# ESTABLISHING POTENTIAL AREAS OF HOSPITAL, CORPORATE, AND INSTITUTIONAL LIABILITY IN MEDICAL MALPRACTICE CASES

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It is axiomatic that hospitals, corporations, and other healthcare institutions can be held liable not only for their own direct negligence, e.g., negligent hiring, negligent credentialing, and improperly maintained equipment, but can also be vicariously liable for breaches in the standard of care by medical care providers who are employed by and, in certain instances, who are under contract with the healthcare facility.

Because of the breadth of information available regarding nursing standards of care and obligations, this paper and seminar presentation will focus primarily upon nursing care in the acute care setting, as opposed to home health or long term care facilities. We will first consider, albeit briefly, two instances when a healthcare facility can be liable on a direct claim: (1) Negligent hiring, training, and supervision; and (2) negligent credentialing. We will then discuss when a healthcare provider may be held liable for the negligence of persons other than the provider's employees. From there, we will examine when hospitals and healthcare institutions are liable for the actions of their own employees and ultimately how nursing negligence can be identified.

## A. DIRECT LIABILITY AGAINST THE HEALTHCARE FACILITY

### Pursuing the Negligent Hiring, Training, and Supervision Claim and Breathing (Some) Life Into the Negligent Credentialing Claim

Negligent hiring, training, and supervision claims customarily arise in the context of a plaintiff suing a hospital or other institution for the negligent acts of one of its nurses or other

healthcare providers. In addition to alleging that the hospital is liable for the negligent acts of its employee pursuant to the doctrine of *respondeat superior*, a thorough Complaint will also allege that the institution negligently hired, trained, and/or supervised its employee. In contrast, negligent credentialing claims are independent, direct liability claims, although they of course depend upon an underlying negligent act by a physician causing harm to the plaintiff. These claims must be considered and analyzed separately from claims of negligent hiring, training, and supervision. A negligent credentialing claim can be maintained based upon the acts of a non-employee, non-agent physician. This claim is not only viable as an independent claim under appropriate circumstances, it also opens the door to additional avenues of discovery under the AMLA.

### 1. Negligent Hiring, Training, and Supervision

The law applicable to a negligent hiring, training, and/or supervision claim in Alabama is well-settled. The Alabama Supreme Court summarized the law on these claims in 2006 as follows:

> In the master and servant relationship, the master is held responsible for his servant's incompetency when notice of knowledge, either actual or presumed, of such unfitness has been brought to him. Liability depends upon it being established by affirmative proof that such incompetency was actually known by the master or that, had he exercised due and proper diligence, he would have learned that which would charge him in the law with such knowledge. This may be done by showing specific acts of incompetency and bringing them home to the knowledge of the master, or by showing to be of such nature, character, and frequency that the master, in the exercise of due care, must have had them brought to his notice.

Pritchett v. ICN Medical Alliance, Inc., 938 So. 2d 933, 940 (Ala. 2006).

There is obvious friction between this common law and the AMLA. Pursuant to the AMLA, a plaintiff in a medical malpractice action is not entitled to conduct discovery on prior acts or omissions. Therefore, a plaintiff will never have access to prior "specific acts of incompetency", so imputing knowledge of these acts to the master borders on the impossible. Even if a plaintiff has

such knowledge, information regarding these prior acts cannot be used in almost all circumstances in claims brought under the AMLA. Therefore, as a practical matter, plaintiffs should focus on the negligent training aspect of this claim. The plaintiff can then determine how the employee was trained for a particular procedure or for provision of care to a particular type of patient and can use that information to determine whether the healthcare provider indeed was negligently trained. Discovery of policies and procedures and orientation documents utilized during the training of the healthcare provider whose care is at issue can provide ammunition for this claim.

### 2. Negligent Credentialing

Negligent credentialing is of course its own independent claim, but it is a claim in very poor health. Negligent credentialing claims have been suffering from a systemic illness caused by two factors. The first is the AMLA's prohibition on discovery of prior acts and omissions. The second is the prohibition on discovery of peer review, credentialing, and quality assurance materials codified at Ala. Code § 22-21-8.

Simply because the negligent credentialing claim is very ill, however, does not mean it should not be considered by an attorney advocating for the victim of a physician's malpractice. Although a plaintiff cannot obtain information directly from a healthcare institution's peer review or credentialing file, the statutory privilege does not apply to any information that originated outside the peer review process. If this information is otherwise admissible, it can be utilized to prove a plaintiff's claim of negligent credentialing.

Any information utilized by a healthcare facility as part of the credentialing process and that is available from its original source is fair game and is not immune from discovery. The mere use of this information by a medical review committee does not cloak the information with a privilege

when the information can be obtained from its original source. Ex Parte Qureshi, 768 So. 2d 374 (Ala. 2000). Alabama law specifically allows a plaintiff to obtain information used in the credentialing process directly from the third party that supplied the information. Ex Parte Krothapalli, 762 So. 2d 836 (Ala. 2000).

The Krothapalli Court was considering a wrongful death, medical malpractice action in which the plaintiff was seeking production of the personnel files for the physician whose care was at issue from two hospitals where the physician had privileges. The Court ruled that the files themselves are not discoverable directly from the hospital under Ala. Code § 22-21-8, but the Court qualified its ruling by finding that the privilege asserted by the defendant that such files are not discoverable "does not protect information if it is obtained from alternative sources. Hence, a plaintiff seeking discovery cannot obtain directly from a hospital review committee documents that are available from the original source, but may seek such documents from the original source." Id. at 839.

The Court went on to note that the peer review statute provides that "[i]nformation in the documents or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were presented or used in preparation of accreditation, quality assurance or similar materials." Id. at 839 (quoting Ala. Code § 22-21-8(b)). Based upon the foregoing case law, a plaintiff pursuing a negligent credentialing action against a hospital or other healthcare facility should always serve discovery early in the case asking the healthcare facility to identify all persons, businesses, trade associations, governmental agencies, and other sources from which it obtained any information, or from which any information was submitted to it, as part of its credentialing process for the physician whose care is at issue.

Despite the availability of this discovery method, pursuing a negligent credentialing claim remains extremely difficult. Absent some compelling evidence from third parties who provided information weighing strongly against credentialing to a hospital or healthcare facility that credentialed a physician whose care is at issue, this claim generally will not carry the day. While the claim should be given adequate consideration during an attorney's investigation of a potential case, and while the claim may open the door to additional discovery, it typically should be utilized as a collateral claim rather than the primary theory to trigger liability.

## B. WHEN HEALTHCARE PROVIDERS MAY BE HELD LIABLE FOR THE NEGLIGENT ACTS OF NON-EMPLOYEES

The question of whether and when a healthcare provider may be liable for negligent actions of the healthcare provider's non-employees, which will typically be persons working as independent contractors, was for several years well-settled. The loaned servant doctrine as it existed for decades served the bench and bar well as the guidepost by which to determine whether a healthcare facility would be liable for the actions of a non-employee. In what can fairly be characterized as a watershed case, the Alabama Supreme Court changed the law in this area by imposing an additional element -- the "right of selection".

The loaned servant doctrine was succinctly stated by the Alabama Supreme Court as follows:

> An employee may be in the general service of another, and nevertheless, with respect to particular work, may be transferred, with his own consent or acquiescence, to the service of a third person, so that the employee becomes the servant of such third person with all the legal consequences of the new relation.

Alabama Power Co. v. Smith, 273 Ala. 509, 520-21, 142 So. 2d 228, 239 (1962).

In a much later case, the Supreme Court clarified the criteria for determining when the loaned servant doctrine applies to include "whether the employee consented to becoming the 'borrowed

servant' of the alleged borrower." Defoor v. Evesque, 694 So. 2d 1302, 1304 (Ala. 1997). The Defoor Court clarified a ruling in the prior decision of United States Fidelity & Guaranty Co. v. Russo Corp., 628 So. 2d 486 (Ala. 1993). The Russo Court had noted that an employee must consent or acquiesce to enter into the service of the purported borrowing employer before the loaned servant doctrine would apply.

All indications in our case law were that this firmly established loaned servant doctrine is applicable to claims brought under the AMLA. In the wake of a sizeable verdict in favor of a plaintiff in a medical malpractice case, however, the Alabama Supreme Court recently modified the law in Ware v. Timmons, 954 So. 2d 545 (Ala. 2006). In Ware, a CRNA, nurse Hayes, was monitoring a patient who had undergone surgery under general anesthesia to correct an over-bite. Nurse Hayes made the decision to remove the breathing tube that is used to counteract the effects of anesthesia. An anesthesiologist was called over the hospital's intercom system to supervise nurse Hayes and to monitor the removal of the breathing tube from the patient.

Dr. William Ware responded to the call over the intercom. He arrived to supervise nurse Hayes as she removed the patient's breathing tube. Dr. Ware was well aware of nurse Hayes's decision to remove the breathing tube and supervised nurse Hayes during the removal. After Dr. Ware supervised nurse Hayes's removal of the breathing tube, the patient was disconnected from the monitoring equipment and was moved to the PACU.

Shortly after the patient was connected to monitoring equipment in the PACU, the patient went into cardiac arrest. It was later determined that the patient's brain had suffered irreversible damage from anoxia caused by events that occurred during her recovery from anesthesia. The patient later died as a result of brain damage.

The patient's mother sued nurse Hayes, Dr. Ware, and an anesthesiology and pain medicine clinic that employed nurse Hayes and Dr. Ware. The plaintiff alleged that nurse Hayes breached the standard of care during her treatment of the patient and that Dr. Ware, as nurse Hayes's supervising anesthesiologist, was vicariously liable for nurse Hayes's conduct. The jury agreed and returned a verdict against Dr. Ware for nurse Hayes's negligence on the basis of *respondeat superior*.

In reversing the trial court and remanding the case for another trial, the Ware majority found that the plaintiff was not entitled to a jury instruction given by the trial court that essentially stated Dr. Ware could be held liable for nurse Hayes's negligence. The Court reasoned that there was no showing that Dr. Ware had the ability, in his individual capacity, to select and to dismiss nurse Hayes. Absent this "right of selection", the Court found that vicarious liability could not attach. The Court found not only that the jury instruction was erroneous, but also found as a matter of law that the jury could not hold Dr. Ware liable based on nurse Hayes's conduct.

In reaching this conclusion, the Court changed the loaned servant doctrine and found that the right of control test that has historically been used to guide application of the doctrine "cannot provide a meaningful answer by itself." While not abandoning the right of control test, the Court added the following requirement that must be considered by all medical malpractice attorneys attempting to attach liability to a principal for the acts of the principal's non-employee agent:

> The general rule is that to constitute the relationship between master and servant for the purpose of fixing liability on the former for the acts of the latter under the doctrine of *respondeat superior*, it is indispensable that the right to select the person claimed to be a servant should exist.

Id. at 552.

The right of selection test muddies the waters in this area of potential liability. Consider the following scenarios and question whether the healthcare provider would be liable for the negligent acts at issue under Ware.

Scenario 1: A long term care facility contracts with ABC Nutritional Services to conduct nutritional screening and assessments on the long term care facility's residents and to ensure that residents of the long term care facility have dietary plans in place that allow them to receive adequate nutrition. ABC hires Jane Smith, RD, to perform the tasks ABC is required to perform under its contract with the long term care facility. Jane Smith miscalculates the protein needs of one of the residents who is at risk for malnutrition and the development of decubitus ulcers. The facility implements Jane Smith's dietary plan and goes to great lengths to ensure that the resident receives the protein called for in the plan. Because the resident is not receiving adequate protein, however, over the next several months she develops decubitus ulcers on her sacrum, elbows, and heels. One of her decubitus ulcers becomes infected, and the resident ultimately dies of sepsis. During this ordeal, the facility has had no right of selection in that they could not select Jane Smith as the RD and could not terminate her from working for ABG.

Scenario 2: A patient presents to a rural hospital with numbness, tingling, and partial paralysis in her lower extremities. An MRI is ordered, which reveals a probable epidural hematoma that will cause permanent paralysis if left untreated. Pursuant to hospital protocol, the radiologist who reads the film dictates his report and provides his dictation to the transcriptionist for priority transcription. Because the transcriptionist is distracted by a telephone call prompted by his resume that he posted on monster.com, the transcriptionist mistakenly types the MRI report as negative for epidural hematoma rather than positive for epidural hematoma. Upon receiving the report, the admitting physician begins to explore other possible causes for the patient's presentation, and the patient is ultimately paralyzed. The transcriptionist was not employed by the hospital. Rather, the hospital had a contract with a transcription company. The third party company's principal is the only person who had the right of selection for the transcriptionist who would be utilized to transcribe the radiologist's report. In fact, this transcriptionist was part of a pool of transcriptionists, and assignments are given to the transcriptionist as they come in based upon which transcriptionist is available. No person employed by the hospital has any authority to hire or fire transcriptionist for this company or to select a specific transcriptionist to transcribe any given report.

These scenarios are not far-fetched and are in fact loosely based upon cases we have handled. Although a claim may still be made in each scenario that the healthcare facility breached an independent duty it had under the applicable standard of care, liability based upon *respondeat*

*superior* does not appear to be viable under the ruling in Ware. Hopefully, this radical change in the law will be corrected when this issue again appears before the Alabama Supreme Court.

## C. WHEN HOSPITALS AND INSTITUTIONS ARE LIABLE FOR THE NEGLIGENCE OF THEIR EMPLOYEES

Fortunately, long-standing law on a master's liability for the negligent acts of its employees remains unchanged by Ware. This law is equally applicable in medical malpractice actions and does not lend itself to protracted discussion.

Despite the change in the loaned servant doctrine established in Ware v. Timmons, traditional avenues for vicarious liability remain for claims brought under the AMLA. As with all cases in which a plaintiff attempts to establish vicarious liability, a master cannot be liable for medical negligence unless one of the master's servants has actually been found to be negligent. University of Alabama Health Services Foundation, P.C. v. Bush, 638 So. 2d 794 (Ala. 1994). Prove the negligence of the employee, prove the employment relationship, and you have vicarious liability available to you.

As an employer's liability for the negligent acts of its employees is so firmly established in Alabama law, a WestLaw® term search for "medical liability act" and "*respondeat superior*" nets only six results in Alabama. Perhaps the most important consideration for an attorney preparing to file a medical malpractice action against a healthcare provider based upon the negligent acts of the healthcare provider's employee is whether to sue the employee himself or herself. More often than not, the reality that you would be suing a nurse in his or her individual capacity would tilt the balance heavily in favor of not naming the individual defendant. This decision cannot be made, however, without giving adequate consideration to whom your individual defendant would be, whether the

healthcare facility may have the luxury of the municipal/county government cap, where your venue will be, and what standing the potential individual defendant may have within the community.

## D. THE NUMEROUS WAYS BY WHICH TO IDENTIFY NURSING NEGLIGENCE

There is a myriad of circumstances under which we could discuss nursing negligence. Although many of the principles discussed herein would apply equally to nursing care across all nursing disciplines, the intent of this paper and presentation is to focus on nursing negligence in the acute care setting.

Nursing negligence can take many forms. To categorize nursing negligence very generally, we can consider two different types of liability that can be pursued: (1) Liability for a nurse's failure to act when confronted with a physician's failure to act in the best interests of the patient; and (2) liability based upon the nurse's or other employee's own actions or inactions, irrespective of any physician conduct. In this section, we will consider those two general areas separately.

### 1. Holding Nurses Liable When a Physician Acts In a Manner That is Potentially Harmful to the Patient - the Nurse as a Patient Advocate

Any Plaintiff's attorney who handles medical malpractice cases against nurses has heard this nursing defense at least once: "Nurses do not make diagnoses; we simply follow physician orders". Not only is this defense untrue on its face -- nurses do make certain types of diagnoses, which are discussed in the next section of this paper -- but it also ignores the nurses' role as advocates for their patients.

Consider the following scenarios in which a nurse could escape potential liability without justification if the Plaintiff's attorney allows the nurse to mount unchecked the defense that nurses do not make diagnoses:

Scenario 1: A patient at a hospital has suffered post-surgical complications. The patient has long-standing respiratory issues that have required the home use of CPAP for several years. Although these respiratory issues are unrelated to the reason for the patient's hospitalization, the issues have manifested during what has become a difficult post-surgery recovery for the patient. While in the critical care unit, the patient shows clear clinical signs and symptoms of respiratory distress. The responsible nurse notifies a physician, who orders an ABG. That AGB results contain panic values and show a patient in respiratory acidosis. Clinically, the patient's respiratory status has also worsened. The responsible nurse again notifies the physician, who refuses to come see the patient and who does not order additional interventions. Rather, the physician simply tells the nurse to monitor the patient. The patient suffers respiratory failure, codes, and later dies.

In a lawsuit against the physician, the deceased patient's family receives a verdict of $2.5 million. Post-judgment of discovery reveals that the physician's liability policy has limits of $1 million, and his net worth is nominal. Consequently, the plaintiffs are able to recover only 40% of the verdict they received.

Scenario 2: A patient presents to a rural emergency room with a dislocated knee suffered 2-3 hours earlier. A nursing assessment reveals absent dorsal and pedal pulses in the affected leg. The nurse notifies a physician, who briefly assesses the patient and orders analgesics only. The nurse, believing that she is in no position to question the physician, administers the analgesics and continues to monitor the patient as ordered by the physician. Once the physician makes it back to the patient, another 8 hours later, irreversible tissue necrosis from an arterial compromise has occurred. The patient loses her leg. The ER physician happens to be a deacon in his church, which is the largest church in this small county, and he has been a volunteer fireman for 30 years. The physician's wife has taught school in the largest elementary school in the county for 25 years, and both the physician and his wife are very well liked in the community.

These scenarios present situations in which the family of a patient who died because of physician malpractice will be denied payment of a verdict they received or for obvious physician malpractice to go unchecked because of the difficulty associated with receiving a favorable plaintiff's verdict in the county where the malpractice occurred. In both instances, the nurses provided primary nursing care to the patients, if sued, would depend heavily on the defense that they are not physicians, do not make diagnoses, and had discharged their duties by informing the physician of the patient's condition.

Attorneys investigating cases such as those in which a nurse properly informed a physician of a patient's condition must be careful to give due regard to the nurse's role as a patient advocate. There are several sources to mine in this area to establish to a jury that the nurse's duty in this regard is an accepted nursing obligation and is not merely a concocted argument by a plaintiff. Before considering those sources, however, it is helpful to note that there is case law supporting this theory of liability against a nurse.

In a Louisiana case, a trial judge read the following instruction to the jury:

> A hospital has an independent obligation and duty of care to its patient which is independent to any obligation or duty owed by a treating physician. This being so, the hospital is not protected from responsibility and liability solely by the fact that its nurses and staff may have strictly followed the orders of a private physician. Even if you believe that the nurses were strictly following doctor's orders, the patient is still entitled to rely upon the hospital's expertise and independent professional judgment to supplement the treating physician's direct orders when necessary to afford the patient the safe and reasonable health care the hospital is obligated to provide . . . . Strict adherence to the physician's orders cannot excuse the failure to provide safe and reasonable care to the patient, nor preclude a finding of negligence on the part of the hospital.

Griffin v. Kinberger, 647 So. 2d 1270, 1277-78 (La. Ct. App. 1994), cert. denied, 650 So. 2d 1187 (La. 1995). The Louisiana Court of Appeals found that the jury instruction adequately stated applicable law.

One of the more commonly cited cases on this point is Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E. 2d 253 (1965), cert. denied, 383 U.S. 946 (1966). Darling was the first case to adopt the corporate liability theory, as observed by the Alabama Supreme Court in Clark v. Allied Healthcare Products, Inc., 601 So. 2d 902 (Ala. 1992). The Darling case resulted in a verdict against a hospital based on the failure of the hospital's nurses to intervene when a doctor failed to take appropriate action. A plaintiff's leg had been placed into a cast, and the plaintiff was

subsequently experiencing great pain and swollen toes that turned dark. The Illinois Supreme Court affirmed a verdict in favor of the plaintiff and noted that, at the point skilled nurses would have recognized a dangerous condition, "it became the nurses' duty to inform the attending physician, and if he failed to act, to advise the hospital authorities so that appropriate action might be taken." Id. at 333, 258.

Despite the foregoing case law, it does not appear that nurses in Alabama have a duty to act as an advocate that is imposed by law. Until such time as this duty is established by law in Alabama, attorneys representing medical malpractice plaintiffs must make sure they are able to establish the duty of a nurse as a patient advocate as a requirement of the applicable nursing standard of care.

Among the many sources through which to establish the nurse's duty as a patient advocate, perhaps none is as important as the healthcare facility's own policies and procedures. The first place to look, and be sure to look early in the discovery process, is at the facility's policies and procedures on chain of command. A hospital or healthcare facility will have policies that specifically instruct a nurse on how to respond if a physician is acting, or failing to act, in such a manner so as to cause potential harm to the patient. Typically, these policies provide that a nurse should report the development to his or her charge nurse. If the nurse does not have the situation rectified by the charge nurse, the nurse should then go directly either to a unit director or the director of nursing for the facility, depending upon the particular facility's policy. More often than not, you will be able to establish that the hospital's expectations for its nurses are that the nurse will advocate on behalf of the patient by pursuing these types of avenues until any potential issue is resolved.

To be thorough, do not stop your efforts simply because you receive a favorable policy and

procedure adopted by the hospital. As with most types of lawsuits, trade associations can provide valuable information favorable to a patient advocate. For example, the American Nurses Association ("ANA") has promulgated a Code of Ethics. This Code of Ethics provides in pertinent part the following:

1. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patients;

2. The nurse's primary commitment is to the health, well-being, and safety of the patient across the life span and in all settings in which healthcare needs are addressed. As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instance of incompetent, unethical, illegal, or impaired practice by any member of the healthcare team, or the healthcare system, or any action taken on the part of others that places the rights or best interests of the patient in jeopardy;

3. Nurses are accountable for judgments made and actions taken in the course of nursing practice, irrespective of a healthcare organization's policies or provider's directives; and

4. When the needs of a patient are beyond the qualifications and competencies of the nurse, consultation and collaboration must be sought from qualified nurses, other health professionals, or other appropriate sources.

(American Nurses Association, "Code of Ethics for Nurses with Interpretive Statements").

The ANA also promulgates "Standards". The ANA even defines the role of Standards as follows:

> Standards are the authoritative statements by which the nursing profession describes responsibility for which its practitioners are accountable . . . . Written in measurable terms, standards also define the nursing profession's accountability to the public and the client out comes for which nurses are responsible.

(American Nurses Association, <u>Standards of Clinical Nursing Practice</u>).

These Standards are available for purchase directly from the American Nurses Association at its web site at <u>www.nursingworld.org.</u> Of particular note is the fact that the ANA has published a position that "[a]ll nurses are legally accountable for actions taken in the course of professional

nursing practice, as well as for actions assigned by the nurse to others assisting in the provision of nursing care." (American Nurses Association, "Nursing's Social Policy Statement").

Once you are in a position to establish through both a facility's policy and ANA publications that the standard of care requires patient advocacy by the nurse, then consider whether any associations or organizations for nursing specialties at issue in a particular case may have published similar information. For example, in the scenario discussed earlier where the patient is in the critical care unit, and indeed in any instance where you are reviewing the care of a critical care nurse, the American Association of Critical Care Nurses' ("AACCN") publications can provide meaningful guidance and a persuasive means by which to define this standard of care.

The AACCN has published a "public policy" providing that critical care nurses must do a number of things, including "intercede for patients who cannot speak for themselves in situations that require immediate action and monitor and safeguard the quality of care the patient receives." The Association of Women's Health Obstetric and Neonatal Nurses has printed a "chain of command" and has noted that failure to use the chain of command "in situations of extreme conflict and/or emergency may increase the likelihood of adverse patient outcome and nursing liability if the situation later results in litigation."

Once you have explored the facility's policy and procedure on chain of command as well as trade association publications with respect to a nurse's duty to advocate for the patient, the final step prior to expert testimony in establishing the standard of care is to survey nursing textbooks and any appropriate nursing journals. As one example, we keep various editions of Fundamentals of Nursing: Concepts, Process, and Practice as edited by Kozier, Erb, Berman, and Snyder and published by Prentice Hall. This nursing textbook provides that "[n]urses are expected to analyze

procedures and medications ordered by the physician." The text also identifies several categories of physician orders that nurses must question "to protect themselves legally", including questioning any order that a patient questions.

We also utilize Fundamentals of Nursing: Concepts, Process and Practice as edited by Potter and Perry. This text contains a heading "Physician Interactions", under which the following is written:

> Nurses may share liability for errors made by physicians and other healthcare personnel . . . . Nurses are obligated to follow physician orders, unless they believe the orders are in error or would harm clients. Therefore, all orders must be assessed and, if one is found to be erroneous or harmful, further clarification from a physician is necessary. If the physician confirms the order and the nurse still believes it is inappropriate, the supervising nurse should be informed. A nurse should not proceed to perform a physician's order if it is foreseeable that harm will come to the client.

We also keep various editions of the Illustrated Manual of Nursing Practice. This text provides that a "difficult problem arises when the doctor does not respond to a patient's complaint or only responds in a perfunctory manner. Again, if the lack of response could jeopardize patient health or safety you are legally obligated to notify your supervisor or the proper administrator." The same text provides that "[n]urses are responsible for helping patients receive adequate and safe care. If a nurse fails to identify a situation in which reasonable standards of care have been violated, the nurse and any other participating healthcare professional may be liable."

Similar information can be found in Foundations of Nursing Practice: A Nursing Process Approach by Leahey and Kaziley. This text provides that, when a nurse determines that a physician order is unclear or that the order may harm a client, or even that the order is of some concern to the nurse, "he or she must immediately clarify the order with the physician who wrote it. If there is no resolution to the nurse's questions about the order . . . , the nurse should then contact the nurse

manager for further clarification as to what the next step should be." This textbook goes on to note that "a nurse surely can be held responsible for carrying out an order that would have been questioned by other reasonably prudent nurses in the same or similar circumstances."

Even with all of the foregoing ammunition available to the well-prepared plaintiff's attorney, the theory that a nurse must act as an advocate for a patient even in the face of physician neglect or an affirmative physician order will only have merit with the jury when we can establish that the negligence of the physician for which we are attempting to hold the nurse responsible is something that a reasonably prudent nurse under the same or similar circumstances would have recognized without difficulty. Using scenario 1 above as an example, we would need to establish that a reasonably prudent nurse could easily appreciate the significance of the fact that his or her patient is clinically suffering respiratory distress and is in respiratory acidosis as reflected in the ABG. Under that scenario, nursing textbooks and other published information could be used not only to establish that the nurse has the obligation to act if the physician does not act under those circumstances, but also to establish that ABGs are routinely ordered in settings such as those presented and that it would be very easy for a nurse to recognize the importance of the values indicated on the ABG.

Under any scenario where a physician is endangering a patient's health by failing to act or by acting inappropriately, nurses have an affirmative duty to intervene. It is not appropriate for a nurse to shirk that duty on the basis that he or she is not a physician. Well worded document requests for policies and procedures and some time invested in the literature will provide a patient's attorney with significant ammunition to defeat the "not a physician" defense. It will not typically be enough just to have a plaintiff's expert establish this standard through testimony at trial, however.

We must ensure that we present the jury with voluminous and persuasive evidence on this point so that the jury can become comfortable with this theory of liability.

### 2. Establishing a Nurse's Liability for His or Her Direct Actions

Beyond the theory that a nurse is liable for his or her failure to intervene when necessary are numerous theories of liability for the nurse's direct actions or inaction. By "direct", we are referring to acts or omissions committed by a nurse independent of any physician action. In this section, we take a more in depth look at how to establish nursing malpractice and the law by which these claims are governed.

#### a. Defining the standard of care with literature and policies

Nurses are considered "other healthcare providers" under the Alabama Medical Liability Act. Ala. Code § 6-5-481 (8); see also Jordan v. Brantley, 589 So. 2d 680 (Ala. 1991). The standard of care applicable to nurses practicing in Alabama is therefore that level of such reasonable care, skill, and diligence as other nurses ordinarily have and exercise in like cases.

The nursing standard of care applicable to a given situation may be established through a variety of means, including expert witness testimony, hospital policies and procedures, nursing textbooks, journal articles, and trade association publications. We have discussed above a variety of publications a practitioner can utilize to establish the standard of care with respect to a nurse's duty as a patient advocate. These same publications also outline a nurse's responsibility in given circumstances and should always be referenced when attempting to establish the standard of care applicable to a given case.

The most persuasive material to a jury when a plaintiff is attempting to establish the standard

of care applicable to a nurse is most likely the employing institution's own policies and procedures. A very effective argument can be made that these policies and procedures were formulated when the hospital was focused on providing reasonable nursing care and was not focused on defending itself or its nurses in litigation. Although nurses involved in litigation, corporate representatives, and defense nursing experts are all very well-versed in the defense tactic that policies and procedures are "guidelines" only, our experience is that most nurses and nurse experts will agree that a hospital's policies and procedures constitute one place to look when determining what an applicable nursing standard of care is. Once you have the corporate representative or the defense expert, or preferably both, committed to this position, the argument can be well positioned for an exploration into why the hospital has policies and procedures.

Healthcare institutions must have policies and procedures in place in order to receive accreditation by JCAHO. These polices and procedures must be reviewed annually. Consequently, with appropriate questioning, a jury can be presented with the fact that policies and procedures are not goals to work toward and, in truth, are not "guidelines" in the truest sense of the word. Rather, they are standards a facility must have in place in order to receive an accreditation that is very valuable to the facility, and the employees of that facility are expected to follow the policies when possible.

b. Identifying specific breaches in the nursing standard of care

There are far too many areas of potential nursing liability to address in this presentation. Some of the more common areas of nursing negligence are:

a. Failure to notify a physician of a material change in a patient's condition;
b. Failure to implement physician orders appropriately and in a timely manner;

c. Failure to prevent injuries;
d. Failure to follow the chain of command;
e. Failure to monitor a patient's condition;
f. Failure to verify informed consent; and
g. Medication errors.

The cornerstone of any malpractice case against a nurse is the nursing process. Every nurse defendant should be asked about his or her understanding of the nursing process, and any nurse who responds generically that the nursing process is to "assess and intervene" should be taken to task for that response. The nursing process is a five-step process that continuously repeats itself: 1) Assessment; 2) Nursing Diagnosis; 3) Care Planning; 4) Intervention; and 5) Evaluation. (See, e.g., Foundations of Nursing Practice: A Nursing Process Approach, Leahey and Kaziley (1998)). Breaches in the standard of care can occur anywhere in this five-step continuum.

For this presentation, we will focus on four areas of potential nursing malpractice: (1) Failure to notify a physician of a change in a patient's condition; (2) failure to follow a physician's order; (3) medication errors; and (4) fall prevention.

1. Failure to notify a physician of a change in a patient's condition

The failure of a nurse to notify a physician of a change in a patient's condition constitutes a breach of the standard of care sufficient to get the claim to a jury. See, e.g., Mobile Infirmary Ass'n v. Tyler, ___ So. 2d ___, 2007 WL 2687321 (Ala. 2007). In Tyler, the Court upheld a jury verdict in favor of a plaintiff and against a nurse for negligently failing to communicate adequately and accurately the nature and severity of a patient's abdominal pain. The plaintiff contended that the nurse's action in failing to communicate a very specific item of information, i.e., that the patient had described her pain as the worst abdominal pain she had ever experienced, fell below the applicable standard of care. The Court, when considering the verdict, found that there was a specific

way in which the nurse could have complied with the standard of care by reporting the information either to a physician or to her supervising nurse.

All nursing textbooks we have reviewed make some reference to the nurse's obligation to relay changes in a patient's condition to a physician. For example, the text Fundamentals of Nursing referenced early in this paper sets forth several areas of "basic nursing care" the nurses are to follow. Among the common intervention errors noted in this list is "failing to bring distressing symptoms and changes in client status to the attention of the physician [promptly]." This text goes on to identify a type of nursing malpractice as "failure to observe and take appropriate action" with respect to a patient's condition.

As a practical matter, it is very unlikely that any nurse whose care is at issue in a lawsuit or any defense nursing expert will quibble with the fact that the standard of care requires nurses to report changes in a patient's condition to a physician. More often, they try to narrow this obligation by limiting it to "material" or "significant" changes in the patient's condition, which can be an appropriate limitation if those words are properly defined. Typically, however, the use of this limiting language will be a stepping stone to a defense argument that the patient's particular change in condition that went unreported did not represent a "material" or "significant" change. This can be a very persuasive argument for a nurse whose care is at issue if the nurse has properly documented findings of his or her assessment and if the patient's clinical condition otherwise demonstrates a stable patient. This will allow the nurse to argue that the change the plaintiff's attorney contends should have been reported was not significant given the patient's clinical picture.

To address this, a plaintiff's attorney must first obtain a helpful definition or establish

meaningful parameters for the discussion of what constitutes a material or significant change in a patient's condition. In our experience, most nurses will agree that a material or significant change is any change, including in the patient's laboratory data or clinical presentation, that reflects actual or potential harm to the patient or a worsening of the patient's overall clinical picture. If a nurse disagrees with a similar definition, that nurse can then be neutralized as his or her credibility will be in serious doubt.

By getting the nurse to agree with a similar definition, it is easier to use isolated information that can be an indicator of a worsening condition to support an argument that the nurse should have notified a physician of this change. Regardless of what change is at issue, it is necessary for the plaintiff's attorney to be prepared to discuss during depositions what constitutes a material or a substantial change and to be prepared for the defense that the information the plaintiff's attorney contends should have been brought to the attention of the physician does not represent a material or significant change given the overall clinical picture.

2. Failure to follow a physician order

It is basic nursing care that a nurse is to follow physician orders unless it would be inappropriate to do so. Even the most anti-plaintiff physicians generally acknowledge that they expect their orders to be implemented timely and accurately. If a nurse fails to do so, assuming the order is appropriate, and harm results, then the nurse has committed malpractice.

Determining whether a nurse failed to implement a physician order or implemented it incorrectly often requires a very close review of the chart. The obvious first step is identifying what orders were entered. Orders may be provided by physicians either in writing or by telephone, or they may take the form of standing orders. Written orders will be easy to identify. Orders received by

telephone should also be written in the physician orders section of the chart. Telephone orders should identify the physician who entered the order and the person who took the order down.

Implementation of a physician order should always be documented in the chart. Implementation of a medication order should be documented in the MAR, implementation of a treatment order should be documented in the treatment sheets, etc. Implementation of orders for a diagnostic test can be confirmed by determining whether the test was done. We can also compare the time the order was taken down with the time the order was implemented to determine if there was timely nursing compliance with the order.

One area of potential failure to implement a physician order that may not be as readily obvious is failure to implement a standing order. The phrase "standing order" is defined in the "Medical Protocols, Standing Orders and Preprinted Orders" as adopted by the Alabama Board of Nursing and Board of Medical Examiners on March 25, 1993. The Protocols define standing orders as "written documents containing medical directives for the provision of patient care in selected stipulated clinical situations. Standing orders are generally formulated by the professional members of a department in a hospital or other health care facility."

The failure to follow a standing order was at issue in Lloyd Noland Hosp. v. Durham, 906 So. 2d 157 (Ala. 2005). In Durham, a patient brought a medical malpractice action against the hospital after she developed a postoperative infection following two surgical procedures. The patient contended she should have been given preoperative antibiotics.

The physician, Dr. McGrady, did not prescribe a preoperative antibiotic in his admission orders. The patient's theory, however, was that the treating physician's group had supplied the hospital with standing orders to be used in admitting patients being treated by a physician within the

group. The patient argued that these standing orders supplemented Dr. McGrady's admission orders. Among these standing orders was an order requiring the hospital to administer preoperative antibiotics. The jury agreed with the patient's theory and found that these standing orders were applicable to the patient and that they required the nursing staff to administer preoperative antibiotics even in the absence of an admission order for such an antibiotic.

As Durham illustrates, failing to implement a standing order can form the basis of liability. Consequently, standing orders should always be reviewed when a practitioner is attempting to determine whether a nurse acted within the standard of care.

### 3. Medication errors

Many nursing textbooks suggest that medication errors are the most common occurrence of nursing negligence. Nursing errors in this area can include failing to read the medication label, misreading or incorrectly calculating the appropriate dosage, failing to identify the patient correctly, administering the medication by the wrong route, or misinterpreting or misreading a physician order for medication. Potential medication errors may be considered in the context of the "five rights" of medication administration -- right patient, right route, right dose, right drug, and right time.

The nurse administering the medication is the last safeguard in a series of safeguards typically established by a hospital. The administering nurse has the last opportunity to prevent a medication error from occurring. Tasks the administering nurse should perform include insuring that the prescription or the order for the medication is legible, is correctly transcribed, and is correctly filled by the pharmacist. Nurses are also obligated to use their nursing knowledge to question any orders that appear incorrect or dangerous on their face. For example, no reasonable nurse would implement an order to inject a patient with 100cc of morphine for pain relief. Any reasonable nurse would hold

that order until the order could be corrected.

An additional area to explore when pursuing a case based upon the medication error is how the error was charted. For example, if an inappropriate dosage of a medication was given, the MAR should reflect the dosage given rather than the dosage prescribed. Additionally, there should be nursing documentation that the nurse reported the error to the physician and nursing supervisor as soon as the error was discovered. If the MAR inaccurately reflects the dosage given, or if the nursing notes are silent as to physician and nursing supervisor notification of the error, the plaintiff's attorney should explore these areas fully to determine whether to argue to the jury that the nurse attempted to conceal the error or instead that the nursing documentation was so sloppy that the documentation is at odds with the reality. This would, of course, bring the validity of the entire chart into question.

Although not a type of medication error, it must also be noted that a nurse is responsible for knowing the intended effects of the medication he or she is giving as well as when the peak effect of the medication should be observed. We have seen this issue when a nurse provided a medication to a patient that would have had a peak effect within 5-10 minutes. The nurse testified in her deposition that she did not inform a physician of obvious changes in the patient's condition because she was waiting for up to one hour for the medication she had administered to take effect. The defense nursing expert had no choice but to agree that the administering nurse fell below the standard of care in this regard.

4. Fall prevention

Another common area of nursing malpractice is lack of appropriate fall prevention. Falls can occur for any number of reasons, such as the failure to raise side rails on a hospital bed and leaving a patient who is at risk for falls alone in the restroom so that the patient may try to self-ambulate

back to the bed. These obvious acts are not difficult to evaluate. The defense argument in these areas will typically turn in some way on whether fall preventions should have been in place at all. If the patient's care plan notes fall prevention as an intervention, then liability for a nurse who fails to implement appropriate fall preventions will be more easily established.

Another factor to consider when evaluating a potential nursing malpractice claim related to a patient's fall is what medications the patient may have been taking. If a prior nursing assessment or a care plan has resulted in a finding that a patient is not at risk for falls, consider then what medications the patient may have received since that assessment. In some instances, particularly when dealing with the elderly, psychotropic medications may have been given. The National Association on Mental Illness has on its web site a thorough list of psychotropic medications. The web site for this association is at www.nami.org.

When psychotropic medications are given to a patient, even if the patient was previously assessed as not being at risk for falls, a persuasive argument can be made by the plaintiff's attorney that the standard of care required the nurse to re-assess the patient to determine whether the medication was causing the patient to be dizzy or confused. If so, then the standard of care likely requires the nurse to care plan for fall prevention.

While there are innumerable potential issues related to the use of physical restraints, this is an area that should be explored when a patient has been injured in a fall. If the patient was at risk for falls, perhaps that patient should not have been put in certain places without some type of restraint. Alternatives that are less controversial than the more well-known restraints may also have been available to help prevent the fall. These could include positioning beds at their lowest level, wedging pillows or pads against the sides of wheelchairs to keep patients properly positioned,

placing a removable lap tray on a wheelchair to provide support, and insuring there is an ongoing assessment process in place to monitor for any changes in the patient's physical and cognitive functional abilities and risk factors.

As with most areas of nursing care, the hospital or healthcare facility likely has a policy and procedure with respect to fall prevention and with respect to the use of restraints. Always request these policies early in litigation.

## E. UNDERSTANDING THE HOSPITAL CHART

In the form in which they are typically produced, hospital charts are often voluminous and confusing. The initial step should always be to ensure that you have a complete chart. We typically list the more commonly utilized sections of the chart when we send a request for a copy of the chart to the hospital. These sections include the following:

1. Admission Documents;
2. Initial Nursing Assessments;
3. History and Physical;
4. Nursing Care Plans;
5. Physician Progress Notes;
6. Nursing Notes or Interdisciplinary Progress Notes;
7. Physician Orders;
8. Medication Administration Records;
9. Treatment Records;
10. Operative Reports and Reports of any other Procedures the Patient Underwent;
11. Radiology Results;
12. Labs;
13. Telemetry Sheets;
14. EKGs and EEGs;
15. Consult Notes;
16. Nursing Flow Sheets;
17. Consent Forms; and
18. Discharge documents, including the Discharge Summary.

The question of how to determine that you have an entire chart and how to determine whether

any inappropriate alterations have been made in the chart are beyond the scope of this paper. You should have a nursing or physician consultant review the chart with you as soon as possible after the chart arrives to help you make those determinations.

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