Chapter 18
Ethical Conflicts and Legal Liability in Professional Nursing

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The Professionalization of Nursing

The field of nursing has evolved dramatically since its organized formation in the mid-nineteenth century. Prior to this, nursing was considered more of a vocation than a profession, and nurses were thought to be an extension of mothers and wives rather than clinicians [60]. The practice of "nursing" was less of an occupation and more of a household responsibility for women, with knowledge being passed on generationally rather than through formal education [53]. In fact, women could be appointed as nurses without any formal training whatsoever [53]. In a paternalistic society, it was believed that the benevolent nature of women would afford them the disposition for this task. It was not until the 1850s, when Florence Nightingale introduced female nurses into a combat zone during the Crimean War, that nursing became recognized as an employable position that required training [48]. This role, however, was still vastly different from that of nurses today.

Although nursing had become a career, the job description of the nurse retained many of the antiquated qualities of its previous years. Early training programs in the United States modeled their educational content after Nightingale's work, only permitting female applicants with good moral conduct, the majority of them being from Caucasian descent [33]. Nurses were considered distinctly separate from physicians with a role focused on the duty of caring. The Nightingale-era scope of nursing practice generally included spending time with patients, dressing their wounds, making their beds, feeding them meals, and maintaining sanitation [33]. Nightingale was a staunch proponent for the division of labor, saying that "the Matron must look to the Medical Officer for professional instructions which she is to obey; but for nothing else [44]." Due to an absence of interdisciplinary collaboration between the various roles in the medical field, nurses were expected to follow physician orders

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without question or input. These limitations to the role of early nurses were compounded by cultural assumptions regarding gender characteristics, in turn leading to the division between physicians and nurses [53].

Formal education for nurses in the United States began in 1862, with hospitals setting up nurse training programs specific to their facilities. It wasn't until the 1920s that the education process moved away from small, employer-sponsored training to a more formal and rigorous university-based system [33]. Reform of the nursing practice was met with conflict, and there were widely differing public opinions on increasing the educational standards for nurses [53]. A small group of reformers, now understood to be the origins of the American Nurses Association, argued that educational restructuring was imperative to the professionalization of nursing and that it would lead to clinical improvements. The opposition believed that increasing the training requirements for nurses would exacerbate the ever-present nursing shortage and push current nurses out of the profession [53]. Many nurses expressed the desire to continue practicing with skills determined by "womanly virtue" rather than professional autonomy [53].

However, practice standards began to change after World War II, when North American nurses led the movement to professionalize the nursing practice [53]. The United States was thriving in the postwar era, and the 1950s brought increased hospital development, the expansion of private health insurance, and an increase in the birth rate (now known as the baby boomer generation). Clinical research became necessary for all medical providers, and many nurses pursued advanced degrees in order to keep in line with practice standards.

Today, professionalism is one of the major components of nursing practice and is highly valued by medical institutions throughout the healthcare system. With an increasing acuity among patients, nursing responsibilities have evolved to include critical thinking, interdisciplinary collaboration, advanced assessment skills, and leadership. Nurses are now seen as essential clinical resources that complement physicians rather than as an adjunct. With the implementation of the Affordable Care Act in 2010, healthcare experienced one of its largest overhauls of the past century. In order to prepare for this transition, the Robert Wood Johnson Foundation and the Institute of Medicine began a 2-year study (2008–2010) of the nursing profession and its potential for growth.

Considering that nurses constitute the largest percentage of healthcare professionals, the IOM and the RWJF advocated for nursing partnership and leadership, stating that the delivery of high-quality care was impossible without a strong nursing workforce. The Future of Nursing Initiative intended to find ways to standardize practice and increase nursing efficiency in order to eliminate present barriers to patient care. The RWJF created a committee staffed with experts in health policy, business, academia, and healthcare delivery. Members were appointed in order to examine the current role of nursing, staff shortages, nursing education, and future nurse recruitment [24].

At the conclusion of their study, the committee produced a detailed report that was 642 pages in length and supported 4 main recommendations. Although this report refers to advanced practice nurses, licensed practical nurses, and registered

nurses, we will focus on registered nurses for the purpose of this chapter. First, it was determined that nurses should be practicing to the full extent of their education and training [24]. Although many nurses receive the same education, their scope of practice is defined by their state of residence. While some states strictly outline their professional standards, others are less clear about staff expectations. Standardizing the scope of practice would eliminate the ambiguity of professional standards across state lines, creating an easily definable job description.

The second recommendation was the promotion of growth in nursing leadership and interdisciplinary collaboration [24]. With their constant presence at the bedside, nurses can offer an informed, real-time, patient assessment, a luxury that physicians and advanced practice providers do not have. It is believed that increased interdisciplinary collaboration can provide a potentially vital system of checks and balances, as enabling nurses to openly communicate with physicians and APPs about care planning could potentially prevent or correct medical errors before they occur. In the committee's report, nurses were encouraged to share their assessment, and interdisciplinary collaboration was proven to be essential in promoting high-quality care. As such, healthcare organizations were additionally advised to engage nursing staff and assist them in developing improved patient care models to leverage these benefits.

In order to help promote these recommendations, nursing education was reformed to include courses in leadership, while clinical practice was designed in such a way that nursing students were given the ability to develop their leadership skills. Once employed, nurses were encouraged to seek out leadership opportunities and strive for professional growth within their careers. It was further suggested that employers offer leadership development and mentoring programs in order to assist their nursing staff.

The third recommendation was the improvement of data collection in order to enhance workforce planning and policy development [24]. Considering that the nursing shortage is only expected to become more severe, the IOM and RWJF suggest that the National Health Care Workforce Commission, the Health Resources and Services Administration, and the Department of Labor should collaborate in order to identify healthcare workforce needs and create a plan to increase the number of nurses for future employment [24]. The committee believed that by utilizing predictive analytic techniques that the data collected could be used to optimize planning for future workforce requirements.

The last, and most emphasized, recommendation from the committee was to increase the educational requirements for nurses due to increasing patient acuity and the varying responsibilities of the profession [24]. The IOM and RWJF agreed that a bachelor's degree was the preferred level of education for registered nurses and aimed to increase the percentage of baccalaureate-prepared nurses from 50% to 80% by 2020. They stated that healthcare facilities should offer incentives for continuing education such as tuition reimbursement and competitive salary benefits for their associate degree nurses. In addition, student loan forgiveness and grants should be made available for those with nursing degrees.

In addition to increasing the proportion of baccalaureate nurses, the committee also emphasizes the need for nurses to partake in lifelong learning while employed. Although it is true that nurses learn daily while on the job, the IOM and RWJF argue that mandated continuing education should be an additional requirement. Continuing education can come in the form of lectures, journal article readings, or participatory certifications. Nurses are also required to complete annual competencies in order to ensure they are up to date with their current facility policies and requirements on how to use the equipment. Some states have already implemented these suggestions, requiring nurses to prove a certain number of continuing education hours when reapplying for their RN license.

With the professionalization of practice, many nurses were experiencing dramatic developments in their clinical roles. Becoming more of a prominent medical liaison at the patient's bedside began to shed light on additional changes that needed to happen within our healthcare system; one being the lack of ethical care that patients were receiving. In the next section, we will discuss some of the most common ethical considerations nurses face in their day-to-day roles.

Ethical Conflicts in Professional Nursing

Historically speaking, ethical care as we know it was not always a priority of medical treatment. The 1950s and 1960s saw rapidly advancing medical technology virtually reshape the culture of healthcare. Hospital staff were practicing within the ethical concepts of beneficence and nonmaleficence when treating patients [50], while new equipment had created the philosophy of "preserve life at all costs [50]." In other words, medical personnel were expected to do no harm and act in their patients' best interests, while simultaneously extending the human body past its corporeal existence. It was not until the 1980s and 1990s that the ideas of patient autonomy and advanced directives became the prominent determinants of care planning [32, 43]. Nursing has played a pivotal role in this paradigm shift, and that role is expanding due to the professionalization of the nursing practice [29].

Albeit morbid, life and death decisions are made daily in intensive care units around the world. As such, it is crucial for physicians and advanced practice providers to be explicit when providing information on care options to patients and families—as seen with the practice of informed consent. Nurses are often an additional resource that is able to supplement the information being provided. As the primary point of contact, nurses have the potential to develop a trusting relationship with patients and families. Through this relationship nurses are able to have discussions about autonomy, goals of care, and quality of life. Nurses then have the ability to articulate discussed directives to the medical team in ways that the patient and/or proxy may not.

Communication is arguably the critical care nurse's most useful tool. In an environment in which multiple team members from various disciplines are constantly circulating through the unit's milieu, it is often the nurse's responsibility to gather

and relay information. The intensive care unit can be intimidating to the layman because it is a high-stress area where patients and their families are required to make substantial decisions involving their care. There are many instances in which patients are unable to speak for themselves, and medical decisions become the responsibility of their surrogate, also known as next of kin. Said surrogate is charged with making decisions that they believe to be in line with the patient's wishes; however, that is not always the case. For example, according to the New York State Attorney General's Office, next of kin has the power to rescind a do not resuscitate order on a mentally incapacitated patient [2], even though the process may not be in line with the patient's wishes.

While the patient remains the main focus of nursing attention, the practice of holistic care is leading family members to become more involved throughout the hospitalization. Although a familial presence can be valuable to the critically ill patient in many ways, it can also lead to an array of ethical conflicts for medical staff requiring oversight through hospital ethics committees.

Ethics Committees and Litigation

Critical care nurses have the ability to voice their ethical opinions among the medical team, but because of their legal limitations as a restricted diagnostician without ordering privileges, their opinions can often be overlooked. One example of this can be the overall limitations of bedside nurses within formal ethical and legal hospital agencies. Many hospitals appoint ethics committees that are responsible for reviewing patient cases within their administration and then assisting the care team by reporting their assessment of the situation. Ethics committees are consulted for many reasons, but they are commonly involved in situations pertaining to medical futility. One study in the Midwest United States found that there was an average of two nurses on hospital ethics committees, and those nurses were serving the hospital in managerial or administrative roles [49]. Although these nurses were formally educated in ethics, many of them lacked familiarity with the patient's experience while in the hospital and did not directly participate in patient care [49]. In contrast, other hospitals have ethics committees that involve nurses with backgrounds in administration, floor nursing, and critical care nursing [21]. While it is vital to have an unbiased committee presiding over potentially life-sustaining ethical treatments, it could be beneficial to bring in witnesses with bedside contact—in the same way that physicians and nurses can be expert witnesses during legal proceedings in court. In this way, ethics committees can gain testimonials from those directly responsible for the care being questioned.

In an effort to become more involved in ethical discussions, nurses formed parallel nurse ethics committees in which all members were from a nursing background. The first NEC was formed in Omaha, Nebraska, in 1984 [28]. In addition, the early 1990s saw both the Joint Commission on Accreditation of Healthcare Organizations and the American Nurses Association require institutions to have standards in place

that allowed nurses to partake in ethical discussions [28]. It is thought that a nurse-based ethics committee would help empower nurses and familiarize them with ethical situations. This would, in turn, assist them in becoming more involved in hospital ethics committees and more ethically minded providers [61].

Although not infallible, ethics committees have been shown to resolve many conflicts before they reach formal legal proceedings. A study conducted by Baylor University Medical Center showed that 98% of conflicts in medical futility cases were resolved by ethics consultations prior to litigious action being taken [16]. Unfortunately, there are times when involved parties cannot come to an amicable conclusion, and those situations are frequently involving the end of life [42]. Even though nurses may not be directly involved with the litigious side of medicine, nurses are largely impacted by the decisions that lead to judicial intervention.

There are many legal cases that involve medical futility and end-of-life decisions. For example, Baby L, *Gilgunn V. MGH*, *In re Wanglie*, and *In re Baby K* all involved patients that physicians believed no longer benefitted from aggressive medical care due to their insurmountable comorbidities [42]. Said physicians wished to withdraw care on the patients, but the family members insisted on the continuation of care and, in the cases of Helga Wanglie and Baby K, ended up pursuing legal action [42]. Litigious proceedings can be time-consuming for all involved. Throughout that time, nurses are at the bedside, continuing to take care of a critically ill patient along with their grief-stricken family regardless of their professional opinions on the care they are being required to provide. This direct exposure to the effects of medical futility is one of the primary causes of staff burnout, a serious and pervasive dilemma within the field of nursing that we will discuss in the next section.

Medical Futility

It has been shown that critical care nurses experience high levels of moral distress when carrying out families' wishes that they (the nurses) believe to be unethical towards the patient. Unsurprisingly, many studies have referenced the most pervasive cause of moral distress to be in cases where the critical care nurses believe there to be an unnecessary prolongation of life insisted upon by the patient's loved ones [20]. At times, critical care nurses have even felt that the family can be a hindrance to patient care [55]. Repeatedly referenced high-stress situations in the intensive care unit often involve patients' loved ones opting for the continuation of aggressive medical treatment that the nurses see as causing the patient undue suffering without providing any tangible medical benefits [12, 19, 20, 36]. Critical care nurses often believe these efforts to be a futile attempt of prolonging life.

Futility is a relatively new concept in medicine. Since the term "medically futile" is heavily subjective and therefore undefinable, groups like the American Thoracic Society have suggested using terminology like "potentially inappropriate treatment" instead [50]. Defined by Kon et al., inappropriate treatment is "when there is

no reasonable expectation that the patient will improve sufficiently to survive outside of the acute care setting, or when there is no reasonable expectation that the patient's neurologic function will improve sufficiently to allow the patient to perceive the benefits of treatment" [29]. The entire medical team is responsible for establishing realistic goals and expectations for patient care, and their constant presence at the bedside allows nurses to play a vital role in care planning. It is possible that frequent time spent at the patient's bedside will allow the nurse to develop insight about the patient and family's wishes.

It is often argued that ethical situations involving end-of-life care are exacerbated by the rapid evolution of medical technology. With the continued advancement of medical equipment, there are higher expectations for positive outcomes among patients, families, and medical professionals, alike. Some nurses interviewed in one study had generally positive opinions about technology within intensive care units [38]. In contrast, others have the opinion that technology has placed them in a precarious position [38]. Many nurses felt that technology had left them responsible "to implement heroic caring for dying patients, while decisions failed to be made on what technology realistically had to offer" [38]. Being employed in departments with life-sustaining equipment, critical care nurses often question their ethical and moral beliefs during advanced patient care. There are many occasions in which critical care nurses are repeatedly exposed to morally distressing situations involving their patients, an experience that is beginning to take a significant emotional and psychological toll on nurses globally.

Staff Burnout and Moral Distress

The continual attention required to care for a grieving, anxious family in addition to an acutely ill patient is a compounding emotional stressor that is increasingly plaguing critical care nurses around the world. As a self-defense mechanism, critical care nurses have been known to emotionally detach from situations that they do not agree with in order to continue providing patient care [19, 36]. After repeated exposure to such stressors, it is possible for nursing staff to become cynical and burnt out [19, 36]. Phrases such as "burnout" and "compassion fatigue" have been topics of conversation among hospital staff for decades, and academics are beginning to take notice.

Staff burnout was first introduced by H.J. Freudenberger in 1974, where he published information about workplace stress in the *Journal of Social Issues* [51]. Initially defined as "a state of fatigue or frustration that resulted from professional relationships that failed to produce the expected rewards" [17], the topic of burnout has since gained much attention from medical providers and researchers, alike.

The definition of burnout evolved in 1982 when psychologist Christina Maslach described it as "a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment that occurred among various professionals who work with other people in challenging situations"

[34, 51]. Through her extensive research, Maslach was able to create a conceptual model, dubbed the Maslach Burnout Inventory, which helps quantify burnout. Drawing from common themes such as cynicism, detachment, emotional exhaustion, and personal inefficacy [14, 35], the MBI has three main domains: emotional exhaustion, depersonalization, and personal accomplishment [51]. Each domain has a various number of questions that ask participants to describe their feelings on a 7-point scale, ranging from never experiencing said feelings to experiencing them multiple times per week [51]. The higher the combined scoring, the more likely the interviewee is to be at risk. Although there are many tools to measure staff burnout, the Maslach Burnout Inventory is the most widely adopted tracking method across numerous professional disciplines [51].

A 2009 study researched the reliability of the MBI in evaluating staff burnout among nurses in adult general hospitals [51]. The sample size was 54,738 nurses working in 646 hospitals across 8 different countries. Using confirmatory and exploratory factor analyses, Poghosyan, Aiken, and Sloane determined that the MBI was validated and performed "relatively similarly" across all eight countries [51]. Using the MBI has allowed many institutions to determine the main causes of burnout among nurses, especially those within critical care.

Nurses working in high-stress fields are more likely to experience burnout from their careers [13, 52]. To quote McFeely, "[burnout] is so pervasive in the ICU that it almost has become a part of the background noise" [37]. Although all medical providers in critical care experience work-related stress, it has been shown that nurses experience increased levels of burnout due to their continual close contact with patients [6, 31]. Moreover, critical care nurses are caring for patients at the height of their illness; progression and improvement are not always witnessed by the healthcare team, increasing their risk of burnout due to emotional exhaustion [5, 6, 31]. As a result critical care nurses often develop coping strategies, such as depersonalization, in order to best care for their patients. Feelings of emotional attachment have the potential to cloud judgment and distract nurses at times when attention to detail is paramount [55]. While this self-preservation tactic can improve care and efficiency in high-stress situations, it presents a conundrum to ICUs given that, according to Maslach, increased feelings of depersonalization and detachment are likely causes of staff burnout. This presents nurses with the unenviable predicament of having to choose between maximizing patient care and protecting their own mental health.

For those working in critical care, another frequent cause of workplace burnout is moral distress. Moral distress takes place when one is unable to act within their moral or ethical code [14, 19]. Critical care nurses, although heavily involved with interdisciplinary collaboration, rarely have control over the prescribed orders and final decisions related to their patients. Due to this lack of control, critical care nurses have been shown to be more vulnerable to moral distress than physicians [6, 20, 31]. Ultimately, the act of accepting and fulfilling physician orders (within reason), whether or not said decisions are in line with the nurse's morals, is the leading cause for this distinction [31].

In addition to discrepancies between medical professional's ethical opinions, critical care nurses are prone to emotional distress when interacting with patient family members. Nurses are often the link between patients, family, and the rest of the medical team. Because of this, it is not uncommon for them to develop emotional attachments to patients and their families. Although nurses recognize the significance of this relationship, it has been shown to cause increased levels of emotional exhaustion among staff [55]. This can lead to a phenomenon called compassion fatigue. Defined by McHolm, compassion fatigue is "the emotional, physical, social, and spiritual exhaustion that overtakes a person and causes a pervasive decline in his or her desire, ability, and energy to feel and care for others" [39]. Compassion fatigue in the intensive care unit often results from constant involvement with critically ill patients and their families compounded by the high-stress environment. It is often argued that the combination of compassion fatigue and moral distress is responsible for high rates of staff turnover among nurses, particularly in critical care units.

Staff Turnover

As professionals, it is easy to diminish the significant amount of emotional distress experienced in the workplace. However, evidence shows that burnout in nursing is associated with poor patient outcomes and increased turnover among nursing staff [40, 41, 58]. A study conducted by Hiler et al. used the Moral Distress Scale-Revised (MDS-R) and the Practice Environment Scale of the Nursing Work Index (PES-NWI) to poll critical care nurses on their levels of moral distress and perceived job satisfaction [23]. While the MDS-R is a survey used to gauge moral distress, the PES-NWI is a survey designed to measure the nurses' overall sense of fulfillment and work productivity. Using these survey methods, Hiler et al. had the intention of studying the relationship between moral distress and nurse turnover. The sample size included 328 nurses employed in intensive care units across the United States, ranging from 1 to >10 years of experience. Although the majority of respondents (59%) echoed job satisfaction, 73% had contemplated leaving their position within the past 6 months [23]. It was found that the nurse's desire to leave their position was significantly correlated to their levels of moral distress [23]. Another study directed by Corely showed that 13% of critical care nurses left their jobs because of moral distress and 5% abandoned the field of nursing entirely [11].

In a profession that is already considered grossly understaffed, the continued loss of nurses due to burnout can be crippling to healthcare institutions. Considering the current statistics of the workforce, the demand for nurses will increase up to 30% by 2020 due to the retirement and aging of the baby boomer generation [3]. Although the nursing profession eagerly welcomes new members, the lack of veteran nurses is becoming evident. A study conducted by Buerhaus et al. revealed that nursing had lost 1.7 million "experience years" to retirement in 2015 and is expected to lose an additional 2 million "experience years" by 2020 [9].

Due to the positive correlation between nurse burnout and years of work experience [54], institutions are beginning to spend more time on nurse retention [3]. Some hospitals are developing employee assistance programs that provide counseling and coping strategies for stressful situations [5]. Others are encouraging off-campus retreats that combine education on mindfulness with scheduled periods of relaxation and self-reflection [7, 30]. Many survey-based studies show that nurses believe they are reducing their levels of burnout by practicing self-care [22].

Legal Liability in Professional Nursing

As with most professions, there are regulatory bodies that dictate standard policy, licensing, and regulation within nursing. The American Nurses Association (ANA) was a pioneer during the early days of nursing. Formed in 1896, the Nurses' Associated Alumnae of the United States and Canada (now known as the ANA) was responsible for setting professional standards and defining the scope of nursing practice [27]. Becoming licensed as a registered nurse is a relatively new concept for the profession. In the early 1900s, some states implemented optional licensure programs for nurses, but many states did not require their nurses to be licensed whatsoever. Optional licensure had spread nationwide in the 1920s, with state boards of nursing being implemented to distribute and monitor said licenses. Each state would have its own licensing exam, which often varied widely from other state's exams. In turn, the scope of nursing practice across state lines often had substantial differences [27].

The ANA formed the National Council of State Boards of Nursing, or NCSBN, after World War II in an attempt to standardize licensing and testing for nurses [27]. The NCSBN was, and still is, a federal agency that is comprised of 59 sub-boards belonging to each state and territory within the United States [1]. Board of Nursing (BON) officials are often elected or appointed, many of whom have experience in patient care from their designated state [45]. One of the key early achievements of the NCSBN was in spearheading the practice of mandatory licensure for registered nurses in the United States by advocating for professional reform. As a result, by the 1950s, US nurses were required to be licensed, each applicant having to take a standardized national exam in order to obtain their license. This national exam helped shape the current National Council Licensure Examination, or NCLEX-RN, required of students today [27].

In an effort to standardize practices and ideologies, the NCSBN also designed a Model Nurse Practice Act, which is meant to be a guide for state and territorial Board of Nursing regulations. The Model Nurse Practice Act outlines licensure qualifications, nursing accreditations and titles, scope of practice, and disciplinary actions resulting from breaking the aforementioned regulations [45]. The NCSBN has tasked each jurisdiction to form their own Nurse Practice Act, which would then be interpreted as the standard regulation governing said jurisdiction's nurses. We will discuss the nurse practice act further in the legal liability section.

Although state BONs base their regulations from the national standards of the NCSBN, states and hospitals are able to more specifically define the current scope of nursing practice should they see fit. According to the American Nurses Association, the scope of nursing practice is determined by a combination of Nurse Practice Acts, JCAHO regulations, the nursing code of ethics, organizational standards, and institution policy and procedure manuals [18]. As such, there are often instances in which the nursing scope of practice varies among different states, or even different hospitals within a single state.

To become a licensed professional, current standards require nursing students to first graduate from an accredited educational institution. Accredited institutions can be verified by transcript work, a diploma, or a letter from the program's dean [27]. Once a student's education is verified, they are then given the authorization to take the NCLEX-RN. With proof of a successful exam result, student nurses can then apply for licensure with their state board of nursing and pay applicable fees. It is the responsibility of individual states and territories to issue licenses to nurses within their region and to further monitor their adherence to prescribed laws based on that state's nursing policies. The applicant must be at least 18 years of age and does not have to be a US citizen [45]. Once approved, permission is granted to practice as a registered nurse in that state. If a nurse wishes to practice in another state, they must apply for licensure through said state's board of nursing. Additionally, some states participate in compact licensure programs. Further, many states also require continuing education in order to maintain licensure. Every time a nurse wishes to renew their license, often every 2–3 years, they must have proof of continuing education that meets their jurisdiction requirements. Most areas require between 20 and 40 hours of continuing education over the 2–3 year period [27].

In order to obtain a registered nurse license, many states require the applicant to display "good moral character as determined by the department" [45]. Licensure application may inquire if the candidate has ever been found guilty of a felony or misdemeanor, if there are any criminal charges pending against them or if they have been accused of professional misconduct [46]. State boards of nursing have outlined extensive definitions of professional misconduct. Some examples may include revealing protected health information, negligence, false reporting or failing to report, practicing beyond the scope of nursing, delegating to unlicensed personnel outside of their scope, treating without consent, or guaranteeing that success will result from medical treatment [47]. As one would expect, these are some of the most common areas in which nurses can experience legal liability within the scope of their practice.

Statutory Law

Throughout the history of medicine, nurses were not commonly considered to be medical professionals that were subject to litigation. The professionalization of nursing has led to increased autonomy and responsibility among nurses, which has

in turn led to the development of numerous laws to help regulate the nursing practice and protect staff. Nursing laws are created by the federal government, states, and hospital policy and procedure manuals, resulting in varying legal implications depending on the location. It is the responsibility of the nurse to know the law; ignorance will not dismiss a legal deposition. Violations of nursing law can leave the accused subject liable for potential monetary fines, suspension or loss of license, and even possible imprisonment [27].

The determinants of nursing law can be broadly divided into two categories: statutory law and common law. First, we will explore examples of statutory law. Statutory law refers to laws that are created by legislative bodies such as Congress or state boards of nursing [27]. Federal statutes are responsible for defining the minimal standards of care for hospital personnel in all facilities that receive federal funds, whereas state statutes deal with more specific legislation, unique to the jurisdiction in which they are applicable.

There are four main federal laws that most greatly impact nurses [27]. First is the Emergency Medical Treatment and Active Labor Law, or EMTALA. Enacted in 1986, EMTALA was put in place to protect uninsured and/or financially vulnerable patients from being refused treatment by emergency departments due to their insurance status [27]. Second is the Americans with Disabilities Act of 1990, with an intent on ensuring that disabled persons receive equal, unbiased healthcare. This law requires institutions to provide assistive devices to accommodate a patient's disability in order to maintain an equitable standard of care [27]. 1990 also saw the implementation of the Patient Self Determination Act, our third federal law, which supported the patient to express preferences of treatment and participate in their healthcare. This law was also pivotal in informing patients about their ability to accept and/or refuse treatment and introduced advanced care directives [27]. The final, and probably most familiar, federal statute is the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA. The primary directive of HIPAA is to ensure the confidentiality of patient protected health information [27].

State statutes are largely determined by nurse practice acts. As we have discussed, nurse practice acts are state-specific pieces of legislation that are designed to protect the public and define nursing responsibilities [27]. Nurse practice acts will generally define the term of registered nurse, outline standards and scope of practice, and give examples of behaviors that are prohibited by registered nurses. Examples of illegal nursing activity may include, but are not limited to, diverting medications, being impaired by drugs and/or alcohol while at work, treating outside of the scope of practice, falsifying records, and physical and/or sexual abuse of a patient [59]. Each state board of nursing has the ability to investigate any deviance from prescribed policies. It is the responsibility of the nurse to understand the policies designated by their state of practice as well as their state's nurse practice act. Failure to comply with one's state nurse practice act can lead to the revocation of professional licensure [59].

Common Law

In contrast to statutory law, common law comes from judicial decisions during medical litigation cases. Once a medical case has been brought to state or federal court and a judge has made a ruling, said ruling is incorporated into the standards of professional nursing conduct [57]. These standards of conduct will partially contribute to the evolution of the nursing scope of practice over time. One prominent example of a legal case determining the expected conduct of nursing was that of *Utter v. United Hospital Center, Inc.*, in which a jury determined that nurses were required to exercise judgment independent of physicians, if necessary, in order to prevent harm to the patient [57].

Plaintiff Garth R. Utter had fallen from a ladder and had sustained injuries to his right wrist, elbow, and back, injuries that were revealed to be a "comminuted compound fracture of the right wrist, a posterior dislocation of the right elbow, and a compression fracture of the second lumbar vertebra," respectively [57]. His right arm was casted by a physician, and he was admitted to United Hospital Center for monitoring. About 48 hours into his hospital stay, the patient began to show symptoms of compartment syndrome in his right arm and from then on rapidly deteriorated. These complications eventually led to his right arm being amputated. Documentation showed that staff nurses had reported the patient's condition to the overseeing physician, but that the physician did not escalate care. Since the nurses did not activate the physician chain of command, they were indicted with negligence. The reason this was considered to be a landmark case is because this was the first time that nurses were seen as legally independent medical professionals, and therefore liable to litigation [27]. Since it had been established that nurses could be subject to litigation as a direct result of their actions or inactions, further education was required on how instances of civil or criminal law could apply to nurses, specifically.

Tort Law: Unintentional Torts

There are many examples of civil lawsuits that fall under the legal umbrella of torts. A tort can either be intentional, as in cases of assault and/or battery, or unintentional, as with issues involving negligence or malpractice. In order for something to be considered a tort, it must be proven that there was a civil wrong committed by one party against another party that violates the legal duties determined by their personal relationship [26]. Reasonableness and social expectations determine whether or not the breach of duty between parties is considered a tort.

In addition to reasonable behavior, professionals are judged against standards of practice; if there is a violation in either of these categories, the practitioner is defined as negligent [56]. Negligence committed by professionals is otherwise referred to as malpractice [27]. Therefore, when considering its application to nurses, the terms

can be used interchangeably. In other words, the nurse-patient relationship is a legally binding personal and professional contract. If the nurse wrongs the patient, whether intentionally or unintentionally, the nurse can be subject to litigation if he/she did not reasonably conform to the standards of nursing practice during the incident.

In order to prove malpractice, the plaintiff must prove that five specific circumstances had occurred. First, it must be proven that the nurse had a duty to the plaintiff. This can be determined by something as simple as the nurse's daily patient assignment. Second, if the nurse-patient relationship was proven, the plaintiff must then define the appropriate standard of care for the nurse in question [4]. The appropriate standard of care is defined as the general degree of skill, knowledge, and care that is ordinarily possessed by a practitioner in good standing within their profession [18]. Nurse practice acts, hospital policy, procedure manuals, and federal regulations all define the general standard of care.

Once the standard of care is determined, thirdly, the plaintiff must prove that the nurse had deviated from the standard of care. Juries test the standard of care by asking whether or not a prudent nurse with the same level of experience would have performed similarly under said circumstances [18]. For example, a critical care nurse with 15 years of experience will not be held to the same standard of care as an outpatient urgent care nurse with 15 years of experience. Additionally, a critical care nurse with 1 year of experience will not be held to the same standard of care as a critical care nurse with 15 years of experience. Next, if a breach in the standard of nursing practice has been identified, the plaintiff must then prove that their injury was a direct result of said breach. Finally, the plaintiff must then prove that said breach had resulted in damages [4].

Critical care nurses are held to the same level of legal liability as floor nurses. However, the standard of care is vastly different for a critical care nurse than that of a floor nurse. The scope of practice is heavily influenced by unit protocols and educational standards, and it is often more fluid and technical than in floor nursing [26]. As an example, the responsibilities of advanced practice providers relative to nurses often falls within a gray area precisely because critical care nurses are expected to interpret clinical signs and symptoms and act upon them immediately. This added level of responsibility over floor nurses crucially differentiates the necessary regulatory treatment between the two roles.

In many hospitals, critical care nurses have standing orders. For example, say a cardiac ICU nurses were to notice that her patient was having premature ventricular contractions and then drew a set of labs and replaced electrolytes per standing orders. Even though there are standing orders telling her to do so, she is technically making the medical diagnosis of PVCs caused by electrolyte imbalances. Legally, diagnosing within the context of nursing practice is significantly different than a medical diagnosis. In fact, if a nurse were to diagnose as a physician does, it would be seen as a breach of the scope of practice. Instead, nursing diagnoses are more related to physical and physiological signs that nurses observe as part of their clinical judgment [45]. This conundrum frequently presents itself in intensive care units

and is part of the reason behind the immense level of continuing education required to be a critical care nurse.

Juries refer to many sources when determining the standard of care for nurses. Some examples of useful bodies of evidence are nurse practice acts, professional organizations such as the American Nurses Association or The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), employee job descriptions, practice standards related to the nurse's specialty, and hospital policy and procedure manuals [56]. In addition to performing within the prescribed standard of care, nurses must also practice using the nursing process. If a nurse is able to demonstrate reasonable execution of assessment, planning, implementation, and evaluation, then they are considered to be practicing within the reasonable standards of care for their profession. If, however, any one of these methods is proven to be insufficient, the nurse may be liable for malpractice [56]. These cases are commonly referred to as the "failure to" cases; failure to assess, failure to evaluate, failure to document, failure to rescue, and failure to report are some examples.

A significant example of a legal case where nurses were subpoenaed for negligence was *Brandon HMA, Inc. v. Bradshaw* [8]. Dawn Bradshaw alleged that the treatment received from the nursing staff was negligent and did not meet the standard of care, said treatment resulting in her permanent disability from brain damage after cardiac arrest. Bradshaw was admitted to Rankin Medical Center on February 17, 1997, with the diagnosis of bacterial pneumonia. On February 21, 1997, a chest tube was inserted for fluid drainage on the affected left lung. Two nurses taking care of Bradshaw periodically took her vital signs and noted no distress after the chest tube insertion.

At 2300, Alex Lewis, LPN, assumed care of Bradshaw. Lewis was assigned to the patient and supervised by charge nurse Pam Nail, RN. Around midnight, Lewis performed his first assessment of Bradshaw, and a set of vital signs were normal other than a slightly elevated heart rate. The chart reflected that Bradshaw was complaining of pain on her left side. Throughout the night, Bradshaw continued to complain of increasing pain on her left side. Lewis did not take another set of vital signs; rather, Bradshaw was medicated with Tylenol for pain and Ativan for anxiety. At 0240, Lewis rounded on Bradshaw to find her sitting up in bed, complaining of significant pain, and with rapid, shallow breathing. Lewis medicated Bradshaw with the narcotic Lorcet Plus and did not take her vital signs. At 0330 Bradshaw was found to be disoriented, diaphoretic, and not following commands. Lewis then checked vital signs and left the room to notify Nail. When both Nail and Lewis returned to Bradshaw's room, she was found cyanotic, apneic, and pulseless. A code was called and CPR was initiated, Bradshaw was transferred to the ICU. While in intensive care, MRIs of the brain revealed that Bradshaw had extensive brain damage as a result of a lack of oxygen.

Bradshaw survived but was left permanently disabled as a result of her brain injury. She was unable to independently perform activities of daily living and requires assistance with mobility. She also requires continual administration of antispasmodic drugs to alleviate her frequent muscle spasms. Bradshaw stated that the negligence of the nursing staff was the direct cause of her injury. The standard of

care would have required Lewis and/or Nail to take vital signs and notify the physician during her continued complaints of pain. The expert witnesses, judge, and jury agreed with Bradshaw and awarded her $9 million in damages.

Tort Law: Intentional Torts

In comparison to unintentional torts, intentional torts are defined as civil wrongs that directly violate a person's legal rights [27]. In respect to nursing, the offensive act of the nurse was intentional, although harm of the patient may not have been the intended result. Some examples of intentional torts are assault, battery, and false imprisonment [27]. Unlike with malpractice cases, intentional torts do not have to be proven by the plaintiff as being a divergence from the standard of care in order for them to be legally processed. Penalties for intentional torts vary based on the type of tort, but fines and punitive damages are often involved [27].

While the terms assault and battery are often grouped together within the realm of intentional tort law, they each have a distinct definition. Assault occurs when the plaintiff claims an intentional act had created reasonable discontent and fear of physical contact from the assailant [56]. It is important to note that physical contact is not required in order to determine an occurrence of assault. Battery, on the other hand, is defined by an intentional act that brings unauthorized or harmful contact to a person [27]. Although the definitions remain consistent across all types of law, the terms assault and battery are not always portrayed in the same way in medicine as they are within society. For example, nurses can face charges of assault for threatening to restrain a patient. Nurses could also be charged with battery for giving a patient a medication that they have refused. In most cases, nurses mold their treatment plan from the ethical principles of beneficence and nonmaleficence, and patient harm is not the intention of their actions. However, they can still be prosecuted if they do not practice within the legal limits of their profession.

As previously mentioned, the Patient Self Determination Act determined that the mentally competent patient has the right to refuse any treatment plan prescribed by healthcare professionals. If a patient is deemed capable of making their own decisions, they are legally able to refuse any treatment that had been previously agreed to. If a nurse were to prevent, either physically or verbally, the patient from acting on their wishes it would be considered false imprisonment [27]. It is important to note that physical restraint is not required for a charge of false imprisonment. Although not commonly seen in critical care, this issue often presents itself when a patient wishes to leave the hospital against medical advice, or AMA. The nurse does not have the authority to prevent the patient's departure and is legally required to let the patient leave. The nurse must simultaneously contact the provider and notify them of the patient's desire to leave AMA [27]. Many facilities have forms that exempt them from some legal liability if the patient's condition were to deteriorate after leaving the hospital against medical advice. Said forms detail the dangers of leaving the facility prior to medical readiness and require a patient signature.

An example of false imprisonment more commonly found in critical care is the application of physical restraints. Patients in intensive care are commonly supported with a multitude of machines. It is not uncommon for patients to have endotracheal tubes, feeding tubes, urinary catheters, and central intravenous access lines simultaneously, many of which are providing life-sustaining treatment. In addition to this, these patients can be taking medications that affect their mental capacity, such as sedatives or potent analgesics. Therefore, it is often difficult to assess the mental competency of an ICU patient. Since the assessment of mental capacity can be subjective, it is sometimes the case that nurses are at risk of prosecution when restraining patients.

The grey area arises when determining whether or not a patient's mental capacity is lacking to the point of warranting restraint application. Patients can often be alert, but it is difficult to discern whether or not they are completely oriented, which could lead to potential safety complications. Due to these circumstances, many critical care nurses often apply "medical restraints." Unlike forensic restraints, medical restraints are applied when patients are believed to be a safety risk or at risk to their medical progression. Confusion and attempts to dislodge medical devices are examples of determinants for the application of medical restraints. Restraints can be physical, such as soft wrist restraints or elbow immobilizers, or they can be chemical, such as sedatives.

Since restraint application is a serious consideration, organizations such as JCAHO and individual medical facilities have protocols involving restraint alternatives, restraint application requirements, and assessment requirements for patients in restraints. The Joint Commission states that nurses are responsible for preemptively identifying behaviors that could lead to restraint application and treating them as necessary. If less restrictive alternatives have failed, the nurse applying the restraints must be able to prove that other alternatives were attempted to maintain patient safety prior to restraint application [26].

Electronic Medical Records (or EMRs) Electronic Medical Records and Their Legal Implications

The use of is on the rise within healthcare systems across the globe. Designed to increase efficiency, safety, and productivity, electronic record keeping has the ability to provide innumerable benefits. With an increased utilization of electronic health records, and the benefits that come with it, healthcare institutions have also encountered significant pitfalls. The risks of patient data becoming public, increased time spent documenting, and lack of communication between different EMR systems are all significant problems that remain to be addressed with this new technology.

Nurses, in particular, are largely affected by the implementation and ongoing requirements of electronic documentation, both positively and negatively. One

positive result of the technology is that electronic systems help documentation more accurately reflect the present condition of the patient. For example, nurses are able to chart on important aspects of patient care as they occur, such as vital signs or fluid output. Electronic monitors often have the capability to transmit some information directly into the chart, therefore reducing possible transcription errors. Once charted on, these numbers become available to all members of the healthcare team, making the distribution of information more efficient. Another benefit is that EMRs also allow for information to be easily located within the chart, especially if a patient has a complex medical history involving multiple hospitalizations.

Along with organizing the distribution of patient information across various health systems, electronic medical records are also being implemented by healthcare institutions with the intention of decreasing medical errors. Electronic order sets reduce prescribing time for providers but also eliminate the need for physically writing out orders. This is seen as particularly beneficial because eliminating illegible handwriting has enormous potential to decrease risk during medication administration and treatment. Additionally, barcode scanning technology provides a second check when nurses are administering medications. Nurses are taught to always scan the patient and the medication before administration, along with checking the "five rights" of medication administration. These safety protocols, both technological and practical, are crucial in reducing instances of medication and dosage errors.

An example of the importance of medication scanning and the rights of medication administration can be seen in the case *Farmer v. Willis-Knighton Medical Center* [15]. This case centered around the disputed events of Ms. Martin's unexplained death. Ms. Virginia Martin presented to the Willis-Knighton emergency room complaining of abdominal pain, vomiting, and diarrhea. After some initial lab work and imaging, Ms. Martin was given the diagnosis of gastroenteritis from Dr. John Reeves. After reviewing Ms. Martin's lab work, Dr. Reeves ordered Demerol for pain, Phenergan for nausea, and potassium for hypokalemia. Nurse Hansen, assigned to Ms. Martin, was responsible for medication administration. The chart reflected the following events: after medication administration at 2140, Ms. Martin's IV infiltrated, at 2144 Ms. Martin's face was mottled, and she had a decreased level of consciousness, and at 2147 a code was called. Resuscitation was attempted for 30 minutes and was unsuccessful. The cause of death was determined to be an acute cardiac arrhythmia and arteriosclerotic heart disease.

Two family members that were in the room during the medication administration, Ms. Farmer and Dr. Johnson, stated that they saw Nurse Hansen draw up three IV medications in similarly sized syringes and administer them all via IV push. It is important to note that, while Phenergan and Demerol can be administered IV push, potassium cannot. Both family members testify that almost immediately after the medication administration, the patient was writhing in pain and screaming that her IV arm was burning. As noted by the chart, that IV had infiltrated. The patient then became unresponsive and cardiac arrested. Both family members testify that Nurse Hansen administered the potassium IV push, which was the direct cause of Ms. Martin's death.

Expert witness Dr. Walter Simmons agreed that the immediate symptoms up to Ms. Martin's cardiac arrest would be seen with undiluted potassium administration and noted that there was a lack of charting supporting Nurse Hansen's actions. Expert witness JoAnne Gongora, RN, agreed that the charting did not meet the standard of care and noted that times were changed and written over in many places throughout the chart. Willis-Knighton Medical Center argued that Ms. Martin's IV had infiltrated during her contrast CT, prior to the medication administration, and therefore she could not have been given IV push potassium. The court eventually sided with the plaintiffs, awarding $60,000 to each of Ms. Martin's 13 children for wrongful death damages, $250,000 in survival damages, and $6833.72 in funeral expenses [15]. If Nurse Hansen had properly utilized the barcode scanning system and reviewed the medication administration order, Ms. Martin's life could have been saved.

Risk management is an essential component of healthcare. Electronic systems have recently developed "best practice advisories," or BPAs. A BPA is triggered when a patient meets certain criteria based on what the nurse has charted; once said criteria are met, nurses are prompted to reflect on their recent charting and assess the results further. For example, many systems have a SIRS BPA. When a patient has vital signs that may represent a potential cause of systemic inflammatory response syndrome (SIRS), a BPA is triggered, and the electronic charting system notifies the nurse to verify the vital signs. The nurse is then further required to chart whether or not the vitals have been addressed by his/herself and the primary care team.

From a legal standpoint, nursing documentation is usually the most referenced part of the chart during litigation. Due to its ability to paint a vivid picture of the patient in "real time," the attorney, judge, and jury depend on nursing documentation to make their decisions [25]. Expert witnesses are often able to ascertain whether or not the standard of care was maintained by assessing nursing documentation. Thanks to electronic prompts, EMRs are able to maintain facility and state charting standards in ways that paper charting could not. By requiring vital checks and manual acknowledgment after a predefined set of warning signs, EMRs ensure that documentation standards are more thoroughly being met. In addition, nurses are responsible for charting on almost every aspect of patient care, meaning their assessment dominates the majority of the electronic record. Accurate documentation is essential in order to protect nurses and hospitals from litigation.

Although there are many positive changes associated with electronic medical records, there are some shortcomings as well. The main concern with EMRs is the maintenance of HIPAA and the security of protected health information. Within the hospital, open computer screens or scraps of paper documentation left at the bedside could be accessed by anybody—potentially risking the privacy of the patient. Many facilities have developed paperless shift handoff systems and auto-locking computer screens in order to reduce these problems. Additionally, when PHI files are shared between departments and healthcare facilities, files must be encrypted if transmitted via email [4]. If the information is being faxed, face sheets are now required to precede any sensitive medical information. All of these protective

measures aim to ensure that institutions can implement these highly beneficial EMRs while still maintaining HIPAA compliance.

Another concern with EMRs is the accessibility of charts. Although records have been shown to be easy to navigate in their electronic form, the same cannot be said for when electronic records are printed out. When an EMR is printed, it is typically a long and cumbersome document, lacking any sense of cohesion. Such documents can be a nightmare to navigate effectively. In some instances, when the electronic chart is not functioning or is getting updated (also known as downtime), nurses are forced to return to paper charting. Younger nurses typically have little to no experience with paper charting, creating a steep learning curve with relatively brief preparation and training.

Skeptics of EMRs also argue that they have made healthcare documentation more cumbersome and time-consuming. Several studies have shown that 30 minutes of patient care now requires 30–60 minutes of documentation for many US nurses [10]. In order to reduce time spent charting, some nurses utilize the “copy and paste” functionality of EMRs. Copying and pasting past nurses’ documentation can lead to errors in transcription and inaccurate charting [25]. As such, nursing staff often find themselves balancing practical time constraints to their charting with the risks of transcription errors when copying and pasting. As is the case with any powerful new technology, EMR systems come with numerous benefits to the global healthcare industry but also substantial drawbacks.

Summary

The nursing profession has developed vastly since its original formation in the mid-1800s, so much so that it would be arguably unrecognizable to its founders. From Nightingale’s early memorandums on sanitation to current global research partnerships and foundations, nurses are continuing to push the boundaries of their career limitations. While providing new platforms for medical research and treatment, nurses simultaneously uphold the original qualities of beneficence and nonmaleficence when treating patients. Although it is becoming difficult to navigate the sea of growing ethical and legal challenges in the workplace, nurses view this as just another challenge that they will adapt to and conquer.

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