TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
School of Nursing/Continuing Nursing Education

Strategies for Decreasing Legal Hazards in Long-Term Care

Presentation on
Legal Accountability for Health Care Professionals and Related Documentation Issues

By
David T. Marks

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Legal Hazards in Long-Term Care

I. Introduction:

A. Objective:

To educate those in the nursing profession and the allied health fields about conduct (relating to treatment and care of the geriatric patient) which constitutes a "red flag" to the legal profession; places health care professionals at risk; and potentially results in civil, criminal, and administrative, liability.

B. Discussion Preview:

In seeking to accomplish the foregoing objective, the following subjects are examined:

Part One: An Emerging Trend -- Legal Accountability for Maltreatment of the Geriatric Patient:

Part Two: When Can a Health Care Provider be Held Legally Accountable for 1) His/her Own Acts- or Omissions? 2) The Conduct of Another?

Part Three: The Failure to Report ElderAbuse/Neglect as the Basis for Liability

Part Four: The Clinical Record as a Source of Proof in a Neglect/Abuse Case

Ill. Part One: An Emerging Trend - Legal Accountability for Maltreatment of the Geriatric Patient [Four Factors] I

A. Factor One: An Awakened Public Coupled with a Receptive Legal Profession

1. In the not too distant past, malpractice litigation involving health care 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 health care setting, it was attributed to an "act of God" rather than to the negligent conduct of a member of the "medical team." Seldom was the conduct of a professional in the health field questioned.

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

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[2].

2. During the past two decades, however, a growing number of consumers and attorneys have become aware of the use of malpractice claims as both 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 professions are not only capable of negligent behavior, but also deception and even intentional acts and omissions constituting foreseeably fatal conduct, the public has begun to regularly question the opinions and actions of the entire health care community. Today, it is commonplace for a patient to seek a second or third opinion regarding his/her diagnosis, treatment, and care management. 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 health care liability. Such effort over the last 20 years has resulted in a plethora of case authority holding that doctors and frequently health care institutions can be liable, not only for damages arising out of negligence[3], but also for crimes ranging from tampering with a government record, theft by deception, aggravated assault, and even homicide[4].

B. Factor Two: Increased Sensitivity to Elder Abuse/Neglect

1 . No where are the factors which precipitated the emergence of legal responsibility and independent liability for the health care professional more pronounced than in the field of geriatric care. As a consequence, a climate ripe for litigation presently surrounds the care of the geriatric patient.

2. This climate has been substantially influenced by a successive flood of profoundly disturbing exposes, studies,

2 Marks DT: Legal Implications of Increased Autonomy. Vol. 19, No. 3 of Journal of Gerontological Nursing, (March 1987).

3 Marks DT: Legal Implications of Increased Autonomy. Vol. 19, No. 3 of Journal of Gerontological Nursing, (March 1987).

4 Perdue: The Law of Texas Medical Malpractice. 22 House. L. Rev. 1, 285 (2d ed. 1985) at 146.

and investigation 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," a sustained epidemic of widespread neglect, recurrent physical abuse and "abysmally poor care"[5] has been chronicled in America's long-term care institutions[6]. Typical of the voluminous findings are those made public in 1974 by the Senate Special Committee on Aging, 93d Cong., 2d Session. Following a fifteen 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[7]. 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[8].

3. Such reports have caused long-term care facilities to become symbols of abandonment, isolation and neglect; galvanized public concern for the quality of care provided the aged; and have increased the likelihood that consumers, in cases where elder malfeasance is suspected, will seek the advice and/or legal assistance of an attorney. Awakened to the effects of iatrogenic and

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

6 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.

7 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).

8 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.

nursigenic[9] 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 professional standards[10].

C. Factor Three: Enhanced Vulnerability of the Aged to Iatrogenic and Nursigenic Behavior

In this atmosphere, a third factor relevant to the legal risk of the physician and allied health professions 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 viscitudes of care, and then leave in an improved condition, the disabled and dependent elderly patient is less able to physically cope with or adapt to nursing care which deviates from professionally recognized standards[11]. Given this reality, it is hardly surprising, that the magnified vulnerability of an elderly patient to problems induced by inadvertent, indifferent or negligent conduct is directly related to an escalated potentiality for legal scrutiny.

D. Factor Four: Extensive Regulation and Documentary Requirements

Further portending the likelihood of expanded liability for the geriatric care professional is a fourth factor. This factor is grounded in the emphasis placed by extensive state and federal nursing home regulations on the level of care expected to be provided for nursing home residents. Extensive documentation requirements and the frequent number (comparatively speaking) of nursing home inspections and surveys conducted by government agencies to assure compliance with the above regulations create a setting which yields bountiful amounts of quality-assurance data and is potentially pregnant with pertinent legal fact. When this factor is combined with those set forth above,

9 For a proposed definition see: Miller M: Iatrogenic and Nursigenic Effects of Prolonged Immobilization of the III Aged. Journal of the American Geriatric Society, 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 propose the term 'nursigenic,' derived from the French 'nourrice'for nurse."

10 Nemore P: Protecting Nursing Home Residents. 21 Trial 1985; 56, and Enforcing Compliance with Federal Stand5ards, in Institute of Medicine Report, 56 (1985), chapter 5, see note 15.

11 Kane R, Ouslander J, Abrass 1: Essentials of Clinical Geriatrics, 1984 McGraw-Hill Book Co.

a litigious environment, increasingly capable of supporting a mushrooming number of lawsuits, evolves[12].

Ill. Part Two: When Can a Health Care Provider be Held Legally Accountable for: 1) His/Her Personal Acts or Omissions? 2) the Conduct of Another?

A. Introduction:

1. usually, in a case against a health-care professional wherein substandard conduct is alleged, the plaintiff alleges that the health care professional failed to perform duties either imposed by law or imposed by professional standards.

2. Regardless of the specific theory advanced, (i.e., whether it arises from a criminal act or omission, civil negligence or malfeasance or administrative violation) the plaintiff must establish:four common elements in order to prevail:

a. Existence of a duty of care: There must be a duty to act within a standard of reasonable care.

b. Breach of that duty: The individual who is alleged to have acted negligently must have breached a duty to act with reasonable care, or failed to perform a duty imposed by law.

c. Proximate cause: The individual who is injured must show that the negligent action of the other party caused the injury.

d. Culpable mental state/responsibility. In both criminal, civil, and administrative actions the imposition of liability requires that a blameworthy mental status be attributable to the defendant. [e.g., In a criminal or administrative case, the defendant must have: 1) intentionally caused the injury; 2) knowingly caused the injury; 3) recklessly caused the injury; or 4) negligently caused the injury. In a civil case the Defendant's blameworthiness is measured by the foreseeability of the consequences as gauged from the standpoint of the "reasonable man" (or "reasonable health care professional").]

B. The Existence of a Duty:

1 . General: The pivotal element of the four requisites listed above is the first element, i.e., the owing of legal duty to provide some type of support or care. The existence and extent of liability are controlled by the existence and extent of the legal duty.

12 See Note 2, supra, at 29.

Without it, no crime or tort is committed regardless of the severity of the harm inflicted or the level of "evil" in the mind of the wrongdoer.

2. The Requisite Duty Under Principals of Criminal Law:

   a. The most commonly cited common law principle pertaining to the type of duty required to exist in a prosecution arising out of neglect is found in People v. Breardsley (1907) 150 Mich 206,113 NW 1128, 13 LRA NS 1020: "The law recognizes that under some circumstances the omission of a duty owed by one individual to another, where such omission results in the death of the one to whom the duty is owing, will make the other chargeable with manslaughter ..." This rule of law is always based upon the proposition that the duty neglected must be a legal duty, and not a mere moral obligation. It must be a duty imposed by law or by contract, and the omission to perform the duty must be the immediate and direct cause of death."

   b. Duties dictated merely by good morals, or by human considerations, are not generally within the domain of the law, and therefore one who did not become a good Samaritan by providing medical care when a witness to the distress of a sick or injured person does not become criminally responsible should death occur to such person because of a lack of medical attention.

   c. Legal rights and duties, however, may arise out of those complex relations of human society which create correlative rights and duties, the performance of which is so necessary to the good order and well being of society that the state makes their observance obligatory. As pointed out in the leading case of Jones v. United States (1962) 113 App. DC 352, 308 F2d 307, there are at least four situations in which the failure to provide medical care may constitute a breach of a legal duty. One can be held criminally liable, first, where a statute imposes a duty to care for another; second, where one stands in a certain status relationship to another; third, where one has assumed a contractual duty to care for another; and fourth, where one has voluntarily assumed the care of another and has so secluded the helpless person as to prevent others from rendering aid.

d. Most of the cases involving a statutory duty to provide medical care also involve a dependency relationship between the defendant and the deceased, such as that of parent and child, or husband and wife. For example, a case, involving a public official upon whom there was imposed the statutory obligation to render medical assistance to a destitute person when application was made for such, held that a homicide prosecution could be based on a breach of the duty to render such assistance where such breach resulted in the death of the person whom the law had intended to protect.[13]

e. It should be further noted that the same principles apply to person who stand in other relationships involving an affirmative legal duty, such as the keeper of a prison or asylum who undertakes, to the exclusion of others, to take care of inmates or a master who as the control and domination of servant or apprentice of tender years.[14]

3. The Existence of a Duty Under Principles of Civil Law:

a. Professional malpractice actions today are distinct from those of ordinary negligence. In a traditional negligence suit, the defendant is required to use the degree of care that a reasonably prudent person would use in the same or similar circumstances. The standard of care that professionals must conform to differs in several respects from the standard applied to laypersons. In the case of a physician, since he/she possess greater skill and knowledge than laypersons, the physician is held to a higher standard when dispensing medical care. Additionally, because matters involving professional skill and knowledge are not readily comprehensible to the layperson, a physician's conduct is in a large measure evaluated by professional standards.[15]Thus, with few exceptions, malpractice must be established by expert testimony.

13See Reg. v. Curtis (1985, Eng) 15 Cox CC 746, Cited in 100 ALR2d 488 §4 Duty to Provide Medical Attention

14 40 AM Jur 2d 384 §90 Homicide.

15 See Note 3 supra at 48.

b. In the first reported medical malpractice case (in Texas), the supreme court outlined the duty and responsibility of the physician as follows:

> It is a rule of law that a medical practitioner never insures the results, but simply engages that he possesses a reasonable degree of skill, such as is ordinarily possessed by a professional generally, and to exercise that skill with reasonable care and diligence; and, again, to exercise his best judgment, but is not responsible for a mistake of judgment. That is, after he has, with reasonable care and diligence, exercised ordinary skill, he is not responsible for a mistake of judgment, or for the result if he should happen to be mistaken. Such are the rules applicable to the ordinary, implied undertaking of a physician. [16]

c. This general principle has been followed in numerous Texas cases. In such cases, the Court has charged the jury concerning the standard of care as follows:

> "Did the physician undertake a mode or form of treatment which a reasonable and prudent member of the medical profession would not undertake under the same or similar circumstances?'

This charge is still recommended for use today. If the jury finds the physician has undertaken a mode or form of treatment that a reasonable and prudent member of the profession would undertake under the same or similar circumstances, the physician will not be subject to liability for harm caused to the patient.[17]

d. A similar requirement is imposed on members of allied health professions. In a civil case involving an allied provider's alleged negligence, the appropriate question to be submitted to the jury is:

> "Did the [nurse, dietician, etc.] engage in conduct which a reasonable and prudent member of the [nursing, dietary, etc.]

16 Id at 49.

17 Id at 50.

profession would not have engaged in under the same or similar circumstances?

e. The proper standard of care is the threshold question in a civil malpractice case involving allegations of substandard care or treatment. The law implies that a provider warrants that (1) he or she possesses a reasonable degree of skill; and (2) he or she will exercise such skill with reasonable care, diligence, and judgment. Once the standard is established, the factfinder determines whether the professional's act or omission deviated from that standard to a degree that constitutes malpractice[18].

4. SOURCES OF DUTY AND STANDARDS COMMONLY APPLICABLE[19]

a. Federal and State Facility Regulations and Conditions of Participation

- Department of Health, Health and Human Services Conditions of Participation Texas Department of Health Licensure Standards

- Texas Department of Human Resources Condition of Participation

b. National Organizations

- Joint Commission of Accredition of Hospitals, Accreditation Manual for Long Term Care Facilities

c. Professional Rules and Regulations Promulgated by Board of Examiners

- Regulations and Licensure Requirements of State of Texas Applicable to Physicians, Nurses and Other Health Care Professionals.

d. Facility Rules and Policies

- Nursing Service Policies and Procedures

18 Id at 50.

19 See Appendix B for discussion of specific duties. See Appendix C for discussion of admissibility of rules, regulations and standards.

- Job Descriptions

- Dietary Policies and Procedures

- Infection Control Policies and Procedures

- Staff Education and Training Programs

- Quality Assurance Programs

- Documentation Policies and Procedures

- Manuals and Handbooks Used by the Facility

e. Authoritative References and Manuals Utilized by Facility

f. Authoritative References Recognized as Such by Scientific Community

g. Other Derivative Sources:

- Periodicals subscribed to or recognized as authoritative literature by the scientific community.

- Applicable textbooks used by Defendant as a student.

h. Expert testimony of minimum standard of professional conduct under circumstances in question.

5. Specific Questions Relating to the Legal Accountability of the Health Care Provider:

- When does a nurse/patient relationship arise?

The nurse/patient relationship is based upon a nurse's employment as a nurse and her position, to the patient who appears seeking medical assistance. By virtue of her position, a hospital nurse is expected to take care of persons coming to the hospital for treatment. Therefore, the relationship arises when the person presents himself to the nurse seeking medical assistance.

- If a nurse asks a patient who has come to the emergency room for treatment questions about his medical condition, has a nurse/patient relationship arisen?

  When the nurse begins the examination of a patient in the emergency room, either by gathering information or by gathering facts from the patient, a nurse/patient relationship has arisen.

  Note: Childs v. Greenville Hospital Authority, 479 SW2d 399 (Tex. Civ. App. -- Texarkana 1972, writ ref'd n.r.e.)

- If a nurse fails to report that a patient is receiving negligent care from a physician, can the nurse be held liable if the patient is subsequently injured?

  Nurses have a duty to recognize and report substandard medical treatment. If a nurse recognizes that a patient is receiving substandard or improper medical care, the nurse has a responsibility to alert the attending physician and, if necessary, to advise appropriate administrative personnel so that corrective action may be taken.

  Note: Katz, Reporting and Review of Patient Care: The Nurse's Responsibility, 11 Law, Medicine, and Health Care 76 (1983).

- Will a nurse be able to avoid liability by following a physician's directive when the directive results in injury to the patient?

  No. Merely following such a directive will not exonerate a nurse or other health care professional. If the individual has reason to question the physician's order, the hospital's procedure for such a question should be followed in verifying the treatment or methods to be employed[20].

C. Breach of Duty: [See Appendix A for actual cases.]

20 Acknowledgement is extended to Richards, Maxwell, Neibel, Texas Health Law Manual, 1984 Butterworth Legal Publishers for answers to the above questions.

D. The Principal of Legal Causation: He Who Sets in Motion a Chain Reaction or Fails to Stop Such a Reaction (When Under a Duty to Do So) is Answerable for the Consequential Harm

- What test is utilized to determine if a causal relationship exists between the conduct of a potential defendant and a specific result?

Two tests are commonly utilized in conjunction with one another: 1) the "but for test" -- but for the conduct the result (harm) would not have occurred; 2) the "foreseeability test" - did the actor at the time of his conduct realize or should he have realized the likelihood that the result would occur.

- How far will the courts extend liability for conduct which can in some way be associated with harm?

Causation as an essential element of liability has undergone in recent times and is still undergoing a marked extension. More specifically, this subject in civil law has been progressively liberalized in favor of claims for damages for personal injuries to which careless conduct of others can in some way be associated. This same trend is also liberalizing and extending liability in criminal cases. [See below examples.]

- What factors influence the extension of legal responsibility?

In determining how far the law will trace causation and afford a remedy, the facts as to the defendant's intern , his imputable knowledge, or his justifiable ignorance are often taken into account. The moral element is here the factor that has turned cases one way or the other. For an "intended" injury the law is astute to discover even very remote causation. For one which the defendant merely ought to have anticipated, it has often stopped at an earlier stage of the investigation of causal connection. And as to those where there was neither knowledge nor duty to foresee, it has usually limited accountability to direct and immediate results[21].

Additionally, a second factor is often employed by the Courts in establishing and justifying a causal link between a

21 Derosier v. New England Tel & Tel Co., 1925, 81 NH 451, 130 A. 145. See also, Seidel v. Greenberg, 1969, 108 NJSuper. 248, 260 A2d 863; Bauer, The Degree of Moral Fault as Affecting Defendant's Liability, 1933, 81 U.Pa.L.Rev. 586, 592-596; Note, 1962, 14 Stan.L.Rev. 362.

defendant's conduct and a plaintiff's injury. The courts frequently rationalize the extension of responsibility by focusing upon the question of whether the duty imposed by law or standard was designed to prevent injury to a class person to which the injured plaintiff belongs. If so, causation generally is established.

- How does the fact that the health status of the geriatric patient is often compromised to begin with effect the extension of legal responsibility?

  The Pre-Existing Condition Rule: If a man be sick of some disease which possibly, by course of nature, would end his life in half a year, and another gives him a wound or hurt which hastens his end by irritating and provoking the disease to operate more violently or speedily, this hastening of his death is homicide or murder, as the case may be. In such case the victim doth not die simply by the visitation of God, but as a result of the hurt that he received which hastened death, and an offender of such a nature shall not apportion his own wrong[22].

Examples:

- Nixon v. Mr. Property Management Company, Inc. et. al.-690 SW2d 546.

  Facts: Owner of vacant apartment complex owed a duty under Dallas City Ordinances to keep doors and entries of a vacant structure securely closed. Owner failed to comply within this duty. Victim, aged 10, was walking home when an unknown man abducted her and dragged her directly from sidewalk into an unsecured vacant apartment (belonging to owner) and raped her. Victim's mother brought action for damages against owner of vacant unsecured apartment.

  Held: Unexcused violation of statute or ordinance constitutes negligence as a matter of law if the statute or ordinance violated was designed to prevent injury to class of persons to which injured party belongs. Applying the "but for" test and the foreseeability test, the Court ruled that the rape was causitively linked to the owner's breach of duty. "But for" the owner's failure to secure the property, this chain of events would not have occurred, reasoned the court. Further, due to the fact that numerous crimes had occurred in the past at this vacant apartment complex, the

22 State v. Morea, 2 Ala. 275; People v. Moan, 65 Cal. 532, 4 Pac. 545; Commonwealth v. Fox, 7 Gray, 585; State v. Castello, 62 Iowa, 404,17 NW 605; People v. Ah Fat, 48 Cal. 61.

"foreseeability" test was satisfied. Therefore, liability can extend to the owner for failure to comply with standards established by law.

- Bartender and bar owner have been held liable for injuries/death caused by the drunk driving of a patron who was served liquor at the establishment after he (driver) was intoxicated. The courts have held: 1) that "but for" the bartenders conduct the result would not have occurred, and 2) such result was a foreseeable consequence.

- See also: People v. Montecino 152 P2d5 (1944) found in Appendix A.

E. Culpable Mental State/Responsibility:

1 . Blameworthiness vs. Error in Judgment Rule:

Once it has been established that a defendant's conduct has, in fact, been one of the causes of a plaintiff's injury, there remains the question of whether the defendant is culpable/legally responsible. The critical inquiry here focuses upon the thought processes of the defendant. In order to be liable, the defendant must be blameworthy. Health care providers are not responsible for a mistake in judgment as long as they exercise the care and skill of similarly situated providers. This is sometimes in law referred to as the "error in judgment rule." It became law in Graham v. Gautier 21 Tex. 111 (1858) when the court, after stating the general rule on exercise of judgment, added that “after [the physician] has, with reasonable care and diligence, exercised ordinary skill, he is not responsible for a mistake of judgment, or for the result if he should happen to be mistaken.

2. Application of the rule is illustrated in Henderson v. Mason 386 SW2d 879 (1964). After receiving an eye injury, the plaintiff-patient was taken to a hospital emergency room where he was examined by the defendant-physician, treated with antibiotics, and released. The following day a specialist discovered a minute piece of steel in the patient's eye. Surgery failed to save the eye, and the patient sued the emergency room physician, alleging negligence in diagnosis or treatment. The court directed a verdict for the defendant, stating that the law resumes that the physician has done his work properly, and he is not considered by the law to be a guarantor or insurer. The physician's obligation is to use his or her best judgment, and the plaintiff can recover only when it is shown that the diagnosis an

treatment was not an error in iudament, but was a matter of negligence that proximately caused the plaintiff's injuries.

Accordingly, it is a basic tenet of malpractice law that a plaintiff in a civil case or the State in a criminal or administrative case, must prove that the defendant's thought processes deviated from the norm.

3. Culpable Mental States: Below are listed four culpable mental states, along with there definition, which will support the imposition of liability in a geriatric maltreatment case:

   a. Intentional = Conscious Desire or Purpose.

   b. Knowledge = Reasonably Certain of the Result.

   c. Reckless = Conscious Disregard for a Known Risk.

   d. Negligence = Failure to Perceive and Avoid a Risk Which the Actor Should Have Been Aware.

5. Application: Generally speaking, the grade and type of criminal offense or civil tort committed depend upon two basic factors: 1) severity of the victim's harm; 2) the culpable mental state of the defendant. For example, under principles of criminal law, the crime is murder when the neglect is willfully, intentionally, or knowingly committed[23], as where a parent intentionally withholds that food, necessary to sustain an infant's life, or abandons an infant in a remote place, or refuses to provide necessary medical care[24].

   On the other hand, the crime is manslaughter when the neglect arises out of recklessness, i.e., the omission results from the defendants conscious disregard for a risk that death will occur, as where a parent, aware of a risk that his child will die unless medical intervention occurs, fails to seek medical assistance, and as a consequence the child die[25]. Continuing down the step ladder of culpable mental states, when the omission, which produces death, arises out of criminal negligence the crime committed is criminal negligent homicide. And if the result of the neglect is not

23 See the following cases for digest keys: Ex Parte Moss 598 SW2d 877 (Tex. Cr. App. 1980); People v. Montecino 152 P2d5 (1944); Lang v. State 586 SW2d 532 (Tex. Cr. App. 1979).

24 61 ALR3d 1207 §2(a) Homicide by Withholding Necessities; and 100 ALR2d 488.

25 State v. Bischert 308 P2d 969 (1957).

death, but rather injury, the crime committed is an assaultive offense as where a parent intentionally, knowingly, reckless omits necessary care that causes disfigurement or serious bodily injury[26].

F. Liability for Conduct of Another: Can the Failure of One Individual to Carry Out His Duties Extend Liability to Others?

1. Introduction: In the health care setting, there are numerous relationships among the various kinds of providers and no one single description of liability is possible. For example, a nurse has committed a negligent act. The nurse assume alone can be held liable (as a minimum). The hospital may also be liable if the nurse was following hospital policies or was working in the course of a nurse's normal duties. (This legal relationships that permits liability to extend to the nurse's employer as well as the nurse is call respondeat superior.) If the nurse was following a physician's orders that were not in accordance with or not addressed by hospital policies, then the physician might also be liable. If the situation were such that there should have been a hospital policy in effect, then the hospital as well as its governing board of trustees might also be liable. (This kind of liability of the governing board is often referred to as corporate liability.)

2. Example: A determination of what groups of individuals might be liable under any given situation will usually depend upon the particular duty that was breached. What might appear to be a "simple" malpractice claim (to be defined below) involving the negligent act of a single provider may ultimately result in liability to a number of individuals or groups. If the negligent act was one of many committed by that same individual, then the hospital should have been aware of the individual's incompetence and could be liable for failing to remove the employee or restrict his duties.

Under that scenario, the individual breached a duty to exercise reasonable care in carrying out specific tasks, and the hospital (or employer) breached its duty to supervise, re-educate or remove the individual in question[27].

26 Ahern v. State 586 SW2d 327 (Tex. Cr. App. 1979).

27 Richards, Maxwell, Neibel, Texas Health Law Manual, 1984 Butterworth Legal Publishers, p. 95-96.

3. Specific Questions: Liability for Another's Misconduct.

- May a physician be liable for the negligent acts or omissions of persons employed by someone else?

  A physician will only be liable for the actions of those who are the employees of another if the "borrowed servant" doctrine applies. The borrowed servant doctrine applies when a general employer, such as a hospital, allows an employee to perform acts at the direction of and under the control of another person, such as the physician. For example, when a nurse performs a sponge count pursuant to hospital rules, the physician is not actually directing or controlling the nurse's actions. In this situation, the nurse is not a "borrowed servant." If the nurse were directed by the physician to manipulate the patient in a specific way, then the nurse would be considered a borrowed servant, and the physician would be responsible for any injuries that the patient suffered as a result of the manipulation.

  The essential inquiry is whether it was the physician or the hospital who had the right to control the negligent employee in the details of the specific acts that led to the patient's injuries. In a lawsuit, the jury will usually decide who had the right to control the employee's actions based upon the particular facts and circumstances present at the time the negligent act or omission occurred.

- Under what circumstances may a physician be responsible for a hospital nurse's actions?

  The borrowed servant doctrine applies to the relationship between the physician and the hospital nurse. Although the nurse is an employee of the hospital, the physician may be responsible for the nurse's actions if she is performing an act at the direction of the physician. The physician must have had the right to control the actions of the nurse when the negligence occurred for the physician to be held liable.

- Will a physician be liable if he requests that nurse perform a procedure in a way that is not in accord with established hospital procedure?

  A physician who specifically countermands an established hospital procedure will probably be held to have assumed control over the nurse's performance of the procedure and will, therefore, be liable for the nurse's actions if some injury occurs.

- May a hospital be liable for the negligent acts or omissions of its employees?

  It is well established that the owner or proprietor of a hospital is liable in damages for injuries due to. the negligence of nurses or other nonphysician employees[28]. In almost every instance, nonphysicians in attendance at hospitals are hospital employees, and, therefore, the hospital is liable for their negligence under the theory of respondeat superior.

  In the past, questions arose as to whether nurses should be considered as hospital employees or independent contractors. This distinction was important because if nurses were considered independent contractors, the hospital would not be held vicariously liable. While some authority holds that nurses are independent contractors[29], the significance of this distinction has lost ground with respect to nursing and technical personnel working in a hospital setting[30].

  Some courts distinguish between medical and administrative functions when considering liability for nurses' acts. When the latter are concerned, courts consider the nurse to be a servant of the hospital and the hospital is held responsible for the nurse's negligence. When medical acts are concerned, however, the nurse is the surgeon's borrowed servant and the hospital is not liable for the nurse's acts[3l].

  New York abandoned the distinction between administrative and medical acts in 1957, relying instead on the determination of whether a nurse was acting within the course of his or her employment.[32] New Jersey held that the nurse may be the employee of both the physician and

28 See Arlington Heights Sanitarium v. Dederick, 272 SW 497, 499 (Tex. Civ. App. -- San Antonio 1925, no writ) (hospital which allowed mental patient to escape breached duty to use ordinary care in watching the patient); Tex. Rev. Civ. Stat. Ann. art 6252-19 §18(2) (Vernon 1970).

29 See Scholendorff v. Socity of N. Y. Hosp., 211 NY 125, 132-33, 105 NE 92 94-95 (1914) (hospital not liable for negligent acts of independent contractors including nurses). Refer to § 4.02(c)(1) infra.

30 Johnson v. Hermann Hosp., 659, SW2d 124,125 (Tex. Civ. App. -- Houston [14th Dist.] 1983, writ ref'd n.r.e.); McGuire v. Overton Memorial Hosp., 514 SW2d 79 (Tex. Civ. App. -- Tyler 1974), writ ref'd n.r.e. per curiam.

31 See, e.g., Ramone v. Mani, 535 SW2d 654, 656 (Tex. Civ. App. -- Eastland 1975), aff'd, 550 SW2d 270 (Tex. 1977).

32 Bing v. Thunig, 2 NY2d 656, 666-67, 143 NE2d 3, 8, 163 NYS2d 3, 11 (1957).

the hospital, thereby creating joint liability[33]. The court relied on the agency theory that a servant may serve two masters simultaneously, even if only momentarily[34]. The realities of modern medical practice recommend the latter approach.[35]

- May a hospital be liable for the negligent acts or omissions of non-employee physicians?
  Yes. The courts may hold a hospital liable when one of its staff physicians causes injuries to a patient, and the hospital knew or should have known of the physician's incompetence. See Purcell v. Zimbelman 18 Ariz. App. 75, 81, 50OP2d 335, 341 (1972) where the court held that consistently poor results were evidence of incompetence.

  In Penn Tanker Co. v. United States[36] the plaintiff initially injured his eyes in a welding accident. The hospital admitted the welder, but as a result of improper diagnosis, preoperative preparation for surgery, and postsurgical care by a staff physician, the patient lost sight in one eye.[37] He subsequently committed suicide. His estate initiated a suit alleging, in part, that the hospital was negligent in selecting and retaining the operating surgeon who, at the time of the operation, was undergoing treatment for alcoholism. The court held the hospital liable for negligence in permitting the physician to diagnose, attend, and treat the patient's condition[38]. Evidence that the hospital breached JCAH hospital accreditation standards was a crucial factor in this determination[39].

  Corleto v. Shore Memorial HospitaI[40] adds another dimension to the principles underlying Penn Tanker. In Corleto, a girl died following surgery, and her parents sued

33 Martin v. Perth Amboy Gen. Hosp., 104 NY Super. 335, 348-50, 250 A2d 40, 48 (Ct. App. Div. 1969).

34 Id.

35 Perdue, The Law of Medical Malpractice 22 Houston Law Rev. 161-164.

36 310 F Supp. 613 (S.D. Tex. 1970).

37 Id. at 617.

38 Id.

39 Id. at 618.

40 138 NJ Super. 302, 350 A2d 534 (1975).

the hospital and its entire medical staff of 141 physicians, alleging that the physicians knew or should have known that the operating physician was incompetent to perform the surgery. The plaintiff also contended that the hospital and staff negligently allowed the physician to remain on the case when "it was obvious that the situation had gone completely beyond his control."[41] The court recognized the general rule that one who engages an independent contractor is not liable for the contractor's acts. The court created an exception to this rule, however, and held the hospital liable. The court stated: "A person [who] engages an incompetent contractor... may be held liable for the ultimate damage caused by such contractor."[42]

Finally, a hospital may be held directly liable for negligence in failing to discharge its duty to supervise, by investigation and review, the general competence of all physicians who use its facilities[43]. This duty creates another exception to the general rule that hospital cannot be held liable for the negligence of physicians considered independent contractors. A hospital can be liable if a physician to whom it grants staff privileges injures a patient and the hospital fails to exercise reasonable care in supervising and reviewing the physician's competence[44] [45] [46].

- May a hospital be held liable for negligence with respect to policy and rules?

  The final area in which liability may be found under the hospital's general duty to provide care and protection for its patients involves the rules and policies that affect the hospital's operations. This area of liability rests upon a hospital's duty to adopt, formulate, and enforce appropriate medical rules or policies. The medical rules, regulations, bylaws, and policies involved include both those adopted in the hospital where the injury took place and those adopted

41 Id at 305, 350 A2d at 535-36.

42 Id at 305, 350 A2d at 537 (emphasis added).

43 See generally Annot., 12 AIR 4th 57 (1982).

44 Perdue, The Law of Medical Malpractice 22 Houston Law Rev. 193-195.

45 Darling v. Charleston Community Memorial Hosp., 33 111 2d 326, 211 NE 2d 253 (1965) cert. denied, 383 US 946 (1966).

46 Acknowledgement is again extended to Richards, Maxwell, Neibel, Texas Health Law Manual, 1984 Butterworth Legal Publishers for answers to the above questions.

by hospitals in the same or a similar community. A hospital may be liable for negligently failing to adopt medical rules or policies necessary for the protection of its patients. Further, a hospital is negligent when it breaches an affirmative duty to adopt appropriate medical rules and policies. Iniury caused by a hospital's negligent failure to enforce its own guidelines also provides theory for recovery.

IV. Part Three: The Failure to Report Elder Abuse/Neglect as the Basis for Liability

A. The Circumstances Giving Rise to the Failure to Report Statutes:

1. The average nursing home patient is female and about eighty-two years of age. The patient generally has four chronic or crippling diseases, and requires help to bathe, dress, and walk, if able to walk at all. Most estimates show that at least fifty-five percent of all long-term care patients are mentally impaired, but at least one study places the figure at eighty percent.

2. These characteristics make many nursing home patients at least as helpless to defend themselves against abuse as the children, which every state has sought to protect through child abuse legislation. Elderly patients, like children, do not have the physical strength to defend themselves against abuse. Because many nursing home patients are mentally impaired, their own reports of abusive treatment might be discounted.

3. An additional problem for nursing home patients, which necessitates protective legislation, is their isolation from the outside world. Almost half of all nursing home patients have no viable relationship with a close relative, and another thirty percent have only collateral relatives near their own age.

4. There is substantial evidence that physicians rarely visit their patients and that when a visit is made, the physician may not perform an adequate examination.

B. The objective of failure to report statutes: A law designed to prevent injury to a class of persons and further the detection of conduct which harms any member of this class.

C. The legal impact of this statute upon the health care professional:

1. A surface examination of a toothless legal mechanism: The lack of penalty for failure to report.

2. CAVEAT: There is more to the failure to report statute than meets the eye: An examination of the severe bite that lurks beneath the surface.

D. Explanation of complaints founded upon a violated duty to report and sample pleading. [For illustration, see Appendix B.)

V. Part Four: The Clinical Record as a Source of Proof in a Neglect/Abuse Case:

A. The Purpose and Import of the Clinical Record:

Clinical records serve a variety of purposes. Their principal purpose is to memorialize by documentation the patient's symptoms and history, examinations and test conducted, findings, diagnosis, treatment and progress. This would, of course, be true whether the patient receives such medical attention while hospitalized or as an outpatient of a hospital or during office visits or a resident of a long term care institution. Medical records serve as a means of transmitting information between health care providers. This is a course absolutely essential to medical personnel who have the responsibility of evaluating a patient's condition and planning medical care. Medical resources are also important because they serve to provide information for researchers and those involved in continuing medical education programs[47].

B. The Clinical Record as a Source of Proof:

A medical record is tangible evidence of the services rendered by a facility, the staff, and physicians. It is a means of communication between the physician, the nurses and other professional groups who contribute to the care of patients. Generally, a good medical chart means that the patient received adequate medical care, while an inadequate chart often reflects poor medical care. The Joint Commission on Accreditation of Hospitals, in both the United States and Canada, selected the medical record as one criterion for measuring the quality of medical attention rendered by a hospital and its staff. Thus, the medical chart is the nucleus of any professional medical negligence case; it must be reviewed not only for what it contains, but often more importantly, for what it does not contain[48].

47 Perdue, The Law of Medical Malpractice 22 Houston Law Rev. 1-280.

48 Lane, Medical Litigation Guide, Chapter 3, Medical Records.

Potentially, this source of evidence can be the lawyer's most damaging proof in a case. As a means of proof, documentary evidence has some distinct advantages over the live testimony witness who actually observed the events made the basis of the lawsuit, in that recordings which reveal care deficiencies and which are made in the normal course of business by an employee (or someone permitted to practice in said facility) who has personal knowledge of the event documented and who records such event at or near the time of its occurrence, are extremely difficult to attack. Defendants can hardly risk taking the position that documentation created by their own employees was falsified within incurring the wrath of a jury who, if typical of the general public, believes in the sanctity of the health care profession and expects truthful verbal and written communication from these individual in "white," especially when such communications affect human life. Consequently, the only two avenues of attack to defense are: 1) question the inherent value of the document itself from an industry standpoint, i.e., "this piece of evidence is just a bureaucratic form which we are forced to fill out by the government and adds nothing to the care of the patient;" 2) question the significant of the event recorded, i.e., "the fact that patient Jones developed an eight centimeter decubitus ten days after admission in no way was a reflection of the care received and absolutely had no bearing upon her ultimate demise. This condition was inevitable." From a practical standpoint, these two attacks cannot be accomplished without the involvement of an expert witness which leads to the second reason that documentary evidence can be as valuable, if not more valuable, than the testimony of an eye witness. In order that the jury may fully understand the facts, the expert witness assumes the role of a "story teller" in the eyes of the jury. Armed only with the clinical record, this educated and hopefully articulate individual effectively becomes a formidable "fact" witness who, because of his background and speaking ability, is more capable of jousting with a defense attorney than the often less educated and less articulate eye witness. Of course, in final analysis, the strongest case of nursing home neglect will be supported by proof from both sources, as one corroborates the other.

C. Evaluating the Chart: The Emphasis Placed on Consistency:

The chart record should be straightforward. It should flow uninterruptedly from start to finish and should present an integrated sequence of information that is internally consistent. Indeed, consistency is the most important characteristic of any medical record. Furthermore, it is inconsistency that should stimulate further scrutiny of the record. Inconsistency may be of many kinds. Medical inconsistency may be found if the diagnosis

postulated; or if the diagnosis does not support the choices of therapy in the case, or if the results obtained by therapy are not to be expected and are not explained by the therapy given.

The chart may also be inconsistent in the time sequence represented either by the diagnostic data or the therapy -- that is, the therapy may have been given before the data justifying that therapy was available[49].

D. A Few Examples of Record Analysis Utilized to Support the Imposition of Liability:

1 . Proof of falsified medication records:
Cross References:
- Discharge and admit date
- Date of Orders
- Drug Destruction Records and Rx Records
- Pharmaceutical Consultant Reports
- Nursing Home Inspection Field Notes
- “Meds Unavailable"
- Back of Administration Records

2. Proof of Falsified Treatment Records
Cross References:
- Supply Availability
- Equipment Availability
- Service Load

3. Proof of Nursing Process Failures
- Assessment: Utilizing the computer to track habitual charting of a "sleeping 11-7 nurse" and comparing the rate at which she detects the occurrences of condition change or complications in the patient population to the statistics from other shifts
- Failure to originate, update or revise nursing care plan
- Failure to follow nursing care plan
- Failure to notify the physician
- Failure to Follow Up a Problem

Patterns in Decubitus Occurrence
- Identification of patients having similar needs
- Inducement rates and progression
- Infection rates

5. Proof of Lack of Physician Visitation

49 See note 26, supra.

APPENDIX A

BREACH OF DUTY CASES