormal state in a patient by inadvertent or erroneous treatment is singularly lacking. In the absence of a suitable word, we proposed the term 'nursigenic,' derived from the French 'nourrice' for nurse."

18. Nemore P: Protecting Nursing Home Residents, *21 Trial* 1985: 56, and Enforcing Compliance with Federal Standards, in *Institute of Medicine Report,* 56 (1985), chapter 5, see note 15.

19. Kune R., Ouslander J., Abrass I.: *Essentials of Clinical Geriatrics, 1984 McGraw Hill Book Co.*

20. *The nursing home industry is more frequently surveyed than the hospital industry and other health institutions. This should not betaken to mean that the frequency of inspection is sufficient to assure compliance with regulations.*

21. *This expert was not an eyewitness to any of the events that transpired, but rather based her opinions on a review of clinical records. She was presented by the defense as a leader and staunch advocate of nursing.*

About reference style

Legal references are cited according to "A Uniform System of Citation" 14 ed. 1986 published by Columbia, Yale, Harvard and The University of Pennsylvania Law Review Association.

About the author

David T. Marks is assistant attorney general of the Consumer Protection Division in Austin, Texas.