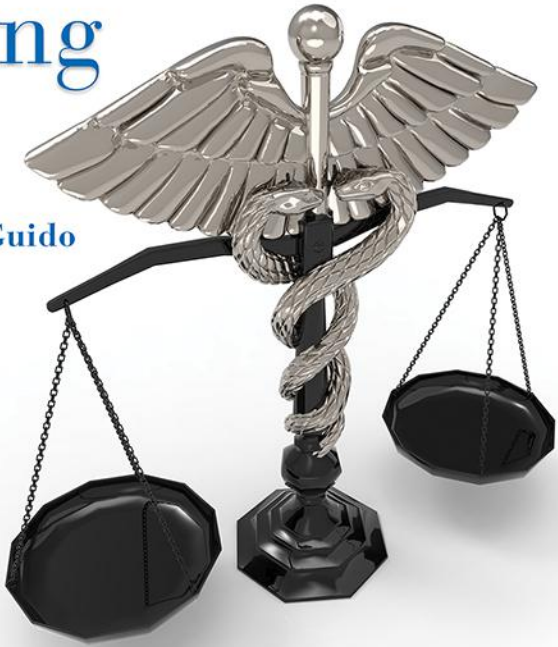
Legal & Ethical Issues in Nursing

Seventh Edition

Ginny Wacker Guido



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Seventh Edition

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About the Author

Ginny Wacker Guido has been active in legal and ethical issues in nursing for all of her professional life. She developed an interest in these areas of nursing while she was teaching undergraduate nursing students in southern Texas, and her excitement for further knowledge and understanding of these content areas encouraged her to pursue a doctorate of jurisprudence degree and attend multiple ethical conferences. Over her career, she continued to attend national and regional workshops and conferences, updating and expanding her knowledge base regarding both the legal and ethical aspects of professional nursing practice. Dr. Guido has authored numerous publications and presented conferences and lectures on legal and ethical issues in nursing, with special emphasis on a variety of clinical practice settings. In addition to publishing seven editions of *Legal and Ethical Issues in Nursing*, she also edited a text on nursing care at the end of life. She remained active in nursing education until her retirement from Washington State University Vancouver in May 2014. Since her retirement, Dr. Guido continues to review legal and ethical articles for the *Journal of Nurse Practitioner*, reads extensively on current legal and ethical issues affecting the professional practice of nursing, and has authored this latest text.

This book is lovingly dedicated to my family:

Ed, Jenny, Joseph, Alexa, and Archer Guido
and
Cecelia G. Wacker

Thank You

Our heartfelt thanks go out to our colleagues from schools of nursing across the country who have given their time generously to help create this exciting new text. These individuals helped us plan and shape our text and resources. *Legal and Ethical Issues in Nursing* has reaped the benefit of your collective knowledge and experience as nurses and teachers, and we have improved the materials due to your efforts, suggestions, objections, endorsements, and inspiration. Among those who gave their time generously to help us are the following:

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Preface

New to this Edition

- Two- or three-part ongoing case studies that assist the reader in applying the chapter content, beginning with Chapter 5
- Expanded ethical scenarios that assist the reader in better incorporating legal and ethical content
- Addition of organizational ethics in Chapter 3
- Expanded decision-making guidelines in Chapter 17
- The electronic edition of the text rather than the more traditional paper edition

As with previous editions of the text, the seventh edition of *Legal and Ethical Issues in Nursing* reflects the continued influence that law and ethics have on the professional practice of the discipline of nursing. This influence may be seen in the expanding autonomous roles of nurses in a variety of clinical settings, changes in the health care delivery structure and client base, increased accountability and responsibility at all levels of nursing, and the development of newer educational programs for nurses, including the mandate for doctoral degrees for advanced practice nurses.

This edition, like its predecessors, is written for the practicing nurse as well as for individuals studying in formal programs of nursing. The text addresses legal and ethical concepts and their application and is appropriate for any clinical practice site. It is envisioned as both a learning tool and a resource for professionals. As in previous editions, the reader is cautioned that this text is not intended to take the place of procuring advice and counsel from practicing attorneys and agency legal services. Rather it is meant to augment the role of attorneys and legal counsel in assisting nurses to better understand the legal process and the interplay of ethics within this legal context. It is hoped that this improved understanding of legal and ethical issues will assist nurses in their clinical judgments and interactions with patients, family members, and their peers.

With each edition, familiar and popular features of previous editions have been retained and new features or content added. Popular features that have been retained include the multiple legal exercises and ethical scenarios that assist the reader in understanding and applying content areas. Key terms, objectives for the chapter, guidelines, chapter previews and summaries, and the "You Be the Judge/Ethicist" features have been retained. The new features include the incorporation of an ongoing case study in the majority of chapters, intended to assist the reader both in applying the content of the chapter and also in understanding how the content could impact the reader in a continuous manner.

As in previous editions, the text is divided into five separate parts. Part 1 addresses the law, the legal system, and the judicial process; the role of the nurse in legal matters; and the importance of case law in developing standards of nursing care. Part 2 outlines ethical theories and principles, the role of ethics committees and organizational ethics, and addresses the application of ethics in nursing settings, including moral distress, moral resilience, the role of advocacy within nursing, and the application of therapeutic jurisprudence. Part 3 presents liability issues that can and do affect nurses in all clinical arenas, concluding with a chapter on professional liability insurance. Part 4 contains multiple chapters presenting how the law impacts professional nursing practice, beginning with nurse practice acts and the scope of nursing practice. Subsequent chapters in this part address the issues of advanced practice nursing roles, employment and federal laws that affect nursing practice, the role of the nurse manager, and laws as they pertain to delegation and supervision. Part 5 applies the impact of the law to specific clinical areas, including acute care, ambulatory and managed health care settings, public and community health, and long-term and home health care settings.

I am always amazed at how much I have learned in the process of revising this text. It is my continued hope that you too will continue to learn and apply this knowledge as you care for the patients that you encounter.

Ginny Wacker Guido, JD, MSN, RN, FAAN

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PART I Introduction to the Law and the Judicial Process

CHAPTER 1

Legal Concepts and the Judicial Process

Learning Objectives

After completing this chapter, you should be able to:

1.1 Use the term *law* and contrast the four sources from which law is derived, including constitutional, statutory, administrative, and judicial (decisional) law.

1.2 Investigate and contrast selected legal concepts, precedents, and processes.

1.3 Analyze classifications of laws and means by which they can be altered or changed.

1.4 Distinguish between substantive and procedural law, and defend why each is important to professional nursing practice.

1.5 Compare and contrast the roles of trial courts, appellate courts, and supreme courts at both the state and federal levels.

1.6 Evaluate statutes of limitations, their significance, and their purpose at law.

Preview

The disciplines of law and professional nursing have been officially integrated since the first mandatory nurse practice act was passed by the New York state legislature in 1938. The nursing profession has continuously relied on statutory law for its right to exist on a licensure basis and on court decisions for interpretation of these statutes. The civil rights movement of the 1960s and the malpractice crisis of the 1970s led to a heightened legal-mindedness in the 1980s and 1990s, which is still very present in practice settings today. Professional practitioners must know, understand, and apply legal decisions and doctrines in their everyday nursing practice. Part of this understanding comes from an appreciation of the origin of laws and the judicial system. This chapter presents an overview of the legal system, sources and types of laws, and the role of the American court system.

Key Terms

administrative laws
attorney general's opinion
civil law
common law
constitutional law
criminal law
discovery rule
due process of law
equal protection of the law
fact-finder
felonies
judicial (decisional) laws

jurisdiction
landmark decision
law
misdemeanors
personal jurisdiction
procedural law
public law
questions of fact
questions of law
rational basis test
res judicata
specific performance
stare decisis (precedent)
state appellate court (courts of intermediate appeals)
state supreme court
statutes of limitations
statutory laws
subject matter jurisdiction
substantive law
territorial jurisdiction
tort law
trial court
U. S. district and territorial court
U. S. Supreme Court
writ of certiorari

Definition of Law

Law has been defined in a variety of ways, using simple to complex terms. The word *law* is derived from the Anglo-Saxon term *lagu*, meaning that which is fixed or laid down. Law may be defined as "a binding custom or practice of a community; a rule of conduct or action prescribed or formally recognized as binding or enforced by a controlling authority" (Merriam-Webster Dictionary, 2018, usage 1). *Black's Law Dictionary* defines law as "a set of rules or principles" (Garner, 2014, p. 946), and subdivides law into constitutional, judicial, and legislative laws. Law, though, may be more completely defined as the sum total of rules and regulations by which a society is governed. Law includes the rules and regulations established and enforced by custom within a given community, state, nation, or international community. As such, law is created by people and exists to regulate all persons.

The actual definition of law is not as important as the impact of law on society. Law is made by individuals, whether as legislative bodies or by justices of the court. Law reflects ever-changing needs and expectations of a given society and is therefore dynamic and fluid. Law is not an exact science, but rather an ongoing and organized system of change in response to current conditions and public expectations.

Sources of Law

Understanding the various sources of law assists in determining their impact on the nursing profession. Each of the three branches of the government has the authority and right to create laws, and these laws form the basis of the judicial system. Table 1–1 gives an overview of the various sources of law with examples.

Constitutional Law

Constitutional law is a system of fundamental laws or principles for the governance of a nation, society, corporation, or other aggregate of individuals. The purpose of a constitution is to establish the basis of a governing system. The Constitution of the United States establishes the general organization of the federal government, grants specific power to the federal government, and places limitations on the federal government's powers.

The U.S. Constitution established, through the first three articles, the three branches of the federal government and enumerates their powers. Article I established the House of Representatives and the Senate, which together comprise the Congress of the United States. Congress has the power to regulate commerce with foreign nations and among selected states and to enact broad and powerful legislation throughout the nation. Article II established the presidency and the executive branch of government. While the powers of the president are not as clearly enumerated as those of Congress, the president has "executive" power, is the "commander in chief," and has power to grant pardons (except in cases of impeachment) for offenses against the United States. Article III established the role and duties of the Supreme Court and the judicial branch.

The general organization of the U.S. Constitution is, in reality, a grant of power from the states to the federal government, and the federal government has only the power granted it by the Constitution (Article X). The federal government can collect taxes, declare war, and enact laws that are "necessary and proper" for exercising its powers. Federal constitutional law is the supreme law of the land, as federal law takes precedence over state and local law. Ideally, state and federal powers should be devised and exercised so as not to interfere with each other, but if there

Table 1–1 Sources of Law with Examples

Constitutional Law	Statutory Law		Administrative Law	Judicial Law
	Civil Law	*Criminal Law*		*Courts of law*
Bill of Rights Amendments to the Constitution	Tort law Contract law Patent law Oil and gas law	Penal codes	Boards of nursing Regulatory boards City ordinances	Trial level Appellate level Supreme Court level

is a conflict, federal laws prevail over state laws, and state laws prevail over local laws.

The U.S. Constitution also places limitations on the federal government. Such limitations have been enacted through the Bill of Rights (the first 10 amendments of the Constitution), which protects a variety of rights such as one's right to freedom of speech, trial by jury, free exercise of religious preference, and freedom from unreasonable search and seizure (*United States Constitution*, Amendments 1–10, 1787).

Constitutional law is the highest form of statutory law (defined in the next section). Statutory laws govern and meet existing conditions; constitutional laws govern for the future as well as the present in that the stability of constitutional law protects from frequent and violent fluctuations in public opinion (16 *American Jurisprudence*, 1995).

Each state has its own constitution, establishing the organization of the state government, giving the state certain powers, and placing limits on the state's power. An important difference between federal and state constitutional law is that the federal government derives positive grants of power from the U.S. Constitution, while states enjoy plenary or absolute powers subject only to limitations by their individual state constitution, the U.S. Constitution, and any limitations necessary for the successful operation of the federal system.

Statutory Laws

Statutory laws are those made by the legislative branch of government. Statutory laws are designed to declare, command, or prohibit. Generally referred to as *statutes*, these laws are created by the U.S. Congress, state legislative bodies, city councils, or other elected bodies. Statutes are officially enacted (voted on and passed) by legislative bodies and are compiled into codes, collections of statutes, or city ordinances. Examples include the *United States Code* and *Black's Statutes*.

The federal and state governments have broad powers to legislate for the general welfare of the public. The U.S. Constitution grants the federal government's power, while the states have inherent power to act except where the Constitution restricts the power to the federal government. The states' power to legislate and govern is often referred to as *police power.* This term is generally seen as allowing the states to make laws necessary to maintain public order, health, safety, and welfare.

An example of statutory laws is nursing licensure laws, which regulate health care providers within individual states. These nursing licensure laws are designed to protect the general public from incompetent health care providers. Known generally as *nurse practice acts* or *nursing practice acts* depending on the individual state, these statutory laws give authority to qualified and licensed practitioners to practice nursing within a given state, the District of Columbia, and/or U.S. territories. Other statutory laws that affect the practice of professional nursing include statutes of limitations, protective and reporting laws, natural death acts, and informed consent laws. Nurse practice acts are described more fully in Chapter 12.

Administrative Laws

Administrative laws are enacted by means of decisions and rules of administrative agencies, which are specific governing bodies charged with implementing particular legislation. When statutes are enacted, administrative agencies are given the authority to carry out the specific intentions of the statutes by creating rules and regulations that enforce the statutory laws. For example, legislative bodies pass the individual nurse practice acts (statutory laws) and create state boards of nursing or state boards of nurse examiners (state administrative agencies). These state boards implement and enforce the state nurse practice act by writing rules and regulations for the enforcement of the statutory law and by conducting investigations and hearings to ensure the law's continual enforcement.

Such authority is given to administrative agencies by the state legislature, since the elected legislative body has neither the resources nor the needed expertise to ensure that statutory laws are properly enforced. Administrative agencies are normally composed of persons with specific qualifications and experience and are given the single charge to implement and regulate the enforcement of a given statutory law. State boards of nursing are usually composed of predominantly registered nurse members, who are actively employed in educational or practice settings within nursing. Their charge is the enforcement of the state nurse practice act.

EXERCISE 1–1

Read the table of contents of your state nurse practice act. Can you distinguish the state administrative body (board of nursing) that is created by the legislature? Which sections of your nurse practice act create the administrative body and which sections serve to distinguish legislative intent?

Administrative rules and regulations have validity only to the extent that they are within the scope of the authority granted by the legislative body. Legislative bodies have some limitations placed on them by state constitutional law. There must be specificity in the charge as given to the administrative agency, and the legislative body remains ultimately responsible for the rules and regulations the administrative body passes.

Some procedural acts may also govern administrative bodies. Such procedural acts delineate how the agency promulgates rules and regulations and provides for comments from the public before the rules and regulations are enforceable. The procedural acts may also provide for publication in a state register prior to the enforcement of the new rules and regulations.

The administrative agency has the initial authority to decide how its rules and regulations are enforced, and the decisions of the administrative agency may be appealed through the state court system. If appealed, courts have limited their review of the agency's actions to one of the following five areas:

1. Was the delegation of power to the specific administrative agency constitutional and proper?
2. Did the specific administrative agency follow proper procedures in enforcing the statutory law?
3. Is there a substantial basis for the decision?
4. Did the administrative agency act in a nondiscriminatory and nonarbitrary manner?
5. Was the issue under review included in the delegation to the agency?

Attorney General's Opinions

A second example of administrative law is the ***attorney general's opinion***. The national or state attorney general may be requested to give an opinion regarding a specific interpretation of a law. Individuals or agencies may request such an opinion, and the opinion is binding until a subsequent statute, regulation, or court order amends the attorney general's opinion.

The attorney general's opinions provide guidelines based on both statutory and common law principles. Sometimes statutes are written in such vague terms that nurses seek opinions concerning the interpretation of the statute. For example, a board of nursing may request a state attorney general's opinion regarding enforcement of the nurse practice act in agencies that fail to comply with the provision of the act. Such a request would seek guidance on how the board of nursing should proceed to ensure compliance with the nurse practice act.

Opinions can also be formal or informal. The greater the liability risks, the more likely it is that a formal opinion will be issued. If legal issues then arise and the nurse has a formal attorney general's opinion, the court is more apt to rule that the nurse acted in a reasonable and responsible manner in seeking clarification on the matter.

Judicial Laws

Judicial (or **decisional) laws** are made by the courts and interpret legal issues that are in dispute. Depending on the type of court involved, the judicial or decisional law may be made by a single justice, with or without the assistance of a jury, or by a panel of justices. As a rule, the initial trial courts have a single justice or magistrate, intermediary appeal courts have three justices, and the highest appeal courts have a panel of nine justices.

All courts serve to rule on issues in dispute. In deciding cases, the courts interpret statutes and regulations or may decide which of two conflicting statutes or regulations apply to a given fact situation. Courts may also decide if the statute or regulation violates a constitution (federal or state), because all statutes and regulations must be in harmony with the governing constitution. The landmark case of *Marbury v. Madison* (1803) established the power of the judiciary in interpreting constitutional law. For example, a nurse who questions the authority of the state board of nursing may file a court action if the nurse has cause to believe that there has been a legal or procedural error on the part of the board's action against him or her.

Two important legal doctrines, which are directly derived from the U.S. Constitution, guide courts in their decision-making role:

1. The doctrine of ***precedent* or *stare decisis*** literally means to "let the decision stand." This doctrine is applied by courts of law in cases with similar fact patterns that have been previously decided by the court system. The court looks at the facts of the current case before it reviews previous decisions that applied the same rules and principles with a similar fact situation and then arrives at a similar decision in the case currently before the court. This doctrine has great implications for nurses, because it gives nurses insight into ways in which the court has previously fixed liability in given fact situations. Nurses are cautioned to avoid two important pitfalls when deciding if the doctrine of precedent should apply to a given fact situation:
   a. The previous case must be within the jurisdiction of the court hearing the current case. For example, a previous New York case decided by an appellate court within the state of New York does not set precedent for a California state court, although the California court may model its decision after the New York case. It is not compelled to do so because two separate jurisdictions are involved. Within the same jurisdiction, the case would set precedent. A New York appellate decision would be relied on by the lower courts in New York State.
   b. The court hearing the current case may depart from precedent and set a **landmark decision**, which is a term that signifies that precedent is being changed by the current court decision. Such a landmark decision is usually reached for one of several reasons. Societal needs may have changed, or technology may have become more advanced. In addition, a court may find that to follow the previous decision would further harm an already injured person. A well-known example of a landmark decision was the U.S. Supreme Court holding in *Roe v. Wade* (1973). That court, for the first time in American history, recognized the right of a woman to seek and receive a legal abortion during the first two trimesters of pregnancy.
2. A second doctrine that courts employ in duplication of litigation and seemingly apparent contradiction in decisions is termed **res judicata**, which means literally "a thing or matter settled by judgment." Res judicata applies only when a legal dispute has been decided by a competent court of jurisdiction, and no further appeals are possible. This doctrine then prevents the

same parties in the original lawsuit from retrying the same issues that were involved in the first lawsuit. Res judicata prevents multiple litigation by parties who lost in the original suit by not allowing those parties to take the same issues to another trial court in the hope of persuading that court to find in their favor.

Res judicata does not apply to competent appeals to an appellate court, nor does it apply to parties who were not named in the original lawsuit. Res judicata likewise does not apply to issues that were not decided by the original trial court so that a second lawsuit could be filed by the same parties on different specific issues.

All laws, regardless of origin, are fluid and subject to change. Constitutional laws may be amended. Statutory laws may be amended, repealed, or expanded by future legislative action. Administrative bodies may be dissolved, expanded, or redefined. Judicial or decisional laws may be modified or completely altered by new court decisions.

Classifications (Types) of Law

Laws may be further classified into several different types. Many nurses may have wondered about classifications such as (1) common law, (2) civil law, (3) public law, (4) criminal law, (5) substantive law, and (6) procedural law.

Common Law

Law may be classified according to the court in which it was first instituted. The federal courts and forty-nine state courts follow the common law of England. **Common law** is defined as law derived from principles rather than rules and regulations. It is based on justice, reason, and common sense. During the colonial period, the English common law was uniformly applied in the 13 original colonies. After the American Revolution, individual states adopted various parts of the common law, and differences in interpretation and enforcement began that still exist to this day. Individual state statutory and judicial findings also account for the variation of common law principles from state to state.

Civil Law

Louisiana elected to adopt civil or Napoleonic laws, because the origins of that state were of a predominantly French influence. Derived from the civil laws of the French, Romans, and Spaniards, Napoleonic or **civil law** may be said to be based on rules and regulations.

Civil law may also be used to distinguish that area of the law concerned with the rights and duties of private persons and citizens. Civil law is administered between citizens (private persons) and is enforced through the courts as damages or money compensation. No fine or imprisonment is assessed in civil law, and injured parties usually collect money damages from individuals who have harmed them. For example, in *West Texas v. US Department of Health and Human Services* (2016), the court assessed a $350 per day civil monetary fine until a skilled nursing facility enacted policies and procedures that were in compliance with Medicare standards.

The court, however, may also decide that an action, known as **specific performance**, be performed rather than allow money damages, if the court deems that specific performance best aids the injured party. For example, in a contract dispute, the court may compel an employer to reinstate a previously discharged worker and to pay the worker compensation for the time he or she was without employment rather than merely paying the worker for the time spent without work.

Civil law may be further divided into a variety of legal specialties, including contract law, labor law, patent law, and tort law. Perhaps the most important area of law to the professional nurse, **tort law** involves compensation to those wrongfully injured by others' actions. This area of law is normally involved in malpractice claims that name specific health care providers. Tort law is covered in depth in Part III of this book.

Public Law

Public law is the branch of law concerned with the state in its political capacity. The relationship of a person to the state is at the crux of public law. Perhaps the best example of public law is the entire field of criminal law.

Criminal Law

Criminal law refers to conduct that is offensive or harmful to society as a whole. If an act is expressly forbidden or prohibited by statute or by common law principles, it is referred to as a *crime.* Most often, crimes are viewed as offenses against the state rather than against individuals, and the state, city, or administrative body brings the legal action against the offender. Examples of crimes include minor traffic violations, theft, arson, and unlawfully taking another's life. Punishment for the commission of crimes ranges from simple fines to imprisonment to execution.

Crimes can be classified as either misdemeanors or felonies. **Misdemeanors** are lesser criminal actions and are generally enforced through monetary fines rather than actual jail time. An example of a misdemeanor could be the theft of less than $500 dollars from a vulnerable adult. Fines that are imposed for misdemeanors are less than $1,000, and imprisonment, if it occurs, is for time periods of less than one year. **Felonies** are more serious criminal actions, most often involving fines of greater than $1,000, and punishment by prison terms of greater than one year. The theft of greater than $500 dollars from a vulnerable adult would be considered a felony in most states.

The same action by a given individual may be the basis for both a civil lawsuit and a criminal wrong. For example, if a nurse removes a ventilator-dependent patient

from a ventilator and the patient subsequently dies, the state board of nursing may revoke the nurse's license to practice nursing (a criminal action) and the family may file a wrongful death suit (a civil suit) against the nurse. In the criminal case, the court would consider the intent of the defendant as well as the actual action. In the civil case filed out of the same action, the court only considers the action performed and the standard of evidence is less stringent. Standards of evidence are more thoroughly discussed in the next chapter.

There are situations within nursing in which the nurse may be said to have violated criminal laws, and the number of criminal cases against nurses appears to be increasing. Examples include backdating of records (*Nevada State Board of Nursing v. Merkley*, 1997), narcotics/medication diversion (*Alterra Healthcare*, 2011; *Ferguson v. United States*, 2016; *Grall v. State*, 2011; *Lewis v. State Board of Nursing*, 2009; *State Board v. Abington*, 2016; *State v. Gradisher*, 2009; *Sygula v. Regency*, 2016), mistreatment of patients (*Loglisci v. Stamford Hospital*, 2011; *Mississippi Board of Nursing v. Hanson*, 1997; *State v. Simmons*, 2011), falsifying records (*Frazer v. Delaware Board,* 2016; *MacLean v. Board of Registration in Nursing*, 2011; *Matter of Kun*, 2016), substandard nursing care (*Davis v. State Board of Nursing*, 2013; *Leahy v. North Carolina Board of Nursing*, 1997; *Stevenson v. State*, 2015; *Zablonty v. State Board*, 2014), practicing without a license (*People v. Odom*, 1999), driving under the influence of alcohol (*Owens v. State Board,* 2015; *Sulla v. Board of Registered Nursing*, 2012), and the administration of drugs that cause or hasten a patient's death (*Jones v. State of Texas*, 1986).

A case example is *State v. Kirby* (2013) and the companion case *State v. Williams* (2013). These two nurses were indicted on criminal charges for failure to provide for a functionally impaired person (a felony) and failure to report child abuse (a misdemeanor) after the death of a 14-year-old individual with cerebral palsy and quadriplegia who was cognitively impaired. She lived with her parents. One of the nurses was the case manager responsible for reviewing the child's care on a semiannual base, and the other nurse was the supervisor for the home-care personnel who cared for the child on a daily basis. On autopsy, the child weighed 28 pounds and had bedsores all over her body, an impacted rectum, a dilated colon, and pneumonia in both lungs. The court held in their conviction for both charges that failure to provide for a functionally impaired individual and failure to report child abuse did not create double jeopardy, which is a risk incurred from two sources simultaneously. As the court further explained, these individuals had a duty to provide safe and adequate care for this individual about whom a reasonable person could suspect had suffered physical or mental injury or a condition that reasonably indicated abuse or neglect.

Sulla v. Board of Registered Nursing (2012) concerned the three-year probation restrictions placed on a nurse's license after he pled no contest to a misdemeanor drunk driving charge after losing control of his car on the way home from a party and colliding with the center divider. His blood alcohol level was 0.16. The nurse had an exemplary work record, character witnesses noted that he seldom drank, and the psychiatrist who evaluated him testified that he did not meet the criteria for alcohol abuse or dependency and that this was a single, isolated episode of poor judgment. Additionally, there was no evidence that consumption of alcohol in any way affected this nurse's ability to practice his profession. Thus, the nurse appealed the restrictions on his license.

The California Court of Appeals upheld the disciplinary actions as imposed by the Board of Nursing. Driving while intoxicated is a behavior that is dangerous to oneself and others. As such, the court found that it met the legal definition of unprofessional conduct for a nurse. To be grounds for discipline with respect to a professional license, it is not necessary to show that unprofessional conduct occurred during professional practice or had any effect on one's ability to practice. Additionally, it is not necessary to show that the unprofessional conduct is evidence of an ongoing state of impairment that could have an effect on one's practice.

A case that supports a nurse's actions is *Shipman v. Hamilton* (2008), which began as a criminal suit against a nurse for obstruction of a police officer. Two officers came to the intensive care unit at midnight to deliver in person an emergency protective order to a 60-year-old male patient. The officers announced their purpose and requested to speak to the patient's nurse. The nurse readily pointed out the patient's room and, when asked about the patient's condition, said it would be better for the officers to speak with the patient's doctor before seeing the patient. The nurse at this point was worried that the patient could experience serious complications if confronted by a stressful stimulus.

The officers then requested that the nurse call her supervisor. After phoning the on-call physician, the nurse notified the officers that the patient would be in the unit overnight and to come back in the morning. The on-call physician also advised the nurse to contact the supervisor, which she did. While speaking with the supervisor, one of the officers became agitated and took the telephone from the nurse's hand. He then spoke with the nursing supervisor, who requested he return in the morning to deliver the protective order.

During the time that the officer was speaking with the nursing supervisor, the nurse caring for the patient returned to the nursing station. The officer went into the nursing station, arrested the nurse for obstructing service of process and obstructing a police officer, and had her taken from the hospital in handcuffs.

In the subsequent trial, the court noted that an arrest requires a warrant or probable cause. There was no way, the court ruled, that the officer could have thought the nurse's actions amounted to either of the offenses for which she was arrested. The nurse told the officer where the patient was located and did nothing to prevent him from contacting the patient. When the nurse informed the officer that it

was not advisable for him to contact the patient, she had two responsible staff members collaborate that fact, leaving the officer to either leave or serve the patient with the emergency order. The court in finding for the nurse noted that obstruction of a police officer, by definition, requires physical resistance intended to obstruct the officer in the execution of his lawful duties. While the nurse refused to give the officer permission to enter the patient's room, permission was not hers to give or withhold. Thus, she did not obstruct the officer.

EXERCISE 1–2

Describe instances in which the conduct of the professional nurse (with regard to the treatment of patients) might be cause for possible criminal charges. For example, the administration of toxic chemotherapeutic agents may place a patient in a more life-threatening condition than the disease process does. How might a court of law distinguish such a case?

Substantive Law

Substantive law, which defines the substance of the law, may be further classified into civil, administrative, and criminal law. Thus, substantive law concerns the specific wrong, harm, or duty that caused the lawsuit or an action to be brought against an individual. Lawsuits brought to remedy violations of these laws must eventually prove the existence of the elements that comprise the actual claims.

Procedural Law

Procedural law, which governs the procedure or rules to create, implement, or enforce substantive law, may vary according to the type of substantive law involved and the jurisdiction in which the lawsuit is brought. Procedural law concerns the process and rights of the individual charged with violating substantive law. Procedural issues that may be contested include admissibility of evidence, the time frame for initiating lawsuits, and the qualifications of expert witnesses.

Due Process of Law and Equal Protection of the Law

Due process of law, a phrase often misquoted, applies only to state actions and not to actions of private citizens. Basically, the due process clause of the U.S. Constitution is intended to prevent a person from being deprived of "life, liberty, or property" by actions of state or local governments (Amendment 14, Section 1, 1787). Although difficult to define, the due process clause is founded on the fundamental principle of justice rather than a rule of law, and ensures that the government will respect all of a person's legal rights, not just some or part of those legal rights, when it deprives a person of life, liberty, or property.

Due process protects the public from arbitrary actions. Laws must operate equally among all persons, and laws must be definite, not vague. Due process is violated if a particular person of a class or community is singled out by the law. A "person of ordinary intelligence who would be law abiding can tell what conduct must be to conform to (the law's) regulation, and the law is susceptible to uniform interpretation and application by those charged with enforcing it" (*State v. Schuster's Express, Inc.*, 1969, at 792).

The two primary elements of due process are (1) the rule as applied must be reasonable and definite, and (2) fair procedures must be followed in enforcing the rule. This latter provision ensures that adequate notice be given before the rule is enforced so that persons who will be affected by it will have time to explain why the rule should or should not be enforced. Nurses become involved in the application of due process when requested to appear before state boards of nursing, in that they must be given proper notice of the upcoming hearing and of the charges that the board will be evaluating during the hearing. In the hospital setting, the concept of due process has been interpreted to include a hospital's right to licensure by the state and the right of qualified medical personnel to staff appointments in public hospitals.

An older case example concerning due process of the law affecting boards of nursing is *Slagle v. Wyoming State Board of Nursing* (1998). In that case, an inmate in the Wyoming correctional system filed a complaint with the Wyoming Board of Nursing, claiming an advanced geriatric nurse practitioner was practicing illegally as an advanced practitioner in adult nursing. The board of nursing sent notice to the nurse, requesting that she substantiate her qualifications in adult advanced practice nursing. The nurse sent back numerous materials, including a letter of recommendation from the head of the University of Utah nursing program that she had attended.

The nurse thought that the board was in the process of updating her qualifications and would be enlarging the scope of her license to include adult advanced practice. In fact, the board of nursing was conducting a disciplinary investigation to see whether the nurse had practiced beyond the scope of her geriatric advanced nurse practitioner standing.

In the subsequent lawsuit, the Supreme Court of Wyoming dismissed the board of nursing sanctions against the nurse because the notice the board of nursing had sent was so misleading that it violated the nurse's constitutional right to due process of law. The final conclusion was that the board of nursing gave this nurse adult advanced nurse practitioner standing.

Note, however, that minor errors will not be seen as failing to give proper notice. In *Colorado State Board of Nursing v. Geary* (1997), the notice from the board of nursing was mailed to the nurse at an incorrect address. In Colorado, notice had to be sent to the nurse at the last

known address and to the attorney, if any, who had notified the board that he or she was representing the nurse. In this case, the attorney received the notice, corrected the incorrect address, and sent the notice to the nurse at her correct address. The nurse received this latter notice from her attorney, but she decided not to appear at her disciplinary hearing. Because she was not at the hearing, the board placed a two-year probation on the nurse's license.

In the subsequent lawsuit, the nurse argued that she had not received notice, as the original notice was misaddressed. The court ruled that when an agency mails out an administrative notice, the law presumes the notice was properly addressed and the person to whom it was addressed received it. The board does not have to prove the nurse received its notice. The nurse must prove she did not receive the notice and, because her attorney had been sent the notice, she had been "duly served." Thus, the court upheld the two-year probation for the underlying charges of professional misconduct. A similar finding was upheld in *Beverly Enterprises v. Jarrett* (2007).

Like due process, the equal protection clause of the Fourteenth Amendment also restricts state actions and has no reference to private actions. More than an abstract right, the **equal protection of the law** clause guarantees that all similarly situated persons will be affected similarly. Laws need not affect every man, woman, and child alike, but reasonable classifications of persons must be treated similarly (*Dorsey v. Solomon*, 1984). Thus, states may not enforce rules and regulations based solely on classifications as determined by race, religion, and/or gender. The due process clause does not preclude states from resorting to classifications of persons for the purpose of litigation, but "the classification must be reasonable and not arbitrary and must rest upon some ground of difference having a fair and substantial relationship to the object of legislation so that all persons similarly circumstanced shall be treated alike" (*Ex Parte Tigner*, 1964, at 894–895).

In determining whether equal protection of the law has been achieved, courts use the ***rational basis test***, which essentially states that persons in the same classes must be treated alike. In addition, this test states that reasonable grounds that further legitimate governmental interests exist in making a distinction between those persons who fall within the class and those persons who fall outside the class (*Ohio University Faculty Association v. Ohio University*, 1984).

A case decided under the equal protection clause of both the U.S. and Arizona Constitutions held that it was unreasonable to allocate treatment within a service category solely on the criterion of age (*Salgado v. Kirschner*, 1994). In that case, a middle-aged Medicaid recipient was denied a lifesaving liver transplant based on an Arizona statue that limits Medicaid coverage for medically necessary transplants to persons under the age of 21. The court found that age was the only criterion used and that age was medically irrelevant to liver transplant outcomes, in that no evidence linking age to a greater survival rate was shown. This case is significant in that age, if used to set restrictions on care, cannot be the sole factor considered nor can it be medically irrelevant.

The distinction between due process and equal protection was perhaps best summarized in a 1983 case in which the court stated that "the difference between due process and equal protection of the law is that due process emphasizes fairness between state and individual regardless of how other individuals in the same situation are treated while equal protection emphasizes disparity in treatment by a state between classes of individuals whose situations arguably are indistinguishable" (*Peterson v. Garvey Elevators, Inc.*, 1983, at 897).

The Judicial Process

To fully appreciate the various types and classifications of laws, substantive and procedural law, and the application of these specific procedures, an understanding of the court system is helpful. The next section addresses the judicial process in the United States.

Questions of Law or Fact

Facts are determined by evidence presented by both sides in a legal controversy. **Questions of fact** present the dispute that the jury answers. Facts are not necessarily what actually happened, because persons on both sides will have perceived a given incident through their own eyes. Thus, each party to the controversy brings unique perceptions to the trial setting. The **fact-finder** has the responsibility to weigh admissible evidence as presented and to decide where the facts of the case really lie. For example, a question of fact could concern such issues as admission to a hospital. Was the patient formally admitted to a hospital so that a patient–hospital relationship was established? Questions of fact could also include the cost of an operation, the cost of a particular hospital service, or the people involved in a particular incident. Typically, questions of fact have concerned professional practice standards and whether these practice standards have set the standard of care for individual patients.

An interesting question of fact occurred in *Estate of Fazio v. Life Care Centers* (2009). In that case, the issue at trial level concerned damages for decubiti ulcers that had developed and progressed while the deceased was a resident of a nursing facility. The judge allowed photographs to be shown to the jury, noting that they were "gruesome," but that they also accurately depicted the extent and severity of the pressure lesions. On appeal, the appellate court upheld the judge's decision to allow the photographs to be introduced, noting that a piece of evidence that proves a point that is material to the lawsuit should not be excluded merely because it might cause an unpleasant emotional reaction by the jury.

Sometimes both sides in a controversy agree to certain facts prior to the trial. In these cases, the only questions to

be resolved concern **questions of law**, which involve the application or interpretation of laws and are determined by the judge in the court. For example, the judge may rule that a particular provision in a nurse's contract was against public policy and is therefore unenforceable. Or the judge may rule that a particular provision in the contract is reasonable and thus enforceable. Federal and state statutes, rules and regulations, prior court decisions, new technology, and societal needs may all play a part in determining the law as it applies to a specific trial.

Fact-finders, usually the jurors at trial, determine the facts that are admissible. These selected people are charged with weighing the admitted evidence, while the judge or magistrate determines questions of law. If there is a trial without a jury, then the judge serves as both the fact-finder and the determiner of questions of law.

A case example may help illustrate this distinction. In *McGothlin v. Christus St. Patrick Hospital* (2011), the facts were relatively simple. It was undisputed that the patient had somehow sustained a patellar dislocation at some point after knee replacement surgery. The original surgery was followed by nine subsequent procedures, including the eventual removal of the patient's patella, which left her permanently disabled. The question concerned how the patellar dislocation occurred.

The patient noted that there were two incidents that could have caused this event. One possibility is that the injury occurred when a single staff member was assisting the patient to use the commode. As she was being positioned, the high seat, which was not clamped to the commode, became unsteady, and the patient fell to the floor. The second possibility was that the injury occurred when the patient was dropped during a two-person transfer from the bed to the chair.

Attorneys for the institution noted that none of the nurses who had cared for this patient had any recollection of either event and that there was no documentation in the patient's chart about these events. Similarly, there were no incident reports concerning either of these alleged falls. The defense did have an orthopedic expert testify that dislocation of the patella is a possible and sometimes unavoidable complication during necessary post-operative ambulation of a patient.

In this case, the jury found that that there was no liability on the part of the defendant nurses and institution. The court concluded that the jury was led by inconsistencies in the testimony of family members and the patient herself in deciding this outcome. As the court noted, the jury is the final authority on the credibility of the witnesses and thus on the facts of the case.

Jurisdiction of the Courts

Jurisdiction, the authority by which courts and judicial officers accept and decide cases, is the power and authority of a court to hear and determine a judicial proceeding (Garner, 2014). Jurisdiction determines the court's ability to hear and rule on a given lawsuit. Jurisdiction may be divided into three categories.

Subject matter jurisdiction, sometimes called *res jurisdiction*, refers to the court's competency to hear and to determine a given case within a particular class of cases. For example, a court may have jurisdiction only in cases that involve probate matters (wills and estates), family matters (adoptions, divorces, and child custody), or criminal matters. Subject matter jurisdiction, along with the nature of the cause of action, may be determined by the amount or value of the claim as pled. For example, courts may have jurisdiction of a given case up to $1,000 or to cases that have a pled-damage figure of between $1,000 and $5,000.

Personal jurisdiction, also known as *in personam jurisdiction*, refers to the power of a given court regarding a particular person. Personal jurisdiction is the legal power of a court to render a judgment against a party or parties to the action or proceeding. For example, personal jurisdiction often involves the county of the defendant. A court situated in the county of the defendant would have personal jurisdiction over the defendant. A court situated in the county of the plaintiff's residence can also have personal jurisdiction over the parties to the lawsuit.

The third jurisdictional issue concerns the court's ability to render the particular judgment sought. Any court possesses jurisdiction over matters only to the extent granted it by the constitution or legislation of the sovereignty on behalf of which it functions. **Territorial jurisdiction**, or the court's ability to bind the parties to the action, is a part of this third meaning of jurisdiction. Territorial jurisdiction determines the scope of federal and state court power. State court territorial power is determined by the U.S. Constitution's Fourteenth Amendment, and federal court jurisdiction is determined by the Fifth Amendment.

Courts may be either state or federal in origin. Federal courts seek to ensure that laws created through the U.S. Congress are enforced, and state courts have their sole jurisdiction within the given state. Overseeing the process is the U.S. Supreme Court, which has jurisdiction over all of the United States and its territories.

Overlapping or concurrent jurisdiction may occur when more than one court is qualified to hear a given dispute. In some areas of overlapping or concurrent jurisdiction and in some instances of specific subject matter jurisdiction, the federal Constitution gives guidance. For example, the federal courts have original jurisdiction over admiralty cases, crimes involving federal laws, bankruptcy cases, and patent laws. The U.S. Constitution gives the U.S. Supreme Court original jurisdiction (that which is inherent or conferred to the court) over cases "involving ambassadors, other public ministers and consuls and those in which a state is a named party" (Article III, Section 2, 1787).

If there is no mandatory court of jurisdiction, the attorneys representing the party filing the lawsuit will advise their client of the optimal court in which to file the lawsuit. Concurrent jurisdiction frequently occurs in cases with multiple defendants and in cases that involve parties

residing in different states. There are many reasons why one court may be more favorable to the party filing the lawsuit, including shorter length of time to trial, more favorable damage awards, and shorter distances for witnesses to travel.

State Courts

Trial Courts

The court of original jurisdiction in most states is the ***trial court***, and it is the first court to hear legal disputes. At this level, applicable law is determined, evidence is presented and evaluated to ascertain the facts, and either a judge or a jury functioning under the guidance of a judge applies the law to the admissible facts. As stated in the preceding sections, the judge determines questions of law and then guides the jury in applying this law to the questions of fact.

Even though the jury's tasks are to determine facts and, after proper instructions, to apply the law to the facts, the judge retains control over the entire trial process. The judge may find that the evidence is inadmissible or that the evidence as presented is insufficient to establish a factual issue for the jury to resolve. The judge may dismiss the case or may overrule a jury decision if he or she finds that justice has not been served.

Most state courts operate on a three-tier system. Sometimes called *inferior courts*, trial courts are the courts with original jurisdiction in most states with three-tier systems. Other names for this first court in which the lawsuit is filed include *circuit courts*, *superior courts*, *supreme courts* (New York), *courts of common pleas*, *chancery courts*, and *district courts.*

State Appellate Courts

The side that loses the case at trial level may decide to pursue the case at the appellate level if there are procedural or legal grounds on which to base an appeal. In a three-tier system, these ***state appellate courts,*** or ***courts of intermediate appeals***, do not rehear the entire trial but base their decisions on evidence as presented in a record of the trial hearing. There are no witnesses, new evidence, or jurors. The intermediate court may concur (agree) with the previous decision, reverse the prior decision, remand (send the case back to the trial level), or order a new trial.

Intermediate courts of appeal have different names throughout the states. They may be called *courts of appeal*, *intermediate appellate courts* (Hawaii), *appellate divisions of the supreme court* (New York), *superior courts, courts of special appeals* (Maryland), *courts of civil appeals*, and *courts of criminal appeals.* Nine states have a two-tier system (Delaware, Maine, Montana, New Hampshire, Rhode Island, South Dakota, Vermont, West Virginia, Wyoming, and the District of Columbia) and thus have no intermediate appellate courts.

State Supreme Courts

The ultimate court of appeal in the state is usually named the ***state supreme court***. This court hears appeals from the intermediate appellate courts and also serves to adopt rules of procedure for the state and to license attorneys within the individual state. This court is the final authority for state issues, unless a federal issue or constitutional right is involved. The state supreme court may hear cases directly from the trial level. For example, if the trial court case concerned the interpretation of the state constitution or a state statute, the case can be appealed directly to the state supreme court. An example of such a direct appeal involving the interpretation of the Missouri nurse practice act occurred in *Sermchief v. Gonzales* (1983).

Other names for this highest court of appeals within the state include *supreme court of appeals* (West Virginia), *supreme judicial court* (Maine, Maryland, and Massachusetts), and *court of appeals* (New York and the District of Columbia). Some states may also have a separate supreme court of criminal appeals (Texas and Oklahoma).

EXERCISE 1–3

Explore your own state court system. What types of trial courts exist and what is their jurisdiction? Which court would most likely hear nursing malpractice cases? To which court would appeals be sent in your state system?

Federal Courts

The structure of the federal court system has varied a great deal throughout the history of the United States. The Constitution provides merely that the judicial power of the United States be "vested in one Supreme Court, and in inferior courts as Congress may from time to time ordain and establish" (Article III, Section 8, 1787). Thus, the only indispensable court is the Supreme Court. Congress has established and abolished other U.S. courts as national needs have changed over time.

Courts are presided over by judicial officers. In the Supreme Court, the judicial officers are called *justices.* In the courts of appeals, district courts, and specialty courts, most of the judicial officers are called *judges.* The authority, duties, and benefits assigned to judicial officers are enacted and amended by Congress.

District Courts

The federal court system mimics the majority of state court systems. The original trial courts in the federal three-tier system are the ***U.S. district and territorial courts*** and the specialty courts such as the U.S. court of claims, the U.S. bankruptcy courts, and the U.S. patent courts. There are currently 94 district and territorial courts, with at least

one district court in each state as well as the District of Columbia. There are also federal specialty courts, including the Tax Court, Court of Federal Claims, Court of Veterans Appeals, and the Court of International Trade. The district and territorial courts normally hear cases in which a federal question (questioning a federal statute or violations of the rights and privileges granted by the U.S. Constitution) is involved or in which the parties to the suit have citizenship in different states (diversity of citizenship). In cases involving diverse citizenship, the federal court system applies rules of federal procedure in deciding applicable state law.

Courts of Appeal

The intermediary courts are the U.S. courts of appeal. These courts were known as the *circuit courts of appeal* prior to June 25, 1948. There are currently 13 courts of appeal, not including the U.S. Court of Appeals for the Armed Forces, and they are frequently called *U.S. circuit courts* even today. These courts are located in 13 areas (or circuits) of the country. The U.S. courts of appeal are numbered 1 through 11, with the District of Columbia Court of Appeals being the 12th court. Each of the first 12 courts of appeal consists of one to nine state regions and territories. The 13th district includes all of the United States and territories and is named the United States Court of Appeals for the Federal Circuit. These courts serve to hear cases originating from the federal trial courts.

Supreme Court

The highest level of the federal court system is the **U.S. Supreme Court**, and its decisions are binding in all state and federal courts. This nine-justice court hears appeals from the U.S. courts of appeal and from the various state supreme courts when state court decisions involve federal laws or constitutional questions based on a **writ of certiorari**, or written petition to hear the case. The Supreme Court ensures the uniformity of decisions by reviewing cases in which constitutional issues have been decided or in which two or more lower courts have reached different conclusions.

Because most cases involving nursing practice concern tort law or state licensure issues, it is rare for lawsuits involving nurses as primary defendants to be heard in the federal court system. Exceptions to this rule are nurses working in the military and veterans' hospitals or other federally funded health care centers. Cases involving these nurses are frequently settled in federal courts.

EXERCISE 1–4

Find out which district court and federal court of appeals have jurisdiction over your city and state. What types of nursing malpractice cases have these courts heard in the past? How did the courts rule on those issues? How did their decisions affect the professional practice of nursing in your state?

Statutes of Limitations

Statutes of limitations, procedural law time frames, are essentially time intervals during which a case must be filed or the injured party is barred (prevented legally) from bringing the lawsuit. Statutes of limitations establish a time frame within which a suit must be brought. Set by the individual state legislatures, most states currently allow one to two years for the filing of a personal injury lawsuit. The majority of the states do not begin measuring time until the injured party has actually discovered the injury that will become the basis of the ensuing lawsuit. According to the **discovery rule**, patients have two years from the time that they knew or should have known of the injury to file a personal injury lawsuit, but many of these time frames have been altered by state law. For example, California has amended its laws so that medical malpractice issues must be filed one year from the date of injury or date of discovery, up to a maximum of three years from the date of injury. The exception in medical malpractice is for cases involving foreign objects where the statute of limitations runs from when the object is, or should have been, discovered. In New York State, the individual must file a medical malpractice suit within 30 months from the act or omission and all claims are limited to this 30-month time frame. Texas allows two years in which to file a medical malpractice case, with a maximum of ten total years. Washington State specifies three years with the discovery rule but no more than eight years from the time of the wrongful act, unless there is an intentional concealment of a foreign object.

Additionally, some states may have specific requirements concerning notification to the health care institution of an impending lawsuit. An example is the case of *Stroth v. North Lincoln Hospital District* (2014). In that case a patient, accompanied by his wife, was transported to the emergency department of a rural hospital. In the emergency department, the patient was left unattended lying on his back and with an oxygen mask on his face. He vomited into the mask during an interval when the nurses were not at his bedside. When alerted to his distress by the wife, the nurses removed the oxygen mask, but did not reposition the patient on his side to prevent aspiration of the vomited material. The patient vomited three more times while still in his prone position. At that point, the patient was airlifted to a regional medical center where it was confirmed that he had aspirated and developed pneumonia. He died several days later.

His widow sued the first hospital, which was a county public health district facility, for negligence and wrongful death. Though sympathizing with the widow, the court nevertheless dismissed the lawsuit on the grounds that neither the widow nor her attorney had filed a notice of claim within the strict time limits required by Wyoming statutes.

Some courts have distinguished between traumatic injury cases and disease cases. In traumatic injury cases, the injury is normally of the type that the patient knows or should have known of immediately. For example, the

patient who has an operation on an opposite extremity or wrong area of the body will immediately know that an injury has occurred. In traumatic injury cases, the one- or two-year statute of limitations is strictly applied.

In disease cases, the statute of limitations may be less strictly applied, because it may be some time before the patient becomes aware of the possible malpractice event. The statute of limitations would begin to measure time when the patient became aware of the injury (event) or when the reasonable patient would have become aware of the injury. Some states have amended this disease case distinction and employ a continuous treatment time frame doctrine, which states that the time limit for filing a medical malpractice case is calculated not from the date of the alleged malpractice, but from the date that the patient was last treated for the condition. The treatment for the same condition must have been continuous, not sporadic, for this doctrine to apply. For example, a patient who entered a nursing home in July of 2006 had an order that she was to be assisted when using the bathroom. During the first week that she resided in this facility, she fell and broke her hip when no one came to assist her to the bathroom. She was hospitalized and then she returned to the nursing home.

In January of 2011, her daughter first learned the circumstances of how her mother broke her hip and had her mother transferred to another nursing home. In assessing if a valid lawsuit could be filed, it was determined that the patient had received continuous care from the original nursing home so that the statute of limitations did not begin to run until her transfer to a second nursing home in January of 2011.

The courts may look at exceptional circumstances when deciding if the statute of limitations should apply or not. In *Sherrill v. Souder* (2010), the court allowed a patient's daughter to file a lawsuit on behalf of her deceased mother after the one-year statute of limitations because there was a genuine issue of fact as to whether the patient was of sound or unsound mind on the date that the cause of action occurred. In *Allredge v. Good Samaritan Home* (2014) the court allowed the successful filing of a lawsuit for fraudulent concealment of the facts. In that case, a nursing home resident was hospitalized for what would prove to be a fatal head injury. A nurse from the nursing home phoned the resident's daughter and said that the resident was prone to sudden transient ischemia attacks that could not be anticipated or prevented. Such an event was most likely what had caused the resident's fall.

Three years after the resident's death, a former employee of the nursing home told the daughter that her mother did not merely fall and strike her head, but was attacked and pushed to the floor by another resident. The daughter then filed a healthcare malpractice suit against the nursing home, but it was filed beyond the Indiana two-year statute of limitations. The court nevertheless allowed the lawsuit to go forward.

The court ruled that fraudulent concealment by a healthcare provider of facts that could be the basis of a malpractice lawsuit extends the statute of limitations. In this case, the statute of limitations was initiated when the patient or family member who had been misled learned or with due diligence should have learned the true account of what happened. A similar finding occurred in *Watkins v. Central* (2016) when healthcare workers fraudulently concealed that a male nurse had performed a pelvic examination of a 19-year-old psychiatric patient in direct violation of agency protocols.

Contrast the above case with *Harris v. Advocate* (2015). In *Harris*, a patient died in the hospital in 2000, two days after sustaining serious head injuries in a pedestrian versus motor vehicle accident. The patient was treated in the hospital's emergency department, underwent surgical intervention, and died in the intensive care unit. In the emergency department, the patient was given four doses of Versed without a physician's order. In total, the patient received four 10 mg doses of Versed, three before she went into cardiac and respiratory arrest and one minutes after she was resuscitated. The patient's adult daughter came to the hospital and was informed by the attending physician that her mother was in a coma caused by her injuries.

A month after the death, the daughter contacted an attorney who gave her a copy of the hospital record, including the nurse's notes about the Versed. The attorney and client agreed it was simply a motor vehicle case and settled with the driver of the car. The hospital's risk management committee met over the incident, raising concern about the Versed administration. A decision was made to circulate a memo internally and not contact the daughter. Subsequently the emergency department physician director dissented with this decision and was fired.

In 2007, the emergency department physician director's attorney contacted the daughter for permission to access the mother's chart for use in his client's wrongful termination lawsuit against the hospital. At that point, the daughter contacted another attorney, who nine months later sued the hospital for malpractice relative to the administration of Versed without a physician's order to a critically injured head trauma patient.

The court ruled that the hospital was not guilty of fraudulent concealment and dismissed the lawsuit as it was not filed timely. Though the timeframe for filing a lawsuit in Illinois is extended up to five years after the true facts are discovered by the party entitled to sue, the court held that the health care providers had no duty to interpret the facts for a patient or representative. In this case, the daughter and her then-attorney had the full facts, including the administration of Versed, within two months of her mother's death.

The rationale behind statutes of limitations is that potential defendants should have the opportunity to defend themselves within a reasonable time period. The purpose of statutes of limitations is to suppress fraudulent claims after the facts concerning them have become obscured from lapse of time, defective memory, or death or removal of witnesses (*Noll v. City of Bozeman*, 1975). If too much time has lapsed between the occurrence and the

lawsuit, facts may be difficult to decipher and witnesses cannot be identified or found.

At one time, courts uniformly allowed one major exception, in the case of minors, to the prompt filing of a lawsuit for personal injury. Because parents may not always seek what is in the best interest of their child, the court allowed minors to reach their majority before the statute of limitations began to be measured. In most states, this means the statute begins to be counted when the child reaches their 18th birthday. The lawsuit must be filed by the time the injured minor reaches his or her 20th birthday or the suit is barred by law. For example, in *Wang v. Mid-Michigan* (2016), an infant was burned by the use of a heated bag of water placed next to his right arm. The incident was fully documented, the infant transferred to the intensive care area of the facility, and a plastic surgery consult was obtained. No further treatment was required and the infant was discharged a week after his birth. Some years later, the child's parents filed a lawsuit against the healthcare institution and staff members involved in the child's care. The court dismissed the lawsuit as it applied to the child's parents as the statute of limitation had expired regarding their right to sue. Even though the child was not yet ten years old, his claims could go forward.

Today, most states are more restrictive and have opted to disallow the right of a minor to bring suit upon reaching adulthood. For example, in Montana, a child under four years of age has until his or her eighth birthday to file suit. For minors four years or older, the state's general three-year discovery rule to a maximum of five years for foreign objects and ten years for legal cases applies. In New Mexico, if the child is under six years of age at the time of the injury, he or she must file by his or her ninth birthday. In at least one state, though, the statute of limitations has recently been increased for parents who sue on behalf of their minor child. In Ohio, the time frame for filing a medical malpractice suit has been increased from one year up to the child's 19th birthday. Minors continue to have until their 19th birthday to file a medical malpractice suit.

EXERCISE 1–5

Decide the following fact scenario: A nursing home resident filed a lawsuit alleging that nurses caring for him were negligent in their care. Specifically, the nurses did not follow the care plan in that they failed to turn him every two hours, they frequently failed to get him out of bed so that he could sit in a wheelchair, and he remained in soiled bedding for long periods of time. As a result, he had multiple open wounds on his buttocks, hips, and heels, which are slowly resolving. He filed this lawsuit three years after being removed from the nursing home. How would the statute of limitations affect this suit? Are there any circumstances he could plea that would allow this lawsuit to continue despite the three-year interval?

Summary

- Law may be defined as the sum total of rules and regulations by which a society is governed.
- The four sources of law include constitutional, statutory, administrative, and judicial law.
- Attorney general's opinions, requested at either the national or state level, provide guidelines based on both statutory and common law principles.
- Law may be classified into several different types, including common, civil, criminal, public, private, substantive, and procedural law.
- Due process of the law and equal protection of the law are special applications of the Fourteenth Amendment and both pertain only to state actions.
- In courts of law, questions of law and fact are determined in reaching a conclusion to the lawsuit.
- Jurisdiction pertains to the power and authority of a court to hear and determine a judicial proceeding and can be subdivided into subject matter, personal, and territorial jurisdiction.
- State and federal courts are generally divided into a three-tier system, including trial courts, appellate courts, and supreme courts.
- Statutes of limitations are time intervals during which a case must be filed or the injured party is prevented from bringing the lawsuit.

Apply Your Legal Knowledge

- Which classifications of law are more commonly applied to professional nursing?
- How do attorney general's opinions protect the practice of professional nursing?
- Do all four sources of law protect the practice of nursing? Why or why not?
- Does the court in which a case is filed affect the ability of the injured party to have a more favorable or less favorable verdict?
- How do statutes of limitations favor defendants in a lawsuit?

You be the Judge

A 58-year-old patient went to her cardiologist's office for a myocardial perfusion scan. She elected to raise her heart rate by exercising on a treadmill as opposed to taking medications. After a few minutes of exercise, the treadmill suddenly increased its speed, and the patient asked one of the nurses to stop the machine. According to the patient, the nurses ignored her request, and she subsequently fell off the machine. Shortly after her fall, the cardiologist evaluated the patient and determined that she had suffered no injury from the fall.

Three years later the patient brought suit against the cardiologist for a knee injury, which she alleged was caused by the fall from the treadmill. She also sued the nursing staff, who failed to heed her request to stop the treadmill in a timely manner.

Questions

1. How does the statute of limitations affect this case?
2. Is there evidence to support the claim that the statute of limitations barred the patient's cause of action?
3. Is there evidence to support the plaintiff's claim that the statute of limitations should not bar this action?
4. How would you decide this case?

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CHAPTER 2
Anatomy of a Lawsuit

Learning Objectives

After completing this chapter, you should be able to:

2.1 Analyze the purpose of the six procedural steps in the trial process.

2.2 Compare and contrast alternate means of resolving controversies, including alternative dispute resolution, mediation, arbitration, and prelitigation panels.

2.3 Distinguish between traditional depositions, court reporter–recorded depositions, and the more modern videotaped depositions, defending the advantages and challenges of each of these methods.

2.4 Compare and contrast lay and expert witnesses and the relevance of their roles in the trial process.

2.5 Examine levels of evidence and select which level is most appropriate in criminal and civil court cases.

2.6 Evaluate the trial process, including the purposes and steps of the various stages in the process.

2.7 Develop selected ethical issues facing the expert witness today.

Preview

The ultimate goal of any court system is to resolve, in an orderly and just process, controversies that exist between two or more parties. To reach this conclusion, the trial process has evolved. This chapter presents all aspects of the trial process, from initiation of the complaint to appeals, and highlights nursing's role, with special emphasis on the role of the expert witness. Alternate means of resolving controversies and conflicts, including alternative dispute resolution, mediation, arbitration, and prelitigation panels, are also discussed.

Key Terms

alternative dispute resolution (ADR)
arbitration
clear and convincing evidence
complaint
counterclaim
cross-examination
default judgment
defendant
deposition
expert witness
injunction
interrogatories
lay witness
legal consultant
levels of evidence
mediation
motion to dismiss
motions
opening statements
plaintiff
pleadings
prelitigation panels
preponderance of the evidence
pretrial conference (hearing)
proof beyond a reasonable doubt
right of discovery
settlement
standard of proof
trial
verdict (decision)
voir dire

The Trial Process

When disagreements occur or when one is charged with a crime, issues are resolved through a **trial**, which is a formal examination of the evidence before a judge and often a jury, in order to decide the appropriate outcome. There are six procedural steps to any given lawsuit. (See Table 2–1.) Each step, with its special application to nursing, is discussed in the following sections.

Step One: Initiation of the Lawsuit

A party, the **plaintiff**, who believes he or she may have a valid cause of action against another individual, initiates the lawsuit. The answering party or parties, the **defendant**(s) in the lawsuit, may then respond. (In reality, the attorneys execute the intentions of their clients, but the parties to the suit are always referenced as though they are the ones controlling and instigating the proper motions, claims, forms, and defenses.)

In most instances, it is rare to have a single plaintiff versus a single defendant. More commonly, there are multiple parties on either or both sides to the lawsuit. In medical malpractice suits, a single plaintiff typically sues multiple defendants, including physicians, the health care institution's board of directors, and various members of the nursing staff. Naming as defendants all possible persons or entities involved in the cause of action may be a wise strategy for the plaintiff, since the plaintiff could be barred by the statute of limitations from later adding defendants to the lawsuit. (Review Chapter 1 for a detailed discussion of statutes of limitations.) Should plaintiffs subsequently discover that a named defendant has been incorrectly named as a party to the suit, that defendant may be nonsuited (sometimes called *dismissed*) and removed from the case entirely.

When the plaintiff's cause of action is well identified, a **complaint** is filed in a court with competent jurisdiction to hear the case. Upon filing the complaint, the court serves the defendant(s) with a summons to appear before the court at a specified time. This process, known as *service* in both state and federal court systems, alerts the named defendants that a lawsuit is now pending against them. The complaint outlines the names of the parties to the suit, allegations of the breaches of standards of care, injuries or damages, and demand for an award. In some states, the demand for damages is a specified amount, whereas other states determine the amount of the award based on the evidence as presented at court.

Once served, the defendants must respond to the complaint within a specified period of time or forfeit their right to defend the suit. The time frame for answering is determined by state or federal law and varies according to the jurisdiction. When served, each defendant should promptly notify his or her liability insurance carrier for representation by one of the retained attorneys or procure a personal attorney. Never ignore the complaint because complaints do not disappear when ignored. If not properly answered within the time period allotted by law, a default judgment will be entered in the court against the defendant. Such a **default judgment** means that the defendants automatically lose the lawsuit, whether they had any liability or not. Each defendant should act promptly, because each jurisdiction sets specific time periods for each phase of the pretrial procedures and motions. Additionally, defendant nurses should never assume that other defendants will respond on their behalf; the named defendant must respond within the set time frame.

Nurse-defendants should remember two points. First, after notifying their insurance carrier and arranging to be represented by an attorney in the impending suit, they should also notify the health care institution's administrative staff of the lawsuit (if they are still employed at the institution named in the lawsuit). This notification allows the health care institution's attorney to better represent the institution's and the nurses' interests. Second, nurse-defendants should not discuss the impending suit with anyone except their attorney and the health care institution's attorney. The less said, the less likely the nurse-defendants will be misquoted, and the less likely that any additional comments will be introduced into evidence.

Mandated by law in some states, **alternative dispute resolution (ADR)** refers to any means of settling disputes outside of the courtroom setting. Typically, ADR includes arbitration, mediation, early neutral evaluation, and conciliation. Although all of these processes are somewhat different in application, all serve to provide ways for parties to legal disputes to avoid formal lawsuits and costly trials. Other advantages of ADR include time saved (most disputes take in excess of six years from actual cause to resolution through the nation's court systems) and privacy (the details of the disagreement and its resolution are confidential). Thus, institutions and health care providers can avoid public disclosure and adverse publicity. A major disadvantage to ADR is possible compromise of fairness and due process.

Two of the more common approaches to ADR include mediation and arbitration. **Mediation** involves one or more professional mediators, usually experts in the discipline, listening to both sides of the dispute and helping each side see the other side's position. Hopefully, the two sides to the dispute will be able to solve their differences. Although this approach frequently is helpful in contract disputes, it has rarely been effective in medical malpractice issues because emotions tend to dominate and health professionals have their careers at stake. Additionally, agreements reached through mediation are generally not enforceable unless both sides agree to a binding decision before initiating the process.

Arbitration is a more formal process and is often viewed as a "mini-trial." Attorneys are present at arbitration, questioning the parties and any witnesses to the arbitration. Testimony is given under oath, so that the process does look like a trial. The differences are that there are no

rules of evidence, no court reporter, and no formal record made of the arbitration process. The arbitrator's judgments are legally binding, as agreed to before the process is initiated (*Bedford Health Properties v. Davis*, 2008; *Skaggs v. Kaiser Foundation*, 2008).

Similarly, a more recent lawsuit upheld the national validity of pre-dispute arbitration agreements (*Marmet Healthcare Center v. Brown*, 2012). This case was the consolidation of three separate negligent actions against Marmet Healthcare Center, a West Virginia nursing home. The lower courts had dismissed the previous causes of action and decided in favor of the nursing home, relying on a state precedent that held that arbitration clauses were not enforceable if signed by the patient or patient's representative prior to the filing of the negligence claim against the facility. The U.S. Supreme Court, in a unanimous ruling, held that the U.S. Federal Arbitration Act is the paramount legal authority in this area. Because it is a federal law, it

Table 2–1 Procedural Steps in a Lawsuit

Step 1: Initiation of the Lawsuit
1. Complaint or summons is initiated by the plaintiff.
2. Service of the complaint is made to the defendant.
3. Health care provider contacts insurance carrier for an attorney assignment, or provider obtains independent attorney.
4. Answer (response) is filed by the defendant.
5. If no answer (response) is made within the legal time frame, a default judgment is entered by the court against the defendant.
6. Alternate means of resolving the dispute, including a prelitigation panel, is held if state or territory has such a pretrial review mechanism/requirement.
Step 2: Pleadings and Pretrial Motions
1. Plaintiff makes initial complaint.
2. Defendant files original pleadings or answer.
3. Motion to dismiss is initiated by either plaintiff or defendant.
4. Counterclaims are filed with the court.
5. Amended and/or supplemental pleadings are entered.
6. Motion for judgment is based on the pleadings.
Step 3: Discovery of Evidence
1. Interrogatories are served to both plaintiff and defendant.
2. Depositions of witness and named parties are taken.
3. Request to produce documents is made.
4. Requests for an independent medical examination of the plaintiff are made.
5. Subpoenas of witnesses are issued as needed.
6. Pretrial conference or hearing is held.
7. Settlements are initiated and may be accepted.
Step 4: Trial Process
1. Jury is selected (voir dire).
2. Opening statements are made, first by plaintiff, then by defendant.
3. Plaintiff's case is presented with cross-examination by defendant.
4. Defendant's case is presented, with cross-examination by plaintiff.
5. Motion is made by defendant for directed verdict against plaintiff.
6. Closing statements are made, first by defendant, then by plaintiff.
7. Jury instructions are given.
8. Jury deliberates.
9. Verdict is decided and announced.
Step 5: Appeals
1. Appellate level or state intermediate level court.
2. State supreme court or highest state court.
3. Federal court.
Step 6: Execution of Judgment
1. Payment of damages.
2. Specific performance or injunction.
3. Imprisonment or fine of defaulting party.

"trumps" any state law, state statute, or state court precedent that is contrary to the act itself. The purpose of the Federal Arbitration Act is to support policy in favor of alternate dispute resolution in healthcare and elsewhere, once the parties have freely and knowingly agreed to arbitration as the means to resolve a dispute. The Act further notes that arbitration agreements are meant to be enforced; that is the basic reason such agreements exist.

Recent lawsuits in this area of the law have mainly concerned residents in nursing homes (for example, *Bardstown v. Dukes*, 2015; *Brandenburg v. Stanton Health*, 2014; *Owensboro v. Henderson*, 2016; *Voorhees Road v. Mallard*, 2015). In each of these cases, the court upheld the arbitration clause, following the emerging trend toward arbitration as a viable alternative to jury trial in nursing home liability cases.

Courts look carefully at the wording, intent, and form of the arbitration clause when determining if the clause is valid, noting if there are individuals or circumstances that are outside the terms of the clause. For example, in *Sheptak v. Transitional* (2015), the resident's family member had full legal authority to sign an arbitration agreement for the resident. After the resident's death, this same individual sued the facility for negligence leading to the resident's wrongful death. The lawsuit demanded a trial by jury, and the health care facility petitioned the court to order the case into binding arbitration, based on the previously signed arbitration agreement. The court declined to enforce the arbitration agreement as the facility had used a set of legal forms that called for arbitration to be conducted under the rules of an organization that had ceased functioning some three years earlier. Thus, the court allowed the jury trial to go forward. The courts also look very closely at the ability of the person to sign a valid arbitration agreement, primarily when the individual's competency becomes an issue. For example, in *Diversicare v. Hubbard* (2015), the 21-year-old patient had been diagnosed with cerebral palsy as an infant. He was profoundly disabled, unable to walk or talk and dress or feed himself. During the time that he received professional care in his home setting, his mother had made all the healthcare arrangements for him, received his government disability checks, managed his bank account, and signed all his Medicaid and Medicare documents. The mother, though, had never been appointed his legal guardian.

When his mother could no longer care for him at home, she had him placed in a long-term care nursing facility, signing the admission documents, which included an arbitration agreement. Following his death from sepsis, his mother filed a lawsuit against the facility, citing negligent care. Determining that the arbitration agreement was not valid, the court noted that an arbitration agreement is valid only if signed by a person with legal authority to do so. In this case, the son was never mentally competent to sign for himself, and he also could not appoint his mother as his agent or attorney-in-fact to sign the agreement on his behalf. Thus, the agreement was not valid.

A similar conclusion was reached in *Liberty Health v. Howarth* (2014) and *Estate of Coleman v. Mariner Health* (2014). In *Liberty Health*, the court relied upon the initial nursing assessment to conclude that the patient was not mentally competent when he was admitted to the nursing facility. The patient was not able to manage his own affairs and was relying on family members to help him. During the initial assessment, he did not know the year, had very poor short-term memory, and was unable to recall a set of three simple words even though clues were given to help him. Thus, the court ruled he could not sign for himself nor could he authorize others to sign for him.

In *Estate of Coleman*, the resident's sister was defined by state law as the closest relative to an individual no longer competent to make her own decisions or manage her legal affairs. The court noted that although the sister's authority extended to making a decision to admit the resident to a nursing home, her authority did not extend to authorizing her to sign an arbitration agreement for the resident. Thus, the current lawsuit would remain in the civil jury trial docket.

Note, though, that the court will reject arbitration agreements if the parties were not fully informed of the significance of the agreement, if the agreement takes away legal rights mandated to a person by state law, or if the signature is not completely voluntary. The court in *Dalon v. Ruleville* (2016) ruled that an arbitration agreement was not valid as the agreement was presented to the resident on a non-negotiable "take it or leave it" basis as a mandatory condition for admission to a long-term nursing care facility.

Courts may also disallow an arbitration agreement if it is determined that the costs to arbitrate are so excessive that the patient, estate, or family are essentially denied their ability to enforce their legal rights. In *Estate of Harmon v. Avalon* (2015), the agreement required family members to pay the fee for one of the arbitrators. In that area of Arizona, arbitrators charged $300 to $475 per hour for arbitration, meaning that a five-day hearing would cost the estate at least $28,500, not to mention additional expenses for expert witnesses. The court noted that if arbitration was the only recourse, given that the estate did not have sufficient assets, the estate would be basically unable to enforce the now-deceased patient's right guaranteed by law. Thus, the case was allowed to be filed in a civil trial court. Additional reasons to invalidate an arbitration agreement include when only the signature page of the agreement is retained, thus making it impossible to determine if the agreement was valid or to determine what the terms of the agreement mandated in order for arbitration to proceed (*Davis v. Hearthstone*, 2015), and when the arbitration agreement was never signed by anyone on behalf of the health care facility (*Caldwell v. SSC*, 2016).

Recent lawsuits have also centered around whose signature is required for binding arbitration as a means of resolving conflicts (*Barrow v. Dartmouth*, 2014; *Bookman v. Britthaven*, 2014; *Diversicare v. Higgins*, 2015; *Gross v. GGNSC*, 2015; *McKean v. GGNSC*, 2014; *Scott v. Heritage*

Healthcare, 2014; *Simmons v. Extendicare*, 2016; *Sovereign v. Schmitt*, 2016; *Zephyr Haven v. Estate of Clukey*, 2014). Generally, these cases held that a family member (wife, husband, daughter, son, or nephew) could or could not legally serve as the signer on arbitration agreements for a competent adult. Fundamental to arbitration is the requirement that the patient knowingly and voluntarily agreed to arbitration. The authority of an agent to act on behalf of the principal must be made apparent by the statements or conduct of the principal, not the agent. For the arbitration agreement to be valid there must be some means of showing that the competent patient had given his or her right of consent to another person.

Recent cases concerning this act on behalf of the principal to an agent have concerned durable power-of-attorney documents and health care proxies. For example, in *Bardstown v. Dukes* (2015), a wife signed a valid durable power of attorney naming her husband as attorney-in-fact. This power of attorney expressly gave the husband authority to enter into contracts, file litigation, and negotiate should there be a legal dispute. The durable power of attorney comes into effect when the person who signed it is no longer able to manage his or her affairs, giving this individual the authority to also sign a valid arbitration agreement. The court further noted that had the wife signed a health care proxy, which allows a surrogate decision maker to make health care decisions and consent to treatment on another's behalf, the arbitration agreement would have been invalid. That is because the health care proxy has no legal authority over finances, property, legal rights, or legal remedies. Similarly, *Florida Holdings v. Duerst* (2016), *Riney v. GGNSC*, (2016), and *Owensboro v. Henderson* (2016) allowed individuals legally appointed with a valid durable power of attorney to sign arbitration agreements on behalf of a relative. The courts in *Morton v. Grace Health* (2015) and *Johnson v. Kindred Healthcare, Inc*. (2014) ruled that a health care proxy did not give the individual's relative the authority to legally sign arbitration agreements on behalf of the principal.

Arbitration in malpractice cases may become problematic because neither party typically wants to give up the ability to be heard in court. Also, because no rules of evidence apply, testimony that is inadmissible in courts of law may be freely offered in arbitration sessions. For example, a health care provider may be asked about substance abuse if that issue is relevant to the case. Finally, there is no appeal process with arbitration, unless one can show that the arbitrator was biased in favor of or against one of the parties.

A separate mechanism for ensuring the appropriateness of causes of actions is the prelitigation panel. **Prelitigation panels** ensure that there is an actual controversy or fact question before the case is presented at court. At prelitigation hearings, a panel of medical and legal experts review evidence concerning the injury, its cause, and its extent. Evidence presented may include medical records, expert reports, photographs, x-rays, authoritative texts, medical journal articles, and medical or legal memoranda.

Not all states employ prelitigation panels, because arguments abound as to whether they should exist. In some states, a prelitigation panel is mandatory (for example, Idaho, Indiana, Maine, and Utah), while in others it is voluntary (for example, Colorado, Georgia, South Dakota, and Vermont). Additionally, some states do not address the issue either way (Kentucky, Minnesota, and Missouri). Defendants' attorneys argue that such panels reduce frivolous lawsuits and expedite the trial process, whereas plaintiffs' attorneys contend that they merely prolong the legal process and increase the overall expense of the trial. Most malpractice cases take three to six years from the time of injury to a decision, and in states with prelitigation panels, the time is increased by six to twelve months.

EXERCISE 2–1

Mrs. G.'s adult son signed an arbitration agreement when his mother was admitted to a long-term care facility. After his mother died, the son in his capacity as administrator of her probate estate sued the nursing home for wrongful death.

What facts would you need to know before deciding who should prevail given these facts? Should the case be decided through arbitration or does the son have a right to file this case in the circuit court?

Step Two: Pleadings and Pretrial Motions

Pleadings, written documents setting forth the contentions of the parties, are statements of facts as perceived by the opposing sides to the lawsuit. Pleadings give the basis of the legal claim to opposing parties and prevent unfair surprise to either side. In actuality, the initial complaint or petition is also a pleading to the court setting out the plaintiff's facts and declaring that an injustice or wrong has been done. Each defendant responds with a pleading, giving his or her version of the facts to the court. In the defendants' original pleadings, the defendants set forth objections to the plaintiff's complaint. These objections cite possible errors in the plaintiff's case. Possible errors may be procedural (e.g., the process of service was incorrectly performed or the lawsuit is filed in a court that lacks personal jurisdiction over the defendant). Possible errors may also be factual (e.g., the defendant named in the suit was in reality on vacation or was not scheduled at the time of the occurrence and thus has no liability in the matter before the court).

The defendant may also file a **motion to dismiss**, stating that there is no valid cause of action on which a claim may be made. The judge may either dismiss the suit upon such a filing or decline to dismiss. If the case is dismissed, the plaintiff may appeal the dismissal. If the motion to dismiss is declined, the defendant must answer the complaint.

A third alternative for the defendant is to file a counterclaim. A **counterclaim** states a cause of action the defendant has against the plaintiff, such as failure to timely pay a hospital bill or comparative negligence on the part of the injured party. For example, if the plaintiff is suing for the improper casting of a broken arm, but failed to keep scheduled appointments to check the alignment of the fracture, the plaintiff could have contributed to the purported negligence.

Either side may then file amended or supplemental pleadings as needed. Amended pleadings correct or add new material to the original pleadings before the court; supplemental pleadings add to the statement of facts already before the court. For example, an amended pleading could be filed to correct a deficiency in the original pleading. Instead of stating that one injection had been negligently given to the plaintiff by the nurse-defendant, the amended pleading might state that two injections, at two separate times, were administered by the nurse-defendant and that both injections resulted in injury to the plaintiff. A supplemental pleading allows the original pleading to stand while supplying additional facts. For example, a supplemental pleading might be filed to bring a third party into the lawsuit.

Pleadings may raise questions of fact or law. If there are no questions of fact, the case may be decided by the judge merely upon the pleadings. Usually, there are a variety of questions of fact and law, necessitating a full trial with or without a jury.

Once the pleadings have been completed, either or both parties may move for a judgment based on the pleadings. Some state courts allow the party seeking a judgment based on the pleadings to introduce sworn statements as evidence showing that the claim or defense is false. Normally, a substantial controversy is involved, and the motion for a judgment based on the pleadings is denied.

Motions, formal requests by one of the parties asking the court to grant its request, may also be filed. Motions may include the need for a speedy trial date owing to the elderly status of the plaintiff or a major witness, the need for a later trial date owing to the length of time needed to obtain necessary documents, or the need for additional documents. Motions are supported with a written narrative, known as a *brief*, that sets out legal arguments for granting the motion. Motions are then argued before the judge, who issues a ruling regarding the motion.

Step Three: Pretrial Discovery of Evidence

State and federal courts allow parties the **right of discovery**, which permits:

1. witnesses to be questioned by the opposing side prior to the trial.
2. the finding of relevant written materials.
3. possible additional examinations of the plaintiff.

Because of the right of discovery, this step of the trial process may take up to two or three years to complete.

There are several methods of allowable pretrial questioning of witnesses. **Interrogatories** are written questionnaires mailed to opposing parties that ask specific questions concerning the facts of the case. Most states limit the number of questions on the questionnaire that a given party may be required to complete. Interrogatories must be answered under oath and returned within a time period that is set by state law.

Parties should not attempt to answer interrogatories on their own. Most attorneys instruct their clients to answer the questions as completely as possible on a separate sheet of paper. The attorneys then complete the interrogatory with their clients, appropriately objecting to objectionable questions, and wording answers so as not to suggest or admit liability. Clients should read the answers as completed carefully before signing and, because they are given under oath, make sure that the answers are true as stated.

A second means of obtaining witness testimony is through a **deposition**, which is a witness's sworn statement made outside the court that is admissible as evidence in a court of law. Depositions are taken of a witness, who is questioned by the attorney representing the opposing side of the controversy. The deposition's purpose is to assist opposing counsel in preparing for the court case by discovering potential testimony from witnesses before the trial.

One must not be fooled by the fact that a deposition is taken at an attorney's office with few persons present. A deposition is a crucial part of the discovery phase, and one must be alert to the questions being asked and their answers. The deposing witness is under oath during the entire deposition. The attorney representing the person deposed normally does not ask any questions during the deposition or take an active part in the deposition. The attorney for the deposing party already knows the extent of the testimony and does not need to reveal strategy to the opposing side.

Also, present at the deposition is a court reporter, who records all questions and answers exactly as they are stated. The deposing party will be allowed to see and read the final written document before signing it; the deposition then becomes sworn testimony. When reviewing the final copy, the deposing witness may correct typographical errors, such as the misspelling of a name, but may make no substantive change to the record, such as changing a previous "yes" answer to a "no" answer.

Deposing witnesses should give their attorneys sufficient time to object to the various questions, and time should be taken when answering each question. The witness may bring medical records, notes, and literature sources to the deposition, and may refer to them as needed during the deposition. Information should not be guessed, but the witness should ensure its accuracy before responding. This same information will be given in court.

An error that health care providers, including nurses, frequently make during depositions is giving too much information. Often, such information is given because the health care provider knows the right questions to ask and the essential information to elicit. Opposing counsel may not be as well versed and may have ignored an entire area of pertinent information during questioning. Do not assist opposing counsel by giving them the answers needed to pursue the case. That is the domain of attorneys, who have the ultimate responsibility to their clients.

A newer concept in taking depositions is to videotape the witness during the entire deposition rather than to record the deposition through a court reporter. If the witness giving the deposition has a pleasing personality and appears to be caring and compassionate on tape, playing of this type of deposition in court mimics the personal effect of a live appearance. It is the option of deposing parties (and their counsel) to choose this type of deposition.

An older case illustrates the danger of videotaped depositions. In *Parkway Hospital, Inc. v. Lee* (1997), the hospital's attorneys objected vigorously during the trial, asserting that the plaintiff's attorneys were trying to embarrass the hospital and prejudice the jury against the hospital by playing back pretrial videotaped depositions of the nurses who had cared for the injured patient.

In that case, a nurse had administered Pitocin to a patient in labor, causing the uterus to quickly rupture, and the infant was born with severe neurological injuries. The obstetrician claimed he had never ordered Pitocin. One nurse gave a videotaped deposition saying that there had been no order for Pitocin, but that the physician's routine orders were to be followed. This same nurse testified that she told the oncoming nurse at the change of shift that the physician's routine orders were to be followed. She also testified that she had never said anything about Pitocin or that it had been ordered.

The second nurse testified in her taped deposition that the first nurse told her to administer Pitocin, so she proceeded with the administration. These two depositions were played back to back at trial. The depositions were dramatic proof that the nurses were confused about the physician's orders and the ultimate care of this patient. The jury was led to conclude that negligence by the hospital's nursing staff caused a nurse to give Pitocin to a patient in the labor and delivery unit, especially since the medication had not been ordered by the patient's physician. The jury found that the physician had no liability in the case, but found liability against both the hospital and its nursing staff.

The court ruled it was a perfectly acceptable trial tactic to place into evidence the conflicting testimony of two different agents of the same defendant. The court also upheld the showing to the jury of an 11-minute videotape that showed the child attempting to walk forward and backward, draw on a piece of paper, and talk, to demonstrate graphically the profound limitation in the child's motor control and functional abilities.

Taped depositions are frequently reserved for witnesses who will not be present for the actual trial. For example, witnesses who are outside the jurisdiction of the court or who may be unavailable during the time of the trial hearing may choose to have their depositions videotaped. Although the same evidence could be read at trial from a traditional deposition, the impact of having the witness in the courtroom setting via a taped deposition carries much more weight with the jury. Additionally, depositions serve to uncover facts for the opposing side and to perpetuate the testimony of witnesses. Elderly witnesses or very ill witnesses may actually have their testimony preserved for trial through pretrial depositions.

Either side in the controversy may also obtain and examine copies of the medical records, business records, x-ray films, and the like through a request to produce documents. The court may also require a physical or mental examination of a party through a request for an independent medical examination of the plaintiff, if the medical information so obtained is pertinent to the case. Either party may object to these requests based on grounds that they are unduly burdensome, seek confidential or privileged information, or are protected as part of the attorney's work product. Generally, the scope of discovery is large, and parties are allowed to discover all relevant materials that would be admissible in the subsequent trial.

During the discovery phase, both sides decide on their strategy for the subsequent trial and interview the witnesses they need to testify in court. Both sides also obtain evidence to submit at trial in the form of x-ray films, medical records, consultation reports, and other tangible items that affect the case. Individual states may also dictate if pre-trial certifications or pre-suit service of a qualifying expert report are mandated by state law. For example, the Tennessee Court of Appeals disallowed a malpractice lawsuit when the patient's attorneys failed to file a state-required pretrial certification that an expert opinion existed (*Thibodeau v. St. Thomas*, 2015). In *Hebner v. Reddy* (2016), a similar outcome occurred when there was no pre-suit service of a qualifying expert report as mandated by Texas state law.

The final phase of the pretrial discovery of evidence is a **pretrial conference**, or **pretrial hearing**. This is a fairly informal session during which the judge and the representing attorneys agree on the issues to be decided and settle procedural matters. The pretrial conference may result in a finalization of a **settlement**, which is favored by the judicial system because it allows for a quick resolution. A settlement is not synonymous with the admission of guilt or liability, but is a means of allowing the parties to forgo the trial process and settle for an agreed-upon dollar figure. Included among the many reasons for settling a case prior to trial are the expense of the trial process, lengthy delays in reaching a trial date, emotional and physical drain on an already injured plaintiff, uncertainty of the jury trial process, and the nature of

the harm complained of and its potential ability to shock a jury. As the case below illustrates, a final reason for a settlement may be because there is no adequate means of defending prior actions.

An example of a case that was settled prior to a court determination was *Ballard v. Henry* (2007). In that case, the patient presented to the hospital in active labor, two weeks before she was scheduled for her third cesarean section. She had a fever of 101.3 degrees, which did not abate despite active Tylenol therapy. A fetal monitor was placed, showing that the fetal heart rate was 170 beats per minute. During the next four hours, the fetal heart rate was recorded as 170 to 180 beats per minute. The neonate, who was diagnosed with moderate right-sided hemiparesis and cognitive impairment from cerebral infarctions and is today developmentally delayed, was finally delivered approximately seven hours after the patient was admitted. The main issue for the court was why an immediate cesarean section was not done, given the mother's presenting symptoms and the fetal heart rate. The defendants elected to settle the case before the trial was initiated. Sometimes the reason to settle out of court is that the case is indefensible. For example, in *Estate of Wells v. White House Healthcare* (2009), the patient was a resident in a skilled nursing home. The resident had a long history of pulmonary emboli and was in the facility for rehabilitation following knee surgery. Eight days after the surgery, her laboratory results showed an unexpectedly high level of clotting, indicating that the dosages of Coumadin should have been increased. The resident's nurse, however, never contacted the physician or forwarded the laboratory results, and the resident died two days later, having experienced a large pulmonary embolus.

After the resident's death, the nurse ensured that the laboratory results were placed in the chart, forged a progress note to the effect that she had timely contacted the physician, and noted that the physician had ordered no increase in the Coumadin dosage. The facility basically admitted the error and settled out of court for $900,000 in exchange for the family dropping the lawsuit that they had already filed in the superior court.

Step Four: The Trial

At the **trial**, the evidence is presented, facts are determined by the jury, principles of law are applied to determined facts, and a solution is formally reached. Evidence is usually presented through various witnesses' answers to specific questions. The jury relies on the testimony and credibility of the witnesses in determining the facts of the case.

If a jury trial has been requested, the trial begins with the selection of the jury, or **voir dire**. Attorneys representing both sides to the controversy question a panel of qualified persons and a 4-, 6-, or 12-person jury is selected and sworn in by the judge. In some jurisdictions, parties to the lawsuit may be allowed to stipulate a jury of six rather than the more traditional jury of 12 persons. If no jury is requested or mandated by law, the judge serves as both judge and jury.

After jury selection, both sides make their opening statements. **Opening statements** generally indicate for the jury what each side intends to show by the evidence it presents. Because the plaintiff has the legal burden of proof to show not only that an incident occurred but also that the incident did in fact cause the plaintiff's injury, the plaintiff's attorney has the first opening statement.

Witnesses are then called, one by one, to answer specific questions. The witnesses are directly questioned first by the attorney calling the witness. The opposing side then has the opportunity for **cross-examination**, during which the questioning attorney attempts to discredit or negate the witness's testimony. The attorney originally calling the witness may then ask additional questions in an attempt to re-establish the credibility of the witness once the cross-examination is concluded.

The **level of evidence** or **standard of proof** that is presented at trial often depends upon the type of case being tried. The standard of proof required in a legal action depends upon "the degree of confidence society thinks one should have in the correctness of factual conclusions for a particular type of adjudication" (*Addington v. Texas*, 1979, at 423). Another way of expressing the standard of proof is what is necessary to convince the judge and/or jury that a given proposition is true and to "minimize the risk of an erroneous decision" (*Addington v. Texas*, 1979, at 425).

In civil court cases, the standard of proof is **preponderance of the evidence**. Preponderance of the evidence is based on the probable truth or accuracy of the evidence presented, not on the amount of evidence. The judge or jury must be persuaded that the facts are more probably one way than another way. Thus, one clearly knowledgeable witness may provide the preponderance of the evidence over other witnesses who have merely a general idea of what occurred. Likewise, a signed agreement with definite terms and definitions will provide the preponderance of the evidence over witnesses' speculations of what may have been intended. Note that this level of evidence remains subjective, despite a witness's best efforts to be as objective as possible.

The intermediate standard of proof is **clear and convincing** evidence. This standard of proof was defined as **proof beyond a reasonable doubt**, which is "proof that a fact is almost certainly true, while clear and convincing evidence means simply proof that a fact is highly probable" (*Allen v. Bowen*, 1987, at 152). For most courts, this is the highest level of proof that can be applied in a civil case and is generally the standard of proof seen in cases involving withdrawal of life-sustaining measures. *Cruzan v. Director, Missouri Department of Health* (1990) remains the classic case where this level of evidence was required. This level of evidence was supported, in the court's view, as the right to life is a fundamental interest, the person whose life was in question could not protect herself, and the extent of harm was irreversible. Chapter 9 presents more detailed information concerning this case and withdrawal of life-sustaining therapies.

The highest level of evidence is **proof beyond a reasonable doubt** and is generally the standard required in criminal cases. This means that the proposition presented by the government must be proven to the extent that there is no "reasonable doubt" in the mind of a reasonable person that the defendant is guilty of the crime with which he or she is charged. Doubts can linger, but only to the extent that these doubts do not affect a reasonable person's belief that the defendant is guilty as charged.

> The reasonable doubt standard plays a vital role in the American scheme of criminal procedure. It is a prime instrument for reducing the risk of convictions resting on factual error. The standard provides concrete substance for the presumption of innocence—that bedrock. . . . principle whose enforcement lies at the foundation of the administration of our criminal law (*In re Winship*, 1970, at 358).

Note that the courts may also enact other rules or **levels of evidence** at trial. An example of an additional rule of evidence that may be seen in malpractice trials concerns rules of evidence to encourage improvements based on adverse experiences. Such a rule of evidence is that subsequent remedial measures undertaken after an event are not admissible to show liability for the event. The purpose of this rule of evidence is to encourage individuals of an organization to candidly evaluate injury-producing events and to implement safeguards to prevent the same or similar events from recurring in the future.

A case that illustrates this rule of evidence is *Alfieri v. Carmelite Nursing Home, Inc*. (2010). In that case, a 91-year-old nursing home resident fell and broke her hip, resulting in surgical replacement of the hip and an extended hospital stay. The resident then filed this lawsuit, which was continued by family members after her death. During the deposition taken from the nurse who had cared for the resident at the time the resident fell, it was disclosed that the nurse had received retaining following the event. The resident's lawyers planned on introducing this retraining at trial to show that there were deficits in the nurse's care of the resident and that the retraining was undertaken to correct this incompetency.

The court noted that it is not necessarily true that such retraining indicated incompetency on the part of the nurse in the resident's care. The caregiver in question may have exercised all the due care that the law requires and that the retraining was merely a measure of caution given that there had been an unexpected accident. Such precautions taken after the fact are not legitimate proof of negligence at the time of the event.

Once the issue of the level of evidence is decided, the plaintiff presents his or her side of the case through the oral testimony of his or her witnesses. The plaintiff's side then rests the case, meaning that it has attempted to meet the burden of proof and has legally established its cause of action. At that point, the defendants' attorneys may petition for a directed verdict, indicating from their perspective that the plaintiff has failed to present sufficient facts on which to decide the case in the plaintiff's favor. This motion for a directed verdict is typically overruled, and the defendants then call their witnesses one by one to present their case to the jury.

At the conclusion of the defendant's entire case, both sides or either side may again move for a directed verdict. If these attempts are overruled (and they traditionally are), the attorneys make their final arguments, and the judge instructs the jury as to their charge and the principles of law involved. This last step varies greatly from jurisdiction to jurisdiction. The jury then retires to deliberate and to reach a **verdict** (decision).

If the verdict that the jury reaches is against the weight of the evidence, the judge may elect to disregard the verdict and determine the ultimate verdict. For example, in *Boxie v. Lemoire* (2008), the jury returned a verdict of no negligence on the part of the defendants. The case involved a patient who had cervical spinal surgery in the not-often-used seated position, where members of the surgical team needed to continuously evaluate the patient for chin-to-sternum clearance. During the surgical procedure, the patient suffered a stroke when his carotid artery blood flow became compromised. The judge found that there was negligence on the part of the surgical team and disregarded the jury's verdict.

Once the verdict is known, the losing side may move for a new trial. If the motion is granted, the entire trial is repeated before a new jury panel. If it is denied, the judgment becomes final, and the losing side may appeal to the proper appellate court if there are legal grounds for such an appeal.

A case example illustrating legal grounds for an appeal is *Pivar v. Baptist Hospital of Miami, Inc.* (1997). In that case, an elderly patient had been hospitalized for several days following hip replacement surgery. The patient was known by the nursing staff to waken several times during the night with the urgent need to arise and go to the bathroom. On the night of the patient's fall, she awoke, feeling the urgency to urinate, and rang her call bell. When no one responded to the call bell, the patient got out of bed by herself and used her walker to get to the bathroom. She placed the walker next to the toilet and transferred herself to the toilet. When she finished urinating, the patient rose, took a step toward the walker, and fell on the water that still remained in the bathroom from an earlier shower.

Detailed for the court was the institution's procedure for showering a patient who had a recent hip replacement. The last part of the procedure was that the nurse assisting the patient is to return to the bathroom once the patient is safely back in bed and clean up any water that may be on the floor from the shower.

In the patient's civil lawsuit against the hospital, the trial judge exercised his prerogative to dismiss the lawsuit without submitting the issues to the jury. The District Court of Appeals held that the trial judge was guilty of a legal error, because there were valid grounds for a civil negligence suit against the institution.

Specifically, the Court of Appeals held that a hospital is "legally bound to exercise such reasonable care as the patient's condition may require, the degree of care in proportion to the patient's known physical and mental impairments" (*Pivar v. Baptist Hospital of Miami, Inc.*, 1997, at 277). Applying this concept to the current case, the court held that it was the nurse's responsibility, given the patient's unsteadiness on her feet and her propensity to use the bathroom unaided when she felt an urgency to urinate, to ascertain that the water had been wiped up after the evening shower and to document that fact in the nursing notes.

EXERCISE 2–2

Jedidiah Monroe sued Thomas Smith for malpractice, stating that he was given an oral medication by Nurse Smith and that he then suffered a severe allergic reaction to the medication. What additional information might cause the court to enter a directed verdict for the plaintiff?

Step Five: Appeals

The appropriate appellate court reviews the case based on (1) the trial record, (2) written summaries of the principles of law applied, and, in many states, (3) short oral arguments by the representing attorneys. Depending on the outcome at the intermediate appellate level, the case may be eventually appealed to the state supreme court. Once decided at this highest level, the judgment typically becomes final, and the matter is closed. Though cases may be appealed to the U.S. Supreme Court, this is rare in medical malpractice cases.

Step Six: Execution of Judgment

Most lawsuits involving nurses result in one of two possible conclusions: the awarding of money damages against the nurse-defendant or the dismissal of all causes of action against the nurse-defendant. Nothing can return plaintiffs to their original, pretrial status, and the American judicial system attempts to compensate plaintiffs (if the evidence supports compensation) with money damages. Other forms of conclusion include an **injunction** requiring the nurse-defendant to either perform or refrain from performing a certain action and a restraining order.

Restraining orders may be granted when preventing an ongoing action is the only logical outcome to the facts as presented. A case example is *Johnson v. Berg* (2008). In this case, the judge enacted a restraining order against the daughter of a nursing home resident, preventing her from any further communication or contact with the nursing home management and staff. The court's decision was based on a finding that the daughter's conduct met the legal definition of harassment.

A family member, noted the court, has the right to consult with caregivers, to voice his or her opinions, and to advocate for alternatives. However, the situation in this case went far beyond reasonable advocacy and became harassment. The resident's daughter repeatedly sent harassing letters of complaint to the nursing staff and followed up with harassing phone calls to staff members. She verbally accused the administrator face-to-face on at least six different occasions and personally interfered with the care of other residents. On one occasion, a security guard had to remove the daughter from the facility. While being bodily removed, she screamed at the nurse and waved some legal appearing papers in the nurse's face, causing the nurse to fear for her personal safety. On another occasion, she phoned the nursing station and demanded that the nurse who took the phone call conduct an immediate review of her mother's care plan to determine if her mother had been assisted to the restroom no later than 7:00 that morning. That was but one of a long series of repeated, angry, demanding, and demeaning phone calls and letters, which finally forced management to file a lawsuit for the restraining order. The court concluded that the nursing home was entitled to a restraining order so that the daughter would cease and desist from further harassing conduct.

After all appeals, the plaintiff will ask that the judgment as provided for by the court be executed. This procedure gives legal relief to the plaintiff if a losing defendant chooses to ignore a court order. If an injunction has been mandated by the court, the defendant may be fined or imprisoned if the injunction is not fulfilled.

A case example of the use of an injunction in a medical context is *Wyckoff Heights Medical Center v. Rodriquez* (2002). In that case, a patient with quadraparesis who had non-insulin dependent diabetes had been admitted to an acute care facility after his home care was discontinued by the local visiting nurses association. The visiting nurses refused to provide further care because of his violent, threatening, and harassing behavior toward the home health aides who either treated him or attempted to treat him. Ten days after his admission, his medical evaluation indicated that he needed no further acute hospital care and he was discharged.

The hospital found him a placement in an adult home. The patient refused to enter the adult home, and the hospital filed suit seeking a mandatory injunction requiring him to leave the hospital voluntarily or, in the alternative, allow the hospital the legal authorization to have him transported to the adult home. The Supreme Court of New York issued the injunction, noting that the very purpose of an acute care hospital is in jeopardy when a patient who no longer requires acute care services refuses to leave, thereby preventing patients who do require the acute care from using the space to receive inpatient care. The court also noted that it would be pointless for the hospital to sue this patient for the money that his continued stay cost. The court concluded by noting, "To evict a person from the hospital who does

require a certain level of professional care is a drastic step, but the patient's unreasonable conduct is equally drastic" (*Wyckoff Heights Medical Center v. Rodriquez*, 2002, at 404).

For a default judgment or money damages award, the defendant's wages may be garnished (i.e., a certain amount of money is taken from the defendant's earnings and given to the winning plaintiff on a weekly or monthly basis) or property may be confiscated and sold to pay the amount of the award. Not all states apply garnishment laws in the same manner, and some states have restrictions on the type of property that may be confiscated. As a result, the execution of judgment varies from state to state.

Expert and Lay Witnesses

Lay Witness

Most nurses are aware of the expert witness status. Equally important in the judicial system is the **lay witness**, who establishes facts at the trial level, stating for the judge and jury exactly what transpired. The lay witness is allowed to testify only to facts and may not draw conclusions or form opinions. Lay witnesses define for the jury what actually happened. Both sides to the controversy will present lay witnesses who attempt to describe for the jury what, when, and how a particular event occurred. The lay witness thus has a direct connection with the case in controversy. Lay witnesses at trial include patients, patient's family members, nurses not named in the lawsuit, and other interdisciplinary staff members. In *LeBlanc v. Walsh* (2006), family members served as lay witnesses to testify that the patient's back and bed linens were completely soiled with blood immediately before the patient coded. The jury discounted the nursing personnel version that the only visible blood was the approximately 5 to 10 cc of fluid in the drain reservoir immediately prior to the patient's code.

Nurses may be called to serve as lay witnesses. In *Glasscock v. Board* (2015), a telemetry technician asked the nurse to check the patient's leads. The nurse determined that the patient was unresponsive and immediately called a code, but the patient did not survive. In the subsequent lawsuit, the nurse testified in her own defense, stating that it was her practice to always check a cardiac telemetry patient's leads each and every time she interacted with the patient. It was also her practice to glance frequently at the monitor screens. She further testified that she had accomplished these same interventions for this patient. The jury concluded from the nurse's testimony and other evidence as presented at trial that the patient's leads had been correctly attached at all times.

Expert Witness

The second type of witness, the **expert witness**, explains highly specialized technology or skilled nursing care to the jurors, who typically have little or no exposure to medicine and nursing. Expert testimony is required when conclusions by a jury depend on facts and scientific information that is more than common knowledge. The court in *Sawicki v. Katzvinsky* (2015) distinguished between lay and expert witnesses. In that case, a nursing technician assisted a post-operative knee replacement surgical patient to the toilet. The toilet had a raised seat and the patient cried out "Whoa" as she sat down, due to the fact that the raised seat was unstable and swayed side to side. The technician assured the patient that she would be all right and left her alone. When the patient leaned to her side, the seat collapsed, she fell, and was severely injured. The court noted that a jury would not need expert witness testimony to decide whether it was negligent to allow someone to use a raised toilet seat that was obviously unstable and capable of being dislodged. However, expert testimony concerning the patient's fall-risk assessment would be required to determine whether the patient was able to use the commode without stand-by assistance and could safely be left alone to call for assistance once she was ready to walk back to her bed.

Similarly, *Trowell v. Providence* (2016) concluded that no expert witness testimony is required where the caregiver's negligence is so obvious that it amounts to ordinary as opposed to professional negligence. Nor does the fact that a registered nurse was assisting the patient make a case of professional negligence requiring expert testimony on the standard of care (*Byrom v. Douglas*, 2016). In that case, the patient normally used a cane for ambulation. A nurse used a wheelchair to transport the patient to a treatment room where the patient stood and was able to safely return to the wheelchair independently. When the nurse was then moving the patient back to her hospital room, the patient attempted to stand, her pant leg became entangled in the foot pedal, and the patient fell, breaking her leg. The court noted that individuals with no medical training often assist persons in wheelchairs, and the patients exit the chair safely. Thus, no expert witness testimony was needed in this case.

However, when additional clarification is needed for the jury to understand facts that are not generally viewed as common knowledge, the use of an expert witness is required for the cause of action to proceed. For example, in *Little v. Riverside* (2016), a patient fell while attending a cook-out on the grounds of a facility where she was participating in an inpatient substance abuse rehabilitation. The court noted that this was not a simple slip-and-fall case, but one that stemmed from the provision of residential treatment services in a health care facility. Thus, the legal liability for injury to a patient in such a case required an expert opinion as to the standard of care for the particular treatment the patient was undergoing.

The use of nurses as expert witnesses has evolved since the late 1970s and early 1980s. Before that time, physicians served as nursing's voice and testified at court regarding the role and accountability of professional nurses. Two precedent court cases in 1980, one in North Carolina and one in Georgia, set the stage for acceptance by the court

of nurses serving as expert witnesses in defining the role of nursing (*Maloney v. Wake Hospital Systems*, 1980; *Avet v. McCormick*, 1980). In *Maloney,* the court held that "the role of the nurse is critical to providing a high standard of health care in modern medicine. Her expertise is different from, but no less exalted than, that of the physician" (1980, at 683). The court in *McCoy v. Serna* (2016) again iterated that a physician was not qualified to give opinions regarding nursing standards of care. Here the patient had a fractured hand casted by a physician. Subsequently the nurse practitioner recommended an x-ray to confirm proper placement, but the patient elected not to have the x-ray due to financial concerns. The nurse practitioner then assured the patient that the x-ray was probably not essential and that it could be postponed until the cast was removed, some eight weeks later. When the cast was ultimately removed, the x-ray revealed that the fracture had not healed properly and additional surgery was required.

At trial, the patient's medical expert who testified regarding the nursing standard of care was an orthopedic surgeon. Though he had lectured extensively to nurses regarding orthopedic issues, that did not make him an expert on the standards of care for a nurse practitioner and thus the nurse was dismissed from the patient's lawsuit.

Similarly, in *St. George v. Plimpton* (2016), the court decreed that a physician, simply by virtue of being a physician, is not qualified and thus cannot testify on nursing standards of care.

Likewise, courts have held that a nurse may not testify as an expert witness about the medical standard of care. In two cases, *Stryczek v. Methodist Hospital, Inc.* (1998) and *Taplin v. Lupin* (1997), the court ruled that a nurse is not legally qualified to render an opinion about a medical diagnosis. There is, in the words of the *Stryczek* court, "a significant difference in the scope of nurses' and physicians' legal authority with respect to diagnosis and treatment" (1998, at 697). A few courts, though, have reached different conclusions. The court in *Detloff v. Absecon Manor* (2009) concluded that courts across the United States are seeing a wider role for nurses in medical litigation and that nurses can testify regarding medical cause and effect. That case concerned adequate fall-prevention care and the role that post-injury immobility contributed to the development of decubiti ulcers, sepsis, and the patient's ultimate death. *Freed v. Geisinger Medical Center* (2009) reached a similar conclusion, stating that a nurse, if qualified through education and experience, is not barred from recognition as an expert in the legal arena merely for being a nurse and not a physician.

Note, though, that the court will not allow a nurse or physician to testify if it can be shown that the witnesses have no expertise in the specifics of the care in question. In *Christus Spohn v. Castro* (2013), the 50-year-old patient sued after he developed a pressure ulcer on his coccyx while hospitalized following a rollover truck accident. In the accident, the patient sustained a dislocated cervical spine, rib injuries, and a collapsed lung. In support of his lawsuit, the patient filed extensive expert reports prepared by both a nurse and a physician who were geriatric specialists with extensive professional experience in the prevention and care of pressure ulcers in elderly nursing home patients. The hospital objected to their expert opinions and the court agreed, noting that their expertise in the care of geriatric patients in nursing home settings did not necessarily translate into expertise in the care of an adult paraplegic trauma patient recovering in an inpatient intensive care unit. The minimum credential for a nurse expert witness is current licensure to practice professional nursing within a state or territory and experience in the area of practice germane to the lawsuit or a background in academic nursing (*Houston v. Phoebe Putney Memorial Hospital*, 2009). Other criteria for selection include total lack of involvement with the defendants either as an employee or consultant, clinical expertise in the area of nursing at issue, certification in the clinical area if possible, and recent continuing or formal education relevant to the specialty of nursing at issue. For example, in *Columbia Valley v. Zamarripa* (2015), the court allowed an expert nurse witness to testify regarding labor and delivery nursing standards of care even though she was then practicing in another clinical area. What was important, said the court, was that she had recently worked in labor and delivery. Ideally, the expert witness should also have earned graduate degrees and authored publications in nursing. Some attorneys will substitute status as a nurse manager, nurse educator, or preceptor for advanced degrees. It is ultimately the role of the trial judge to decide whether an expert witness possesses adequate skill, training, education, knowledge, and/or experience to serve as an expert witness in a specific lawsuit (*People v. Munroe*, 2003).

The purpose of these criteria for the nurse expert witness is to display for the jury that the nurse is well qualified to be an expert witness. Therefore, credentials that speak to the highest level of nursing expertise and knowledge of the appropriate standard of care weigh favorably with judges and jurors. Such criteria also further ensure the objectivity of the nurse expert. Expert witnesses who have either worked for the defendant institution or who are associated with defendant nurses on a personal level may be seen as giving subjective testimony. Such subjective testimony is most likely to result in a verdict for the plaintiff and against the defendants.

A case that illustrates this point is *Landry v. Pediatric* (2016). In that case, during questioning as a potential juror for a medical malpractice case, a nurse revealed that she had previously worked at the defendant hospital and had been involved in the actual care of the plaintiff. On appeal, the case was remanded to the trial court for determination of any possible prejudicial effect that her service had on the outcome of the case.

When nurses are first contacted about the possibility of serving as expert witnesses, they should consider

some guidelines. First, is the case of interest to them and is it in their area of current expertise? Second, all materials sent should be reviewed carefully and a determination made whether a standard of care has been upheld or breached. The nurse should not put thoughts and opinions in writing at this stage because such writings may be viewed by both sides to the controversy. Formal writings can be done once the position of expert witness has been confirmed. Third, the nurse should decide on the fee schedule before proceeding. Acceptable fee schedules can be determined by the geographic area and whether the nurse will appear at trial. Finally, the nurse should know the time frames for discovery and the actual court trial so that the expert witness can be available for an extended period of time, if that is foreseen or may be a possibility.

GUIDELINES

For Testifying as an Expert Witness

1. Personal characteristics are important. Be attentive and alert. Look at the person asking the question, showing that you are giving great thought to what is being asked and are interested in what is being asked of you. Do not try to impress anyone. Use normal, conversational language, and refrain from using jargon or "hospital talk." The judge and jury must be able to understand your answers and relate them to the issues as presented.
2. Time must be taken when considering the answer to each question. Once spoken, an answer cannot truly be retracted. Ensure that you understand the question before answering or ask that it be repeated or rephrased. Remember that not all questions are valid; give your attorney time to object to the question. Objections after an answer is given serve little value in jurors' minds.
3. A favorite ploy of opposing counsel is to fluster, confuse, or anger an expert witness. Such ploys may prevent a clear and concise answer and may cause you to blurt out the first thought that enters your mind. All answers must be considered carefully, giving only the information that answers the question. The battle being played out in court is about the facts of the case, not about people and personalities. Remain as objective as possible, take a deep breath if needed, and answer objectively, not defensively. Strive to portray an individual to whom the judge and jury will want to listen.
4. Remember that there are several ways to accomplish any given intervention. The selection of an alternative approach does not equate with substandard care. Do not allow yourself to be backed into a corner where only one means of implementing an intervention is correct. Keep your options open, and iterate that any of these approaches could have been selected.
5. Ensure that interventions as presented were appropriate at the time of the occurrence, not at the time of the court case. The expert witness should not be manipulated into discussing current practice standards, because they are most likely not reflective of the standard at the time the incident occurred.
6. Testimony previously given during a deposition is sworn testimony and cannot be changed at trial. If you are unsure of your previous testimony, such as quoting the patient's blood pressure or pulmonary wedge pressure, verify the information before speaking. You may refer to your deposition or to the patient record before responding. If the answers are different, the next question by opposing counsel will inevitably be, "Tell me, nurse, are you lying now or were you lying before?" Either answer destroys all credibility you may have had with the jury.
7. The expert witness should answer only what pertains to nursing, a nursing role, or standards of nursing care. If you cannot answer the attorney's questions without testifying to medical standards, then say it is outside the scope of nursing and you cannot answer. You may ask the attorney to rephrase the question so that it pertains to nursing standards of care.
8. Remember to dress appropriately, in a suit or more conservative attire, because appearances make a valuable first impression with the jury. Look at the jury as you give your answers, thus showing your sincerity and knowledge.
9. Give only enough information to answer the question. If a simple yes or no will suffice, stop after stating yes or no. Frequently, nursing experts damage their credibility by trying too hard to ensure that the jury is aware of their knowledge base. The jury will already know that the expert is knowledgeable by the introduction of your credentials.
10. If opposing counsel asks if you are being paid to appear and testify, the answer is yes. However, stress that the payment is not for testimony, but for any provisions or inconveniences you had to make to be in court, such as travel to a distant court, lost work hours, child care, and review of pertinent facts and standards. The difference is subtle, but extremely important.
11. Expect opposing counsel to question your credentials. Remember, they are trying in every way possible to lessen the weight of your testimony in the eyes of jurors. Rather than credentials, it may be ethics that are attacked, such as a question asking if you had solicited the attorney of record for the opportunity to testify.
12. Be positive in your answers. Do not predicate your answers with "I believe," "I think," or "in my opinion." These are words of equivocation that impair your credibility as a witness.
13. Remember the three Cs of testifying: Be calm, courteous, and consistent in your demeanor.

An expert witness may also serve as a **legal consultant** whose name is not revealed to the opposing side and whose reports or comments are not disclosed. Nurses who are named as expert witnesses should understand that their reports and comments are discoverable by counsel on both sides of the controversy.

When the need for an expert witness arises, both sides in the controversy retain their own experts. Testimony is generally in the form of opinions and answers to hypothetical questions. This practice has evolved because expert witnesses have the ability to analyze facts presented and to draw inferences from those facts, something the lay witness is not allowed to do.

Once selected as an expert witness, the nurse is prepared for this role by the attorney. Legal doctrine or state procedural rules that pertain to the individual case are discussed. Each nursing expert witness should review the following:

- The facility or area where the incident occurred, to identify special environmental factors and the location of the patient in relation to needed equipment, medications, and staff
- The state nurse practice act and any relevant rules that the board of nursing may have promulgated
- Relevant nursing literature to ensure the status of acceptable practice at the time of the occurrence
- The applicable nursing process of the institution during the time of the occurrence
- All written records pertaining to the incident or that may have implications for assessment, planned actions, implementation, and evaluation of the incident
- Supportive management records and/or patient classification acuity records
- Support functions provided by the institution for nursing

Each of these has implications for the applicable standard of care during the incident.

Unfortunately, the number of malpractice and disciplinary actions against nurses continues to increase (Phillips, 2017). The role of the expert nurse is therefore becoming more vital. The role of expert nurse witnesses is anticipated to continue to increase in importance as nurses testify not only in malpractice cases, but in custody and abuse cases.

Nurses are the only professionals with the competency, credentials, and right to define nursing or to judge whether the appropriate standard of care has been delivered. As nurses come forward to assume this role, the system will adjust to incorporate them and to actively solicit their professional testimonies.

EXERCISE 2–3

List three possible instances in which no expert witness testimony is needed to assist the jury in their deliberations. An example: Mr. Gonzales is an elderly man who was admitted to the general surgical unit from the postanesthesia care unit. Earlier in the day, he had surgery to remove his gallbladder. After his admission, Mr. Gonzales fell out of bed, breaking his knee and right wrist. Judy, his primary care nurse, admitted leaving both siderails down and the bed in its highest position.

Summary

- There are six procedural steps in any lawsuit:
  1. the initiation of the lawsuit
  2. pleadings and pretrial motions
  3. discovery of evidence
  4. trial process
  5. appeals
  6. execution of judgment.
- Alternate dispute resolution, including mediation and arbitration, can be a means of settling a lawsuit outside the courtroom.
- Pleadings are written documents setting forth the contentions of the parties to the lawsuit.
- Discovery of evidence includes interrogatories, written questionnaires mailed to opposing parties to a lawsuit, and depositions, which are witnesses' sworn statements made outside a courtroom that are admissible as evidence in a court of law.
- Depositions serve to uncover facts for the opposing sides of a lawsuit and also to preserve the testimony of witnesses.
- Settlements may occur during the third phase of the trial process, serving as a quick resolution to the dispute.
- During the trial process, evidence is presented, facts are determined, principles of law are applied to determine facts, and a solution is reached.
- The level or standard of evidence presented during the trial process includes:
- Lay witnesses establish facts for the judge and jury, defining what actually happened.
- Expert witnesses explain highly specialized technology and skilled nursing care for the judge and jury, so that they can reach a conclusion based on the evidence presented.

You be the Judge

The 82-year-old patient was assessed as not a high fall risk when she was admitted to the nursing home. On her fourth day, a nursing assistant found the resident on the floor of her room at 4:00 A.M. The resident had a broken arm and was transferred to an acute care facility for treatment. At the acute care hospital, the resident was diagnosed with a *C. difficile* infection and she died from the infection 10 days later.

The family's lawsuit contended that the nursing home's negligence caused the resident's fall and that the broken arm from the fall caused her ultimate death. At trial, the family's expert witness argued that a bed alarm should have been implemented for this resident. Additionally, the resident should have used her specially fitted orthotic shoes at all times when ambulating.

Questions

1. Was an expert witness needed for the jury to understand the issues being tried?
2. Were the two issues that the expert witness raised germane to the resident's ultimate care?
3. What questions regarding the expert witness's expertise and clinical background might be raised by the defendant nursing home?
4. How would you decide the appeal?

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PART II Ethics in Nursing Practice

CHAPTER 3
Introduction to Ethics

Learning Objectives

After completing this chapter, you should be able to:

3.1 Compare and contrast the different ethical theories that underlie ethical nursing practice.

3.2 Contrast law from ethics.

3.3 Apply the ethical principles of autonomy, beneficence, nonmaleficence, veracity, fidelity, justice, paternalism, and respect for others to nursing practice settings.

3.4 Analyze the roles of hospital ethics committees and ethics grand rounds.

3.5 Evaluate the concept of organizational ethics and explore strategies for implementation of organizational ethics in everyday clinical settings.

Preview

Nurses, in all practice arenas, continue to be confronted with the interplay between ethical and legal concepts, often asking themselves if the legal rights of the patients have been fully protected while also being sensitive to the individuals' ethical rights. Though it may seem that these are two wholly separate entities, in reality legal and ethical issues often intertwine, greatly affecting professional practice. Nurses must be knowledgeable about both concepts so that the legal and the ethical rights of patients are protected and advanced.

Nurses continue to struggle with complex ethical concerns, including how to best ensure that the ethical issues of all involved persons are considered and evaluated. Though some of these decisions may seem clearer and more easily made than others, all ethical situations demand considerable reflection and evaluation. Nurses often find themselves trapped in the midst of ethical dilemmas among physicians, patients, family members, and even their own peer group. This chapter explores the distinction between law and ethics, describes the various ethical theories and principles employed in health care settings, and highlights the importance of institutional ethics committees and organizational ethics.

Key Terms

act deontology
act utilitarianism
applied ethics
autonomy
autonomy model
beneficence
compensatory justice
concept of double effect
deontological theories
descriptive ethics
detriment-benefit analysis
distributive (social) justice
duty ethics
ethical grand rounds
ethics

ethics committees
fidelity
justice
metaethics
nonmaleficence
normative theories
organizational ethics
paternalism (parentialism)
patient benefit model
principlism
relational ethics
respect for others
retributive or correctional justice
rule deontology
rule utilitarianism
situation ethics
social justice model
teleological theories
utilitarianism
veracity
virtue ethics

Definitions of Ethics and Values

Ethics is the branch of philosophy concerned with evaluating human action. Derived from the Greek word "ethos" meaning character, customs, or habitual uses, ethics encompasses a process of distinguishing right conduct from wrong conduct. A broader conceptual definition is that ethics involves the principles or assumptions underpinning the way individuals or groups ought to conduct themselves; ethics is concerned with motives and attitudes and the relationship of these attitudes to the individual. Many people envision ethics as dealing solely with principles of morality, defining ethics in terms of what is good or desirable as opposed to that which is bad or undesirable. In such a context, morality incorporates norms about right and wrong conduct into everyday social agreement (Beauchamp & Childress, 2013). Thus, morals and ethics might be viewed as interchangeable.

A more deliberate way of viewing morals encompasses the idea that morals are personal principles that are acquired from life experiences, family and peer relationships, religion, culture, and the law. Morals are generally seen as appropriate for more routine decisions, but inadequate for resolving the more complex issues arising in clinical practice settings (Phillips, 2006). Ethics, what is right or wrong based on reason, can be distinguished from morals, what is considered right or wrong based on social custom. Thus, ethics describes conduct or principles, whereas morals actually propose restrictions on what may be considered appropriate behavior (Barrocas, Yarbrough, Becnel, & Nelson, 2003). In this context, ethics provides structure for placing conduct into action. As Levine (1977) noted over 40 years ago, ethical behavior involves how individuals communicate and react to each other in everyday encounters.

Using the broader conceptual definition interweaves values with ethics. Values are personal beliefs about the truths and worth of thoughts, objects, or behavior. Videbeck (2004) described values as "abstract standards that give a person a sense of what is right and wrong and establish a code of conduct for living" (p. 4). Such abstract standards may include honesty, hard work, truthfulness, and sincerity. Values are usually derived from societal norms, family orientation, and religion; as one matures, values may change. Values are individual components of values systems, which may be distinguished into personal, professional, and societal value systems. Ultimately, one's values help determine the actions that one takes in his or her everyday life. To more fully understand one's own values, value clarification, a process aimed at understanding the nature of one's own value system and its vast impact on the individual, should be undertaken.

Ethics, like values, is individualistic. One's values and ethics are fashioned by previous experiences, education, and the environment. It is essential to remember that nurses' ethics and values are just as individualist as patients' ethics and values. How one views ethics may also change as the individual ages and matures or encounters new environments and cultures. Understanding one's ethics and values is the first step in understanding the ethics and values of others and in assuring the delivery of appropriate and ethical nursing care.

Similarly, health care values may change over time. For example, during the late 1960s the concept of resuscitation for all hospitalized individuals became a standard. The slogan "A heart too good to die" was often cited as the reason that all hospitalized individuals, when they experienced a cardiac or respiratory arrest, had resuscitation efforts initiated rather than being allowed to die without such heroics (Harkness & Wanklyn, 2006). As societal values changed, including allowing individuals to determine their own end-of-life decision making, the approach to resuscitation began to more accurately reflect the individual's value system as well as the value system of individual practitioners.

Distinction Between Ethics and the Law

The legal system is founded on rules and regulations that guide society in a formal and binding manner. Although made by individuals and capable of being changed, the legal system is a general foundation that gives continuing guidance to health care providers, regardless of their personal views and value system. For example, the law recognizes the competent patient's right to refuse therapy. The patient retains this right whether health care deliverers agree or disagree with the person's choice.

This right, however, is not absolute. Overriding state interests may dictate that treatment be mandated against a patient's or parent's wishes. Cases concerning Jehovah's Witnesses, mandatory immunization statutes,

Table 3–1 Distinction Between Law and Ethics

Concepts	Law	Ethics
Source	External to oneself; rules and regulations of society	Internal to oneself; values, beliefs, and individual interpretations
Concerns	Conduct and actions; what a person did or failed to do	Motives, attitudes, and culture; why one acted as one did
Interests	Society as a whole as opposed to the individual within society	Good of the individual within society as opposed to all of society
Enforcement	Courts, statutes, and boards of nursing	Ethics committees and professional organizations

and fluoridation of water enactments are three examples of such overriding state interests.

Ethical values are subject to philosophical, moral, and individual interpretations. Both the health care provider and the health care recipient have a system of rights and values. Can one justify allowing competent adult patients to refuse therapy if the cost is their lives? Do ethics allow the refusal of health care therapies and treatments based on one's religious convictions that all medications and therapies are against God's law?

Many health care providers have difficulty in areas that transect both law and ethics, including issues related to death and dying, genetics and genomics, abuse of others, and futility of health care treatments. Table 3–1 distinguishes these two opposing concepts. To fully appreciate the interaction between law and ethics, though, one must first understand ethics and ethical decision making.

Ethical Theories

Ethics involves systematizing, defending and recommending concepts of appropriate and acceptable behaviors. A variety of different ethical theories have evolved over the course of history. The most basic distinction in ethics concerns non-normative and normative ethics. Non-normative ethics may be divided into two classifications. The first is descriptive ethics, which uses scientific techniques to understand how individuals reason and act. Individuals use **descriptive ethics** to better understand the norms and attitudes that are expressed in professional codes, institutional mission statements, and public policies. In a health care context, descriptive ethics help describe the attitudes and norms that underlie patients' informed consent and surrogate decision making.

A second division of non-normative ethics is **metaethics**, which seeks to understand the nature of statements, attitudes, and concepts, addressing such questions as "What is goodness?" Metaethics attempts to analyze the meaning, justification, and inferences of moral concepts and statements, investigating where ethical principles originate and what they mean. The metaethical component of this type of ethical theory involves exploring whether moral values are external truths that exist in an "otherworldly" realm or merely aspects of human conventions. Said another way, metaethicists attempt to determine why one should act in a moralistic manner rather than how one should act to be of moral character.

Normative theories of ethics concern norms or standards of behavior and values, and the ultimate application of these norms or standards to everyday life, thus taking a more practical view that arrives at standards that regulate right and wrong conduct. Normative ethics are universally applicable, involve questions and dilemmas requiring a choice of action, and entail a conflict of rights and obligations on the part of the decision makers. The key assumption in such ethical thought is that there is but one ultimate criterion of moral conduct.

Like non-normative ethics, normative ethics may also be subdivided into two overarching theories. **Deontological** (from the Greek deon or "duty") **theories** derive norms and rules from the duties human beings owe one another by virtue of commitments that are made and roles that are assumed. Generally, deontologists hold that a sense of duty consists of rational respect for the fulfilling of one's obligations to other human beings. The greatest strength of this theory is its emphasis on the dignity of human beings.

Some ethicists further divide the deontological theory into virtue and duty ethics. Essentially, **virtue ethics** places less emphasis on learning rules and regulations and more emphasis on the development of good or appropriate character and habitually performing in this quality character mode. For example, because a person has mastered the concept of benevolence, he or she will continue to act in a benevolent manner toward other persons. Virtues that are frequently listed by virtue ethicists include wisdom, courage, temperance, justice, fortitude, generosity, self-respect, good-temper, and sincerity. The first four of these virtues were emphasized by Plato and dubbed *cardinal virtues* (Cooper, 1997). Virtue ethicists additionally denounce the acquisition of bad character traits, such as cowardice, insensibility, injustice, and vanity.

The second subdivision of the deontological theory is **duty ethics**. This subdivision is based on the premise that there are some obvious obligations that one has as a human being, such as the duty to not commit murder and a duty to tell the truth. First advocated in the seventeenth century, these duties were classified as duties to God, duties to oneself, and duties to others (Frankena & Granrose, 1974). Duties to self include avoiding the wronging of others, treating people as equals, and promoting the good of others. W. D. Ross (1930/2002) emphasized what he termed *prima facie duties*, a subdivision of duty to self. These duties include the following:

- Fidelity, or the duty to keep promises
- Reparation, or the duty to compensate others when we harm them

- Gratitude, or the duty to thank those who help us
- Justice, or the duty to recognize merit
- Beneficence, or the duty to improve the conditions of others
- Self-improvement, or the duty to improve our virtue and intelligence
- Nonmaleficence, or the duty not to injure others. (p. 6)

Deontological ethics look not to the consequences of an action, but to the intention of the action. It is one's good intentions that ultimately determine the praiseworthiness of the action. A branch of deontological ethics is commonly referred to as **situation ethics**, wherein the decision maker takes into account the unique characteristics of each individual, the caring relationship between the person and the caregiver, and the most humanistic course of action given the circumstances. Situation ethics are frequently relied on when the nurse has cared for a particular patient over an extended time frame. Sometimes situation ethics are referred to as love ethics, conveying the deep respect one has for the human person being treated.

Deontological theories can be further subdivided into act and rule deontology. **Act deontology** is based on the personal moral values of the person making the ethical decision, whereas **rule deontology** is based on the belief that certain standards for ethical decisions transcend the individual's moral values. Example of such a universal rule could be "all human life has value" and "one should always tell the truth."

A second major division of normative ethics, **teleological** (from the Greek telos or "end") **theories** derive norms or rules for conduct from the consequences of actions. Teleological theories became popular in the eighteenth century among philosophers who desired a means to quickly assess an action by appealing to experience rather than to a long list of questionable duties. Perhaps the most attractive feature of these theories was that one could quickly determine observable consequences of actions, with right actions consisting of those that had good consequences and wrong actions those that had bad consequences. Teleologists disagree, though, about how to determine the rightness or wrongness of an action.

This theory is often referred to as **utilitarianism**; what makes an action right or wrong is its utility, with useful actions bringing about the greatest good for the greatest number of people. An alternate way of viewing this theory is that the usefulness of an action is determined by the amount of happiness it brings.

Utilitarian ethics can be further subdivided into rule and act utilitarianism. **Rule utilitarianism** seeks the greatest happiness for all. It appeals to public agreement as a basis for objective judgment about the nature of happiness. **Act utilitarianism** attempts to determine, in a given situation, which course of action will bring about the greatest happiness, or the least harm and suffering, to a single individual. As such, utilitarianism makes happiness subjective.

A final way of viewing normative ethics is through applied ethics. **Applied ethics** is the branch of ethics that concerns the analysis of specific, controversial moral issues such as abortion, euthanasia, genetic manipulation of fetuses, the use of stem cells, genome editing, and the status of unused frozen embryos. To be considered an applied ethical issue, two key characteristics are important. First, the issue needs to be controversial with significant numbers of persons both for and against the issue. Second, the issue must concern a distinctly moral issue. Because of the controversial nature of the issues, resolution of these types of ethical issues is most often approached via the use of ethical principles rather than through the application of ethical theories.

An ethical theory that emerged over the latter half of the 20th century is **principlism**, which incorporates various existing ethical principles and attempts to resolve conflicts by applying one or more of these principles. Ethical principles actually control professional decision making much more than do ethical theories for a variety of reasons. McCarthy (2006) noted that the incorporation of principlism in nursing may emphasize the various ethical principles and create more "deliberate weighting of arguments" (p. 163) in a positive light. Principles encompass basic premises from which rules are developed. Principles are the moral norms that nurses both demand and strive to implement daily in clinical practice settings. Each of the principles can be used separately, although it is much more common to see the principles used in combination. In the most traditional view of principlism, only four ethical principles are considered: respect for autonomy, nonmaleficence, beneficence, and justice (Beauchamp & Childress, 2013). Gastmans (2013) further noted that the discipline of nursing continues to primarily rely on these same four ethical principles as nurses enact dignity-enhancing nursing care.

A second emerging ethical framework has evolved to assist health care deliverers to apply ethical principles in clinical situations. Termed **relational ethics**, this concept redirects the issue of rights and responsibilities of the autonomous individual to view the relational commitments that individuals have to each other, thus moving the decisions into the context of the environment in which these decisions are made and creating a more "practical action-oriented" ethics (Bergum & Dossetor, 2005). These authors noted that there are four components of relational ethics: engagement, mutual respect, embodiment, and environment. Engagement requires that communications be expressed and considered that allow both the rational and emotional aspects of individuals' lives to be included in ethical decision making. This component denotes a shared relationship with obligations and responsibilities to other persons. Mutual respect acknowledges differences and individuality, incorporating a broad understanding of culture and language as they affect ethical principles and issues. Embodiment reflects the connection needed between persons so that interactions between them

are meaningful and fully acknowledged. Environment includes the breadth of the relationship, moving beyond individual personalities so that a broader relationship can be established and appreciated (Bergum & Dossetor, 2005). Thus, relational ethics are the ethics of care and caring (Ellis, 2007).

Relational ethics is not meant to eliminate other ethical theories and guidelines, but to add a further method of understanding and applying a practical means of addressing the ethical issues that arise in everyday practice settings. Relational ethics, by engaging all parties to a potential dilemma, creates continued dialogue and consideration of all possible and realistic outcomes (Bergum & Dossetor, 2005).

Ethical Scenario 3–1

Making Difficult Ethical Decisions

In 1982, a woman in the United States gave birth to an infant who was severely mentally disabled and who had multiple birth defects including a separation of the esophagus from the stomach, resulting in the inability of the infant to receive oral nourishment. Although surgery could correct this deformity, the parents did not want to raise a severely mentally disabled child and chose to deny consent for the surgery, food, and water. This decision was supported by the local court system and the infant died six days later. Using the ethical theories previously presented, conclude whether these theories as described assist in determining the ethics of allowing this infant to die. Do these theories support the refusal for surgical intervention? Does the fact that the infant was also severely mentally disabled alter how the theories are applied? Could you argue, citing ethical grounds, that this child should have had the necessary surgery to correct this single birth defect?

Ethical Principles

Nurses apply a variety of ethical principles in everyday clinical practice, using some principles to a greater degree than other principles. The ethical principles include autonomy, beneficence, nonmaleficence, veracity, fidelity, paternalism, justice, and respect for others. Each principle is discussed separately in the following sections.

Autonomy

Autonomy addresses personal freedom and self-determination; the right to choose what will happen to one's own person. The legal doctrine of informed consent is a direct reflection of this principle. Autonomy involves health care deliverers' respect for patients' rights to make decisions affecting care and treatment, even if the health care deliverers do not agree with the decisions made. Because autonomy is not an absolute right, restrictions may be placed on a person's right to endanger others, as in the case of communicable diseases.

Autonomy, though, is not merely a simple matter of deciding to accept one type of therapy over another option; underlying the principle of autonomy are issues of competence and adequacy of information. To make an autonomous choice, the individual must have the capacity to fully comprehend and the needed information with which to make an informed choice. The four important components of autonomy are liberty, self-determination, independence, and agency.

Liberty is freedom to choose without coercion or manipulation from others. There must be freedom to take positive actions, knowing that one has the skills and capabilities to understand which actions are possible and which will be the most beneficial to the individual. Choices should be those that are good for the individual. For a hospitalized individual, these choices could include procedures and treatments that cure a specific condition or disease or care that supports comfort measures in the final stages of life. For staff members, these choices could include the opportunity to take on the responsibilities of a manager position or continue with one's current assignment. Others may assist in helping an individual make such choices, and social support from family members and friends may be needed to help an individual make an appropriate choice.

Self-determination is the ability to access information, select which information is critical to decision making, and having the power to act upon that information. For an individual hospitalized for a major illness, this would be the ability to understand the information as presented and determine how a proposed therapy or medication will affect the individual, and then make a decision and act upon it. The more life-threatening the condition or diagnosis, the more the capacity for decision making is affected. If a decision can be delayed, there are clinicians who advocate for allowing at least a full 24 hours between the presentation of information and the final decision by the patient. This time frame is seen as necessary for the patient to fully comprehend the situation, the proposed action, and how he or she should decide to act.

Independence is being able to act, reason, and decide for oneself. It is the ability to "stay true to oneself over time; preserving the values that have shaped one's life" and to act on these values (Personal communication, Dr. Rebecca Kukla, June 5, 2012). Independence is threatened when one is ill, when there are major changes in one's environment, or when one lacks needed support systems. Independence, the ability to follow one's values, is crucial at the time of autonomous decision making.

The final component of autonomy is *agency*. Agency may be defined as the power to be in command and responsible for one's actions. Agency requires the capacity and opportunity to act, as well as the ability to take responsibility for one's decision and actions. Agency requires the ability to critique and defend one's decisions and actions in order to fully take responsibility for them.

Thus, autonomy is much more than merely being presented with new knowledge and making a choice. It is respect for the core ethical construct that some have termed self-governance, free will, and choice (Jonsen, Siegler, & Winslade, 2015). It is also much more complicated than believing that individuals who decide not to follow a specific recommended medical option are merely unable to understand how the therapy or medication will enhance his or her well-being. Does the fact that a person refuses therapy that the health care provider considers appropriate and necessary mean that the person is unable to make a valid decision for him- or herself? Perhaps the refusal is based on the patient's need to follow his or her own value system and ethics, preserving his or her agency and independence.

Beneficence

Beneficence states that the actions one takes should promote good. Beneficence is the basic obligation to assist others. Beneficence is often viewed as one of the core values in health care ethics, though at least one bioethicist believes it is the fundamental principle in health care ethics (Beauchamp & Childress, 2013). In caring for patients, good can be defined in a variety of ways, including allowing a patient to die without advanced life support. Conversely, good can prompt nurses to encourage the patient to undergo extensive, painful treatment procedures if these procedures will increase both the quality and quantity of the patient's life. Nurses frequently consider this principle when viewing the long-term outcomes of invasive and noninvasive procedures. The difficulty with this principle is in defining good.

Beneficence may also be viewed as the promotion of health, often defined by the patient's perception of how he or she defines health and considering how that individual perceives what is good. Thus, health care providers may need to be cautioned to undertake the performance of promoting good as seen through the eyes of the patient and the patient's family. For example, when caring for patients with critical life-altering injuries, such as a patient who sustained an anoxic episode during resuscitation and is now in a vegetative state, are health care providers promoting the patient's "health" through continuous life-support measures?

Nonmaleficence

Often denoted as the corollary of beneficence, **nonmaleficence** states that one should do no harm, including the inflicting of pain and suffering on others. Nonmalefience also demands that one should not impose risks of harm. But not all actions bring intentional pain and suffering; often this aspect of harm is different for individual patients. Health care providers may employ the concept of a **detriment-benefit analysis** when the issue of nonmalificence is raised. Using such an analysis, the focus of the projected treatment or procedure rests on the consequences of the benefits to the patient and not on the harm that occurs at the time of the intervention. For example, a nurse gives a patient an injection for the relief of post-operative pain. Even though the injection imposes some degree of discomfort and suffering at the moment the injection is administered, the overall benefit is less suffering from the operative pain once the effects of the medication are felt by the patient.

A second way to support interventions that may have harmful effects is through application of the **concept of double effect**. Four conditions must be present for this concept to be used: (1) The action itself must be "good" or at least morally indifferent. (2) The practitioner must intend only the good effect. (3) The undesired effect must not be the means of attaining the good effect. (4) There is a proportional or favorable balance between the desirable and the undesirable effects of the action. Using this concept, one could be justified in administering a morphine drip in a terminally ill patient with pulmonary edema, as the desired effect is the relief of pain and suffering and not the further respiratory depression that the medication will affect.

A means of distinguishing these two seemingly contradictory principles of beneficence and nonmaleficence is that nonmaleficence is required, where beneficence is more a matter of individual choice. Ethicists often reserve the principle of nonmaleficence for issues of major impact, such as "Can one preserve the life of anencephalic infants merely as a source for organ transplantation?" Today, ethicists consider this ethical principle when concerning themselves with the issue of human cloning, gene editing, and the preservation of frozen embryos.

Veracity

Veracity concerns truth telling and incorporates the concept that individuals should always tell the truth. This principle also compels that the whole truth be told. This principle is followed when one completely answers patients' questions, giving as much information as the patient and/or family can understand, and telling the patient when information is not available or known. An example of the difficulty in applying this principle occurs when nurses desire to convey knowledge that would enable the patient's autonomous decision making in an environment where family members or other health care professionals are demanding that information be withheld from the patient. Often, the arguments that these individuals verbalize against giving the patient additional information center on their perceptions that the patient would forgo needed and appropriate medical care if he or she knew the entire truth. Health care providers, though, need to be cognizant of the fact that patients cannot make fully autonomous decisions unless they know all the facts, as these issues pertain to their diagnoses and potential treatment options.

When following this principle, nurses must remember that the principle of veracity may be violated in multiple ways. The first is the obvious telling of a falsehood.

The second violation is through omission of critical and relevant facts, particularly when discussing alternative options to a suggested therapy. To make an informed choice, the patient must have knowledge of all the relevant and appropriate options available. The third means, which is the most subtle, is to cloak the truth in so much medical jargon that the patient and family members truly are unable to understand the full meaning of the facts. Health care professionals are encouraged to ensure that patients understand what is being said. One means of ensuring that the patient and family members understand is for the healthcare provider to repeat the information using different terminology or alternate wording. A second means of ascertaining if the patient and family members understand is to allow them to repeat what they understand about the information that the healthcare provider has just imparted.

Fidelity

Fidelity is keeping one's promises or commitments. Staff members know not to promise patients what they cannot deliver or what they do not control, such as agreeing with a patient when the patient asks that nothing be done should he or she stop breathing, before consulting the patient's primary health care provider for such an order. Keeping one's promises may become an issue if that patient's family members are assured that they will be fully informed about their loved one's condition; yet, emergencies can occur, and procedures must be implemented rapidly in order to prevent further complications. Fidelity may also arise when nurses assure patients that they will be kept pain free following a surgical procedure, as complications, such as a hemodynamic instability, may develop that prevent adequate pain control.

Fidelity may also be viewed as one of the core values in the nurse-patient relationship. Obligations of fidelity arise when one establishes a significant relationship with a patient, understanding that to breach this relationship is to breach fidelity. The second provision of the American Nurses Association's *Code of Ethics for Nurses* (2015) reminds nurses that the primary commitment is the patient, however the patient presents.

Paternalism

Using the strictest definition, **paternalism** (also known as parentialism) involves completely making the final decisions for others and is thus seen as an undesirable or negative ethical principle. Paternalism allows no collaboration in the decision-making process, but totally removes the decision from the patient or patient's family members. This principle, though, when used to assist in decision making with competent patients who lack the expertise or ability to fully comprehend data needed to make decisions, is generally seen as appropriate and acceptable. In this context, the principle of paternalism becomes shared decision making, allowing the patient to make what some consider a more appropriate and informed decision. Others contend that in this context, paternalism is part of the advocacy role of nurses and that there is a very slight distinction between the two concepts (Zomorodi & Foley, 2009).

For example, when faced with a difficult decision, a patient may inquire what the nurse or primary health care provider would do in a similar case, allowing the health care deliverer to help in the decision-making process and further encouraging communication. This may be interpreted as either paternalism or advocacy for the patient, both desirable outcomes in this instance. When the entire decision is taken from the patient, the principle of paternalism is to be avoided.

Justice

Justice states that people should be treated fairly and equally. Ideally, justice means giving to each person what he or she deserves or giving each person his or her due, following a standard of rightness. Fairness often refers to the ability to judge without reference to one's feelings or interests, allowing each person to be treated equally. Fairness is also used to refer to the ability to make judgments that are specific and concrete to a particular case or set of circumstances. These two terms are often used interchangeably though there are some differences. Generally, where people may differ between justice and fairness is when decisions must be made about how benefits and burdens will be distributed among individuals. This principle of justice thus arises in times of short supplies or when competition for resources or benefits exists, such as when two equally deserving patients are awaiting a kidney transplant, when only one intensive care bed is available and more than one individual requires intensive care monitoring, or when additional resources become available. Fairness comes into play once the competition for the resource or benefit has been decided. For example, should two intensive care beds become available, both patients will receive the same quality nursing and medical care.

Justice may be subdivided into distributive justice, retributive or corrective justice, and compensatory justice. **Distributive justice** (also termed **social justice**) refers to the extent to which society ensures that benefits and burdens are distributed among society's members in ways that are fair and just. Disparities in health care delivery among various members of American society are frequently cited as not meeting distributive justice principles. **Retributive or correctional justice** refers to the extent to which punishments are fair and just, often cited when disciplinary outcomes appear to be very different for similar infractions of rules. **Compensatory justice** refers to the extent that people are fairly compensated for their injuries by those who have injured them with just compensation proportional to the loss that has been inflicted on an individual. This latter type of justice forms the final issues in most medical malpractice suits and determines, once liability is shown, what fair and just compensation entails.

Justice is a central core of ethics and must be considered when evaluating decision making. Justice is a principle that expresses the mutual recognition of each other's basic dignity and the need to ask whether one's actions treat all individuals as equally as possible.

Respect for Others

Respect for others, seen by many ethicists as the highest principle, incorporates all other principles. Respect for others acknowledges the right of individuals to make decisions and to live or die based on those decisions. Respect for others transcends cultural differences, gender issues, religious differences, and racial concerns. This principle is the core value underlying the Americans with Disabilities Act and several discrimination statutes. It is also the first principle enumerated in the American Nurses Association's *Code of Ethics for Nurses* (2015). Nurses positively reinforce this principle daily in actions with peers, interdisciplinary health team members, patients, and family members.

GUIDELINES
Ethics

1. Recognize the difference between the legal and ethical rights of individuals. While both concepts are important, if conflicts arise legal rights must be afforded the patient.
2. Nurses understand and appreciate that their ethical views and values often differ greatly from the patient's culture and value systems. Such an understanding allows nurses to remain objective when caring for patients and advocating for patients' decisions and desires.
3. When legal issues do not take precedence, nurses are guided by the ethics of the profession, the organization, and their individual personal values. There is never a time that ethics is not an important consideration.
4. If the values of patients and nurses interfere with competent, quality nursing care, it is recommended that nurses remove themselves from that particular patient's care, as possible.
5. Ethical dilemmas have no perfect answers, just better answers. Legal questions have right and wrong answers. When in conflict, follow the established legal principles.
6. Know and follow the American Nurses Association *Code of Ethics for Nurses* (2015).

Ethical Scenario 3–2

Identifying Ethical Principles

In the following examples, identify the ethical principles that nursing staff are employing through their reasoning and actions. Were you able to identify any conflicting ethical principles in the examples?

1. Jody, an 8-year-old, has been admitted to an acute care hospital for an emergency appendectomy. Her parents have been given information about the surgery and what to expect in the immediate post-operative period. Three members of the nursing staff have also assured these anxious parents that they will be notified as soon as Jody is admitted to the post-anesthesia area or sooner if there are complications with the procedure.
2. Mrs. Hernandez, who speaks English as a second language, appears to be having difficulty understanding the discharge instructions that she was given prior to leaving the family doctor's office. The community health care nurse caring for Mrs. Hernandez has finally secured an interpreter to ensure that Mrs. Hernandez fully understands the instructions. The nurse also has the interpreter read the discharge instructions to the patient, and the nurse answers all questions that Mrs. Hernandez asks.
3. Mr. Cho, a 72-year-old man, is admitted for acute lymphocytic leukemia. The hematologist caring for this patient has explained reasonable treatment options for an individual of Mr. Cho's age and general medical condition. His daughter, who is obviously distraught and unable to fully comprehend all that is happening, tearfully asks the nurse, "If it were your father, what would you do?" The nurse helps the daughter understand what the diagnosis means, the treatment options, and what would be a reasonable treatment option for Mr. Cho.
4. Jane is the nurse manager for a busy ICU. There are two patients awaiting admission to the ICU; one is a 42-year-old bank president admitted through the emergency center with a diagnosis of an acute myocardial infarction, and the second patient is an elderly woman who experienced a cardiac arrest on the general medical unit. Jane surveys all the patients already in the ICU and elects to contact Dr. Emerson about discharging Mr. Houseman so that there will be two beds available for the two patients awaiting admission.

Ethics Committees

With the increasing numbers of legal and ethical dilemmas in patient situations today, health care providers often seek guidance with decision-making. Perhaps one of the best solutions for both long-term and short-term ethical issues is the creation of an institution ethics committee. **Ethics committees** have as their goals the following:

- Promotion of the rights of patients;
- Promotion of shared decision making between patients (of surrogates) and their health care providers;
- Promotion of fair and equitable policies and procedures that maximize the likelihood of achieving appropriate and acceptable quality patient-centered care; and
- Enhancement of the ethical tenor of healthcare professions and health care institutions.

To achieve these goals, ethics committees provide structure and guidelines for potential problems, serve as an