LEGAL ACCOUNTABILITY IN NURSING PRACTICE

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Far away there in the sunshine are my highest aspirations. I may not reach them, but I can look up and see their beauty, believe in them, and try to follow where they lead.

- Louisa May Alcott

My love and thanks to all those who helped me see the sunshine on cloudy days.

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CHAPTER 1

INTRODUCTION

In the rapidly changing profession of nursing, legal liability for professional misconduct is emerging as an area of immediate concern. At one time nurses were considered judgment-proof. Few carried liability insurance and fewer still earned salaries which could support a judgment in malpractice litigation. Primary liability fell on the employing agency and/or the physician, even though the conduct of the nurse may have been the alleged cause of harm.

Today, nursing is concerned with providing services in an ever-expanding health care system. As health care becomes more complex and professional nursing more autonomous, an extension of legal liability follows. The employer or physician can no longer protect the nurse from liability. The nurse's role has changed from one of legal dependency to one of legal accountability.

Accountability for one's actions also implies accountability to oneself and the nurse's right to all knowledge and tools that will protect her rights and the rights of others. Legal accountability implies that the

nurse performs at a level which equals or exceeds that of a reasonably prudent nurse practitioner, utilizing the knowledge and skills of her profession.

As an autonomous person capable of decision making involving the life and/or welfare of others, the professional nurse must accept accountability for her actions. Whether such actions are taken in response to medical direction or result from her assessment of a situation and recognition of the need for nursing intervention does not affect her accountability.

The capability of the law either to extend or limit nursing action, under certain circumstances, demonstrates that knowledge of the law should, at all times, be an integral part of the nursing process. Clinical judgment alone is not always sufficient to move the nurse from assessment to the decision that precedes action. This judgment must be considered within the context of its relationship to other dimensions; namely, professional standards and traditions, institutional policies and procedures, and relevant statutory and common law.

Problem of Study

The problems of this study were:

1. To determine the relationship between

professional nurses' knowledge of the law governing professional practice and their application of this knowledge to specific nursing care situations.

2. To determine if the professional nurse's level of basic nursing education has an effect upon her knowledge of and ability to apply the law to nursing practice.

Justification of Problem

In the new world of nursing practice, legal liability for professional nursing conduct has emerged as an immediate concern. However, the negative approach is commonly found in discussions of the law's impact on health care practitioners. Too often emphasis is placed on the punitive aspects of the law and the need for malpractice insurance to protect against a supposedly hostile public (Murchison, Nichols, & Hanson, 1978).

The law can be a positive force in planning and implementing health care. It provides the guidelines necessary for making the proper decisions with regard to nursing actions.

Blackstone (cited in Willig, 1970) has defined the law as a rule of civil conduct prescribed by the supreme power in the state, commanding what is right and prohibiting what is wrong. Over the centuries, the

practice of medicine and nursing has come to be bounded by many different types of law. In the United States police power, derived from constitutional law, provides for the establishment of nursing practice acts. These acts constitute the organic law of the United States. The law of torts and crimes is used to determine negligence and culpability. Most areas of nursing concern and litigation fall under the general category of civil law. The nursing practice acts are a mixture of civil law and criminal law (Willig, 1970).

The earliest state nursing laws were enacted in 1903 in the states of North Carolina, New Jersey, and New York. Even though all states now license professional nurses, there is no uniformity in the statutes in the definition of what constitutes nursing practice. The particular functions a nurse legally may perform are not delineated. In addition there is a marked overlap in the technical areas common to medical and nursing practice. The same act may be clearly the practice of medicine when performed by a physician and the practice of nursing when performed by a nurse (Anderson, B. J., 1970).

The body of judicial opinion relating to nursing practice does not demonstrate that nurses incur increased exposure to liability because of their expanded role in

providing patient care services. Failure to exercise that degree of care and skill in the performance of nursing functions expected of reasonably prudent nurses under similar circumstances, however, may increase such exposure (Anderson, B. J., 1970).

In general it may be said that the law imposes an obligation on everyone to use a reasonable degree of care in carrying out his or her affairs so that they will not harm other persons or the property of others. Rothman and Rothman (1977) define reasonable care as that degree of care which a reasonable, prudent person would use under the circumstances. A nurse may be guilty of malpractice if someone can prove she violated the ordinary and reasonable standards of care and, in so doing, directly caused her patient harm (Williams, 1976).

When considering liability, nurses often confuse "ethical" (moral) liability and "legal" liability. A nurse may do many things that her profession frowns on without causing injury to anyone, and she may never be called to account in the sense that she has to pay damages. But any time that she acts--or fails to act--in a manner not up to the standards of her profession in a particular situation, she is in danger of incurring legal liability. All that is required is injury to a

patient. Legal liability occurs when both of these elements are present: (a) failure to meet standards and (b) resulting injury to another person (Lipman, 1971).

Anderson, B. J. (1970) stated that court cases indicate that the most common acts of nursing negligence are the failure to carry out the proper orders of a physician; failure to recognize and report a patient's symptoms; failure to see that faulty equipment is removed from use or that protection from hazards attendant to its use is assured; and failure to recognize dangers inherent in carrying out the orders of a physician, e.g., when the patient's condition contraindicates the execution of particular procedures. Fundamental concern for the patient's welfare and safety has always been the nurse's prime focus, but her ability to achieve this objective depends upon her knowledge of her legal parameters in patient care as well as her knowledge of nursing practices. Thus, if she is to function effectively, today's nurse must fully understand the legal rules and doctrines that govern her daily activities (Bernsweig, 1975).

A person who recognizes a duty to another person can reasonably foresee why he should perform that duty, and, having ordinary foresight and judgment, he is able to foresee what might happen if he did not perform that duty.

This is the concept of foreseeability, and it bears directly on proof of negligence (Willig, 1970).

Conceptual Framework

The concept of accountability formed the framework for this study. Accountability defies easy definition. It is multidimensional, connotes applicability and limits, and has many determinants. There are philosophical, moral, and ethical-legal connotations. Accountability deals with the rights and responsibilities; the "answer-abilities" or liabilities of individuals and of groups and the interrelationships among them (Petzold, 1975).

The concept of accountability had its inception in the early 1900s with the beginnings of the American consumer revolution. Theodore Roosevelt signed the first Pure Food and Drug Act on June 30, 1906 (Rothman & Rothman, 1977). At about this same time the efficiency era in education began. From this period arose the concept that accountability in education means a focus on the learning to be achieved as stipulated before the process begins (Sabin, 1973). Beginning as a flickering spark in the twilight of the 60s, and fanned into flame by the federal government, politicians, taxpayers, unhappy parents, as well as private learning

corporations, accountability has been transformed from a theoretical notion to a formidable force in American education (Sciara & Jantz, 1972).

John F. Kennedy, while campaigning for the presidency, stated, "The consumer is the only man in our economy without a high-powered lobbyist. I intend to be that lobbyist" (cited in Rothman & Rothman, 1977, p. 83). About one year after Kennedy was elected, he set forth what he called the "Consumer Bill of Rights." This bill of rights included: (a) the right to safety, (b) the right to be informed, (c) the right to choose, and (d) the right to be heard (Rothman & Rothman, 1977).

The American Hospital Association, in November of 1972, adopted a statement of 12 principles which became known as the "Patient's Bill of Rights." In 1974, at a workshop titled "The Terminally Ill Patient and the Helping Person," sponsored by the Southwestern Michigan Inservice Educational Council, a bill of rights was created entitled "The Dying Person's Bill of Rights" (Rothman & Rothman, 1977).

The American Nurses' Association has attempted to set standards for the nursing profession by establishing Standards of Nursing Practice in 1974. The Michigan State Nurses' Association's resolution on nurses' rights

has become a model in the United States. These standards apply to nursing practice in any setting. Also, in 1974, the Educational Commission of the United States developed a criteria on student and institutional rights and responsibilities. In 1972, the Equal Rights Amendment was proposed by Congress.

Autonomy, and with it, accountability, has not been imposed on nurses. The nurse probably could have remained safely within the protective shadow of medicine if such behavior had not been contrary to the very nature of nursing. From the beginning of modern nursing, the profession has struggled to gain stature, to build curricula that would provide the basis for autonomous practice, and to provide the means for continuing intellectual growth that would ensure the right and obligation of nurses to share in the expansion of health services. Today the professional nurse demands the right to think and act responsibly and, in so doing, must and does stand ready to be held accountable (Murchison et al., 1978).

Accountability for one's acts also implies accountability to oneself. Inherent in this belief is the nurse's right to all the knowledge and tools that will safeguard her rights and the rights of others (Murchison et al., 1978).

Accountability has been referred to as the payment of dues for the increased economic status and independence being enjoyed by nurses today. The nursing profession must be willing to be both legally and ethically responsible for the care it gives. In the past nursing has been held accountable but not to the consumer of its health care. Rather, it has been held accountable to the medical profession or to the institution or agency by which its members were employed. However, the hallmark of professionalism is the ability to monitor what is acceptable performance for the profession within the profession itself (Rothman & Rothman, 1977).

Assumptions

The assumptions in this study were:

1. All professional nurses have some knowledge of the legal aspects of nursing practice.

2. Professional nurses need to be familiar with the laws regulating their profession in order to be safe practitioners.

3. Accountability for one's actions is an inherent part of nursing practice.

Hypotheses

Based on the purposes of this study the following hypotheses were formulated:

1. There is no relationship between the professional nurse's knowledge of the law as it relates to the practice of nursing and the application of this knowledge to specific nursing care situations.

2. There is no difference in professional nurses' knowledge of or ability to apply the law to nursing practice than can be attributed to their level of basic nursing education.

Definition of Terms

For the purposes of this study, the following terms were defined:

1. Malpractice--any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct.

2. Negligence--the failure of a professional person to act in accordance with the prevalent professional standards or failure to foresee possibilities and consequences that a professional person, having the necessary skill and training to act professionally, should foresee.

3. Professional nurse--a registered nurse performing such duties as described in Article 4518 Section 5 of Vernon's Civil Statutes of the State of Texas (1977), currently employed in her profession within hospitals or institutions, physicians' offices, or schools of nursing.

4. Patient--a health care consumer.

5. Accountability--to answer to someone for something that one has done.

Limitations

There was no attempt at control for:

1. The area in which the subjects practice nursing.

2. The length of time the subjects have been in nursing.

3. The ages of the subjects.

4. The lack of homogeneity of the testing setting.

5. Subjects who submit to testing may have more knowledge of the law than those who do not volunteer.

Summary

Nurses must accept that they are accountable for their actions; in the event a patient is harmed, nursing accountability becomes a measure of legal liability. Accountability implies duty and that a reasonable standard of care will be taken in the exercise of that duty.

For nurses who have learned the relevant legal concepts in the nursing process, legal accountability will be one key to improving nursing practice.

CHAPTER 2

REVIEW OF LITERATURE

In this chapter the concept of accountability as it applies to nursing practice is presented. The concept is defined and distinguished from the concept of responsibility. Several studies are presented which identify nurses' attitudes toward accountability; and finally, the requirements necessary for attaining accountability, i.e., peer review, primary nursing, and quality assurance, are reviewed.

The second section of this chapter deals with the areas of law that are of primary concern to the nurse practitioner. Intentional torts and the tort of negligence are presented. State nursing practice acts, as a basis for nursing performance, are discussed.

Professional Accountability in Nursing

The byword for the present era might well be "accountability"--a word that has had enormous popularity both within and outside the profession of nursing during the past decade (McClure, 1978). In 1977, Dorothy Cornelius, the outgoing president of the International

Council of Nurses, pronounced as a watchword for the quadrennium for 1977 to 1981, the concept "Accountability." Mrs. Cornelius stated:

> As the ICN moves forward in its thrust to enunciate standards for nursing, in its collaboration with organizations representing other disciplines, in its advocate role for the consumer of nursing services, the credibility of the organization will be measured by nurses and the public at large. The watchword "Accountability" acknowledges the ICN and its constituents welcome scrutiny of its goals and activities. It also implies the ICN recognizes its responsibility to nurses and to the consumers of nursing practice throughout the world. (International Council of Nurses, 1977; Anstey, 1979)

When accountability in nursing is discussed in any depth, the clarity of the concept immediately diminishes. Accountability is closely related to commitment. Both words imply responsibility to another person or to oneself (Risk, 1975). The Report of the Committee on Senior Nursing Staff Structure (Salmon Report, 1966) drew distinction between the words accountability and responsibility, and since then there seems to have been considerable confusion in the minds of many nurses as to the relationship of these two words. Salmon felt that an element of control was necessary for responsibility, whereas accountability was a formal procedure of reporting without the element of control.

The Position on Nursing Practice approved by the Michigan Nurses' Association in 1971 defined accountability as the responsibility for the services one provides or makes available. In the legalistic sense, however, accountability has a liability dimension that responsibility lacks. If one is accountable, one is liable to be called to account. It does not mean one will always be, but when one is called to account, one is held liable to the extent to which the actions taken were consistant with the responsibilities for which one contracted (Peplau, 1971).

Neff (1973) proposed a distinction between the terms accountability and responsibility. He used responsibility to refer only to the voluntary assumption of an obligation, while accountability referred to legal liability assigned to the performance or nonperformance of certain duties. Accountability carries with it the notion of external judgment.

Froebe and Brain (1976) have discussed the meaning of the word accountability at some length. They presented the definition "acknowledging definitive delegated function as one's right and duty within a system of interrelated functions" (p. 9f). They agreed with Peplau's definition. Thus they disagreed with the view of Salmon

on the relationship between the two terms. Froebe and Brain (1976) said:

> Accountability can be delineated more sharply than responsibility, which is given a meaning relating to a quality which a person imparts to an organization, not to an outcome. (p. 9f)

Responsibility is of a lower order than accountability which calls for a legalistic, delegated, or established standard (White, 1977). Responsibility expresses the expectations of performance, while accountability implies that one's actual performance will be judged against expected performance (Peplau, 1971).

Peplau (1971) went on to give a succinct definition of accountability: "To be accountable means to answer to someone for something that one has done." In discussing other concepts that are closely related to this attribute, she described responsibility as a "charge to do something for which one is answerable or accountable to someone" (p. 7). An important corollary to this notion is that responsibility, whether assigned or taken, must carry with it the authority to carry out the responsibility (Passos, 1973).

Gaver and Franklin (1978) stated:

> Accountability exists whenever there is delegation of authority or responsibility. In this sense, accountability refers to the extent to

> which an entity--person, group, or organization--is liable, responsible and/or answerable for its performance. (p. 11)

Accountability in nursing is a personal, professional accountability. To say this assumes that the individual nurse is perceived as a professional person--as a member of a profession. The degree to which the individual nurse accepts a professional accountability to her patients must depend upon her own perceptions of her status. If she perceives herself as a professional person, it should follow that she accepts the status with all the rights and responsibilities that go with it. The question that arises is whether or not nurses fully understand the implications of their professional status and their professional accountability (White, 1977).

The major findings of a study by Monnig (1976) examining the expanded role of the nurse indicated that nurses believe more strongly than physicians in what the nurse practitioners are now doing and what they should do with respect to the professional characteristics of autonomy, identity, and accountability. Nurses and physicians both stated that nurses in the expanded role are now accountable to some degree but should be more accountable.

Wilson (1975) found a gap between the doctors' expectations of the nurse's knowledge and the nurse's actual scoring. Nurses' knowledge was less than the doctors had expected. In a study of nurses in Great Britain, Anderson, E. R. (1973) found doctors identified technical skills in nurses as being of prime importance while nurses rated patient care of most import.

Simpson (1971) postulated that the nursing profession had not yet reached the position where research played an important part in nursing practice. She added that every nurse should be cognizent of the latest developments so that as knowledge becomes available it is quickly translated into practice. Yet as important as it is to professional practice to use the best available knowledge, when Howarth (1975) researched the use of mouth care procedures for the very ill, she found that they had been used, more or less unchanged, since before the 1950s. She showed that a number of ill-conceived ideas had been handed down over the generations, which had not been tested nor evaluated.

In a survey of the expanded role of the clinical nurse by White in 1976, a wide range of attitudes was shown by respondents to their work and to the directions which their accountability took. Within their sphere of

work there were nurses who felt that there was added interest and a release from the burden of routine nursing care to be found in taking on technical tasks which were passed on to them by the physicians. Others feared that the imposition of these tasks would detract from the nursing care they wished to give their patients. In discussing the direction of their accountability it was noticeable that they were often confined by policies set by their employing authorities rather than by any widely accepted parameters set by the profession (White, 1977).

Perhaps the reason for the nature and intensity of reactions to the attribute of accountability lies in its highly personal nature. Accountability in nursing practice has been described as the dues paying aspect of the increasing emphasis in nursing on greater autonomy and independence for the nurse practitioner. Every individual nurse has to recognize that rights and responsibilities go hand in hand. They have to decide collectively whether or not they want to be a profession. If they decide that they do so wish, they have to be prepared to accept professional accountability, and this must infer some sort of professional audit or peer review (White, 1977).

Maas (1973) listed several requirements for attaining accountability in nursing: rigorous entry; educational and socialization standards of the profession; the requirement of peer standard setting, review, and evaluation; and the legal common definitions of liability of practitioners. Peer review is one form of accountability that may one day become a generally accepted method of evaluation. As peers, nurses can translate the American Nurses' Association's broad standards into the particular standards for their patients in their setting. If nurses are to be accountable, they must use these standards (Kelly, 1978).

Christman (1978) stated that, theoretically, we are approaching the point of knowledge about organizational theory where it is feasible to construct designs of care that will make it possible to define and monitor perfect accountability. Thus, every error of commission or omission could be traced in an unerring way to its source. But, so too could excellence in performance be identified and rewarded. He emphasized that standards of nursing care that are relevant and measureable must be established. They must be empirical but based on scientific content, and the tools must be reliable and relatively

uncomplicated. A major characteristic of a reliable instrument must be its inscrutability.

Christman (1976) described an instrument developed by Rush-Medicus investigators, Jelinek, Haussman, Hegyvary, and Newman, for measuring the quality of nursing care with precision. Multiple criteria have been developed to assess each element of nursing care. Through testing, weaknesses can be identified and corrected.

Another means of gaining accountability in nursing is through the utilization of primary nursing care. Manthey (1970), who helped introduce the primary nurse into the Nursing Service Department of the University of Minnesota Hospitals, stated that conceptually primary nursing establishes a one-to-one client-professional relationship which:

> Embodies an arrangement of nurse and patient that facilitates professional practice and the delivery of nursing care. It incorporates the strong components of responsibility and accountability into the role of the hospital nurse. (p. 65)

The professional nurse's autonomy for nursing care requires the decentralization of decision making to the nurse-patient level. The relationship between nurse and patient will thus be one-to-one (Graves, 1971). At the same time, this must be accompanied by accountability for professional and patient decision. Nursing care

activities must be explicable and defendable in terms of scientific rationale. Such accountability for nursing care must be continuous 24 hours a day, 7 days a week (Maas, 1973).

The creditability of all persons and groups who have considerable social power is undergoing much public scrutiny and reevaluation. The members of the various health professions, because they hold social monopolies, are included in the searching examination. The rapid expansion of science and technology, a better educated public, and coverage in considerable depth by the media, have all acted as catalyzing agents in raising questions of the degree of accountability and the quality of the services given by health care providers. Accompanying the external impact is the growing interest in developing methods of measuring and monitoring care by researchers in the health professions, the definite social concern about the quality of practice by members of the professions, and the realization by leaders in the health professions that the issues cannot be avoided and must be dealt with intelligently and quickly (Christman, 1978).

A long-range program objective of the American Nurses' Association, in effect since 1966, states that professional nurses must assure the public that

professional nursing service of high quality and in sufficient quantity will be available for the sick of the country. The obvious corollary to this aim is that nurses must have the autonomy necessary to determine their own professional activities. The professional nurse must be free to use her knowledge to promote the patient's welfare, and in turn she must accept responsibility for the results of her judgments (Maas, 1973).

The Law in Nursing Practice

The term "law" may be workably defined as those standards of human conduct established and enforced by the authority of an organized society through its government (Creighton, 1975). Law is the sum total of rules and regulations by which a society is governed. It is man-made and it regulates social conduct in a formal and binding way. It reflects society's needs, attitudes, and mores. However, the law is not rigidly fixed, but a composite of court decisions, state and federal statutes, regulations, and procedures. Interpretations of diverse state laws by different courts, or small variations in the circumstances of a case may lead to very different conclusions in two seemingly similar situations. In attempting to familiarize herself with the legal aspects

of nursing care, the nurse can only hope to understand the general principles of law to apply to a set of facts. The application of the principles of law to a work situation will usually result in an appropriate legal response. It is necessary to act within the framework of the law at the particular time one is reviewing the facts (Hemelt & Mackert, 1978).

The area of law most frequently encountered by nurses is the law of torts. A tort is a legal wrong, committed against a person or property independent of contract, which renders the person who commits it liable for damages in a civil action. According to the law of torts, a person is liable for invading or encroaching upon the interest of another person if the interest invaded is protected against the unintentional invasion, if the conduct of the first person is negligent in regard to such an interest, if such conduct is a legal cause of invasion, and if the injured party has not disabled himself by his conduct so that he is prevented from bringing the action (Creighton, 1975).

There are certain specific torts known as intentional torts that are distinguished from the tort of negligence. Some of these specific torts are assault and battery, false imprisonment, defamation, invasion of

privacy, and fraud (Willig, 1970). The discussion which follows defines and illustrates some of the more common principles of law the nurse should understand regarding intentional torts.

Assault and Battery

The law protects individuals from unpermitted and unprivileged contact to his person. If a patient has refused a particular injection and the nurse approaches the patient and attempts to administer the medication, it would be an assault. If the nurse administers the injection, it would be a battery (Hemelt & Mackert, 1978). Creighton (1975) further stated that assault is the unjustifiable attempt to touch another person or the threat to do so in such circumstances as to cause the other reasonably to believe that it will be carried out. Battery means the unlawful beating of another or the carrying out of threatened physical harm.

False Imprisonment

The tort of false imprisonment refers to the conscious restraint of the freedom of another individual without proper authorization, privilege, or consent of the individual restrained. The problem of the use of restraints often confronts nurses who care for

disoriented, irrational, and restless patients. Whatever restraint is used should be adequate for the purpose but limited to that which is necessary to protect the patient or others (Hemelt & Mackert, 1978). In some situations, besides restraints, continuing observation by some member of the nursing team may be necessary for the safety of the patient. Therefore, the nurse must know when and how to use restraints correctly, since, depending on the circumstances, there may or may not be a medical order. Even when patients are restrained accidents can happen, so it is important to understand that the use of restraints imposes an obligation on the nurse to observe the patient more frequently and carefully (Creighton, 1975).

The Doctrine of Informed Consent

HEW regulations require that a patient's informed consent be obtained before a physician undertakes any therapeutic intervention. The principle of informed consent is derived from Anglo-American law, which holds that an individual is master over his own body, and if mentally competent, may refuse to accept even a life-saving treatment. Court cases through the years have defined carrying out procedures without consent as

constituting either battery or negligence. Battery may occur only when there has been additional treatment to which the patient has not given consent. Negligence should be considered when there has not been sufficient disclosure of risks to the patient (Besch, 1979).

The court cases involving the issue of informed consent are clear and consistant in placing the responsibility of giving the necessary information to the patient on the physician (Hemelt & Mackert, 1978). Nurses must realize that there is a need for medical disclosure regarding the choices of treatment for the patient. Although nurses are frequently asked to fill in the consent form and witness the signature, they are not responsible for the explanation of medical care to the patient as it relates to informed consent. The nurse is merely witnessing the patient's signature, an act that could be done by any layman (Rothman & Rothman, 1977). However, the nurse could be held personally liable if she knew or should have known that the patient was uninformed and did not take remedial measures. It is her responsibility to notify the physician of his patient's lack of information (Hemelt & Mackert, 1978).

Nurses must also be aware that many jurisdictions provide that no consent for care is needed in a true

emergency, that is, when delaying treatment would jeopardize the life of the patient (Willig, 1970). The law implies that the victim in an emergency would want everything done to save his life and protect him from harm (Rothman & Rothman, 1977).

Negligence

Rothman and Rothman (1977) stated that negligence is one of the most frequent grounds on which actions for tort are brought in the courts. Negligence has been defined by Prosser (1964) as the omission to do something which a reasonable person, guided by those ordinary considerations which ordinarily regulate human affairs, would do, or as doing something which a reasonable and prudent person would not do (p. 5).

Negligence law is a broad field which includes many types of negligent conduct in carrying out one's legal responsibilities to others. In law, every person is always responsible for conducting himself in a reasonable and prudent manner, whether he is a layman or a professional. When a person fails to conduct himself in a prescribed manner and thereby causes harm to another, the law says he is legally negligent. Negligence law embraces the area of malpractice law and includes the

negligent conduct of all professional persons. The term negligence as used in malpractice law is not necessarily the same as carelessness. While conduct which is careless is usually negligent, conduct can also be held negligent in the legal sense even if one acts carefully. Acting carefully and acting negligently are not necessarily mutually exclusive (Hemelt & Mackert, 1978).

Malpractice in the usual sense implies the idea of improper or unskillful care of a patient by a nurse. In Valentine v. La Societe Française, in 1956, the court held that malpractice is the neglect of a physician or nurse to apply that degree of skill and learning in treating and nursing a patient which is customarily applied in treating and caring for the sick, wounded, or similarly suffering in the same community. This "locality rule" was challenged in Brune v. Belinkoff (1968) when the court charged an anesthesiologist practicing in a smaller city must meet the general standard of care applicable to all specialists in his field regardless of where they were located.

In Hallinan v. Prindle (1936), a malpractice action brought against a hospital, a registered nurse, and a physician, the nurse was found liable for giving the surgeon an improper medication which he, in turn, gave the

patient. The court held that the surgeon was allowed to rely on the skill and care of trained nurses and similar persons. A registered nurse must exercise all the due care and reasonableness associated with the education and training of members of her profession.

The initial ruling supporting the premise of negligence by omission came from the well-known Darling case, in which an 18 year-old man's leg had to be amputated because of inadequate care. Subsequent cases have either upheld this decision or have brought about new interpretations based on different circumstances. The principal concept arrived at as a result of the Darling decision is that the hospital has a duty to maintain a competent nursing and medical staff and to establish a system to ensure that competency is maintained. As was made clear by this decision, it is a nursing function to recognize when a patient is not responding to one method of care, and it is her responsibility to intervene if the care provided is not in the best interest of the patient (Sheffield, 1978).

Nurse Practice Acts

Since the adoption of nursing practice acts, the nurse has a source to guide her nursing actions. The

nurse practice acts constitute the organic law, or basis, on which nursing legislation rests. Though they may differ somewhat from state to state, the typical nurse practice act contains the following:

1. Definition of professional and practical nursing.
2. Composition and responsibilities of the state board of nursing.
3. Requirements for licensure as a professional or practical nurse.
4. Grounds for revocation of licensure.
5. Provisions for reciprocity for persons licensed in other states.
6. Regulation of study programs offered nurses.
7. Penalties for practicing without a license (Rothman & Rothman, 1977; Willig, 1970).

In defining professional nursing the legal boundaries of nursing functions are delineated. The ANA Code for Nurses (1956) stated that the function of the professional registered nurse is the performance for pay of services to a patient that requires the application of nursing principles depending on the biological, physical, and social sciences. Most states have adopted this language in their nursing practice acts.

As the profession and the state legislatures turn their attention to current needs for revision of nurse practice acts, most of the changes are in the direction of lessening the restrictions on nurses themselves, including most notably the prohibitions against diagnosis and treatment (Bullough, 1975). New York State has defined the term diagnosing as follows:

> Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to the effective execution and management of a nursing regime. Such diagnostic privilege is distinct from a medical diagnosis. (Bullough, 1975, p. 161)

With all of the similarities among the new nursing laws throughout the country, there still remains a great deal that is unique to each state law. It is the professional's responsibility to be familiar with the nurse practice act of the state in which she practices.

Summary

This chapter has presented a review of the literature on the concept of accountability, attempting to clarify the definition of the term. Research studies have been presented which deal with the nurse's attitude toward acceptance of accountability for her actions. Several

possible means of attaining accountability in nursing practice were presented.

A review of the law that is most pertinent to nursing practice was presented, including the intentional torts most frequently committed by nurses and the tort of negligence. State nurse practice acts were discussed as a basis upon which nurses should pattern their nursing care.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The descriptive comparative survey approach was used to collect information regarding the nurse's knowledge of the law as it applies to nursing practice and her application of this knowledge to nursing care situations. The subjects were grouped according to the type of nursing education they had initially received, i.e., Associate Degree, Diploma, or Baccalaureate Degree. Fox (1976) stated that a comparative survey is used when the researcher wishes to obtain data to enable him to decide which of two or more entities is superior in terms of specific criteria. The variables in this study were (a) legal knowledge, (b) application of knowledge, and (c) basic education of the subjects.

Setting

The study was conducted in a large metropolitan area in the southwestern United States. Groups of nurses were tested, each group consisting of 10 to 12 subjects. They were obtained from nursing organization meetings

and university classes where they were enrolled in the Baccalaureate program. The test was given at the end of the general meeting or class session.

Population and Sample

The population consisted of professional nurses who were currently employed in nursing. All were licensed by the Board of Nurse Examiners for the State of Texas.

The sample consisted of 50 subjects obtained through incidental sampling. According to Guilford and Fruchter (1973) if significant properties of the incidental sample can be shown to apply to new individuals, those new individuals may be said to belong to the same population as the members of the sample.

Protection of Human Subjects

Prior to administering the tests, the volunteer subjects were given an oral explanation of the problem under study and the purposes of the study as stated in the thesis (Appendix A). The risks and discomfort to the subjects were the time needed to take the tests and minimal personal discomfort. The tests were not timed and the outcome of the tests had significance only to the investigator for the purposes of this study.

Anonymity was strictly protected by using a coding system. The Professional Background Sheet (Appendix C) and the testing instruments had a number assigned. The informed consent form (Appendix B) was not coded so that association could not be made between the number and name of the subject.

The benefit of the study was an increased awareness among the subjects of the need for a solid base of knowledge of the law as it relates to nursing practice. Since each nurse is held accountable for her own actions, she must know what her legal rights and limitations are at all times.

Questions about the study and testing procedure were answered, and the subjects were instructed that they could withdraw their consent or discontinue participation at any time. They were then given Consent Form B to sign.

Instruments

Two instruments were used in this study: (a) The Law in Nursing Practice (Appendix D) and (b) Case Presentation (Appendix F). They were designed by the investigator for use in this study.

The Law in Nursing Practice

This instrument was used to test the professional nurse's knowledge of the law by presenting 20 questions to be answered true or false. Each question was worth one point.

Content validity of the testing instrument, The Law in Nursing Practice, was determined by a panel of three judges, two of whom were practicing attorneys; one specializing in malpractice litigation for an insurance company, the other practicing general law. The third member of the panel was a nurse-practitioner in private practice who also serves as an expert witness in malpractice cases.

A list of 30 items was sent to the panel (Appendix E). They were asked to rank the items from one to thirty, one being best. They were also asked to evaluate the content of the instrument as regarding clarity, phraseology, and correctness of the answers. The best 20 items were used in the instrument. Each question and answer had to be acceptable to two of the three judges.

Case Presentation

This instrument presented two actual court cases (Appendix F) in which allegations of negligence or

malpractice had been made and the defendant had been found liable. Subjects were asked to identify:

1. What is the legal question in each case? (6 points).

2. Who is liable in each case? (6 points).

3. What would you have done if you were this nurse? (37 points).

The content validity of the testing instrument, Case Presentation, was accepted on the basis of the judicial decision which had been handed down from the bench. The rating of the answers to question 3 was accomplished by giving the total list of responses obtained after testing to a panel of three judges; two of whom were in nursing education, and the third, a hospital nursing supervisor. They were asked to place each response under the appropriate heading, i.e., assessment, intervention, or referral of responsibility. They were then asked to score each of these sections according to importance as indicated by the case presentations. Two of the three judges had to agree to make the response acceptable in each section.

Reliability

Reliability of the instruments was established in a pilot study in which 10 subjects were tested, then retested two days later. Details of the pilot study are given under Data Collection.

Data Collection

Before data collection was initiated, permission for the study was obtained from the Human Research Review Committee of the Texas Woman's University (Appendix B). Permission was also obtained from the hospital in which one of the nursing organizations held their meetings and from Texas Woman's University (Appendix B).

After determining that the nurses qualified for inclusion in the study, an oral description of the study was given (Appendix A), and the subjects were asked to sign the consent form (Appendix B). When the participants had completed the tests, they were asked to separate the consent form from the tests and place them in separate piles so that anonymity could be maintained. The investigator was present during the test-taking period.

Pilot Study

Before using the testing instruments in the study, the reliability was estimated by testing-retesting with an interval of two days between sessions. A group of 10 nurse-practitioner students who were not involved in the study took the pilot test. The time needed to take the instruments was approximately 20 minutes. The product moment correlation of their scores on these two administrations was .758 ($p < .018$) which was considered acceptable reliability for use in the research. No changes were made in the testing instruments following the pilot study.

Treatment of Data

The demographic data was utilized in two ways; first to describe the sample, and second to correlate the educational levels of the nurses with the knowledge and application scores. Tables were used to illustrate the outcome of data interpretation for both hypotheses.

Hypothesis 1 was answered using Pearson's Product Moment Correlation between the knowledge scores and the case presentation scores. Hypothesis 2 was answered by using a one-way analysis of variance of the knowledge scores blocked by the level of education and a one-way

analysis of variance of the case presentation scores blocked by level of education.

CHAPTER 4

ANALYSIS OF DATA

This chapter presents the findings of the data collected in the study. The sample will be described using the demographic data provided by the subjects. The findings will be used to accept or reject the two hypotheses:

1. There is no relationship between the professional nurse's knowledge of the law as it relates to the practice of nursing and the application of this knowledge to specific nursing care situations.

2. There is no difference in professional nurses' knowledge of or ability to apply the law to nursing practice that can be attributed to their level of education.

Description of Sample

The sample consisted of 50 registered nurses who were currently employed in nursing. As a means of determining specific characteristics of the sample, the following demographic data were obtained from each participant: age, level of basic nursing education, highest level of

education, work area, type of position, and years actively employed in nursing.

The ages were arranged in categories of 10-year increments. Of the 50 subjects, 26 were from 20 to 29, 16 were from 30 to 39, 7 were from 40 to 49, and 1 was 50 or over. The three levels of basic education were the associate degree, the diploma, and the baccalaureate degree programs. There were 13 nurses who had graduated from associate degree programs, 15 from diploma programs, and 22 from baccalaureate programs. Of the 50 subjects, 11 had gone on to earn advanced degrees, either in nursing or in other fields. The age and educational data are shown in Table 1.

Table 1

A Comparison of Ages to Levels of Education

Age	Associate Degree	Diploma	Baccalaureate Degree	Total
20 to 29	7	7	12	26
30 to 39	5	4	7	16
40 to 49	1	3	3	7
50 and over	0	1	0	1
Total	13	15	22	50

The majority of the subjects worked in hospitals, with 28 employed as staff nurses and 8 as head nurses or supervisors. There was 1 nursing administrator. Of the remaining 13, 5 were staff nurses in an outpatient dialysis clinic, and 1 was the supervisor of the clinic; 2 were occupational health nurses; 2 were nursing instructors; 1 worked in a physician's office; 1 was a school nurse; 1 was a nurse practitioner who was in charge of a college health center.

The years of active employment in nursing ranged from 1 to 30 years. There were 21 subjects who had worked 5 years or less, 18 who had worked from 5 to 10 years, and 11 who had worked over 10 years. These data are shown in Table 2.

Table 2

A Comparison of Years Worked to Levels of Education

Years Worked	Associate Degree	Diploma	Baccalaureate Degree	Total
5 or less	6	3	12	21
5 to 10	5	6	7	18
Over 10	2	6	3	11

Findings

Hypothesis 1, there is no relationship between the professional nurse's knowledge of the law as it relates to the practice of nursing and the application of this knowledge to specific nursing care situations, was tested using Pearson's Product Moment Correlation. The knowledge scores for all 50 subjects considered as a single group ranged from 10 to 19 out of a possible score of 20. The application scores ranged from 7 to 30 out of 39. The r value was not significant at $r = .036$ nor was the p value significant at $p = .80$. The associate degree group had a range of from 12 to 16 with $r = .23$ and $p = .46$. The diploma group had a range of from 10 to 17 with $r = .10$ and $p = .72$. The baccalaureate degree group had a range of from 12 to 19 with $r = .11$ and $p = .63$. None of the p values were significant; therefore, the null hypothesis was accepted. Data relative to Hypothesis 1 is shown in Table 3.

Hypothesis 2, there is no difference in professional nurses' knowledge of or ability to apply the law to nursing practice that can be attributed to their level of education, was tested using a one-way analysis of variance, first on knowledge of the law scores by basic education levels, and second, on application of the law

Table 3

Regression of Knowledge with Application

Group	Range		Pearson's	Level of	Number
	Knowledge	Application	r	Significance	
All Groups	10-19	7-30	$r = .036$	$p = .80$	50
Associate Degree	12-16	11-28	$r = .23$	$p = .46$	13
Diploma	10-17	7-30	$r = .10$	$p = .72$	15
Baccalaureate Degree	12-19	8-29	$r = .11$	$p = .63$	22

scores by basic education levels. The analysis of variance (ANOVA) for knowledge by education yielded $p = .19$. The ANOVA for application by education yielded $p = .89$. Therefore, the null hypothesis was accepted. These results are set out in Table 4.

An incidental finding of this study was the influence of years of experience in nursing on knowledge of or ability to apply the law to nursing practice. A one-way analysis of knowledge of the law scores by years of experience was first performed followed by a one-way analysis of application of the law scores by years of experience. The ANOVA for knowledge by years yielded $p = .67$. The ANOVA for application by years yielded $p = .63$. There was no significant difference which could be attributed to years of experience. Table 5 shows these results.

Summary of Findings

The findings of this study can be summarized in the following manner:

1. There is little difference among nurses in their knowledge level of the law as it pertains to nursing practice and their ability to apply the law to

Table 4

Analysis of Variance on Knowledge by Education and Application by Education

Variable	Associate Degree		Diploma		Baccalaureate Degree		Level of Significance
	Mean	(S.D.)	Mean	(S.D.)	Mean	(S.D.)	
Knowledge	14.15	(1.21)	15.20	(1.74)	15.00	(1.63)	$p = .19$
Application	17.85	(4.65)	18.73	(6.12)	18.77	(6.71)	$p = .89$
Number	13		15		22		

Table 5

Analysis of Variance on Knowledge and Application by Years of Experience

Variable	5 years or less Mean	(S.D.)	5 to 10 years Mean	(S.D.)	Over 10 years Mean	(S.D.)	Level of Significance
Knowledge	14.71	(1.15)	15.11	(1.57)	14.64	(2.34)	$p = .67$
Application	17.62	(6.61)	19.50	(5.34)	18.64	(5.89)	$p = .63$
Number	21		18		11		

nursing care situations. The findings were not significant at $p = .80$.

2. There was no relationship between individual subject's knowledge scores and application scores. Those who scored high in one area did not necessarily score high in the other area.

3. When the subjects were divided into groups based on their educational level there was little difference among the groups on the mean scores for knowledge or for application. The associate degree nurse group had the lowest means for the two variables. The findings were not significant at $p = .19$ for knowledge and $p = .89$ for application.

4. The subjects who had worked from 5 to 10 years had the highest means for knowledge and for application, however there was little difference in the means for the 3 groups. The findings were not significant at $p = .67$ for knowledge and $p = .63$ for application.

5. In analyzing various aspects of the testing instruments, the following data was of interest:

    a. Of the 50 nurses in the study only 5 correctly answered a question in the Knowledge of the Law tool pertaining to the definition of negligence. Thus it can be assumed that they did not know what

must be involved, by law, to make an act one of negligence.

b. In the case presentations on the Case Presentation tool the subjects were asked to identify the legal question in each of the two cases. In Case I, 24 of the 50, or 48%, answered correctly. In Case II, 48 of the 50, or 96% answered correctly. The subjects were also asked to identify who was at fault in each case. In Case I, 23 of the 50, or 46%, answered correctly. In Case II, 30 of the 50, or 60%, answered correctly.

c. The doctrine of informed consent was one of the major issues in Case I. Of the 50 subjects 17, or 34%, stated that the patient should have been allowed to refuse ambulation, indicating that they had an understanding of this doctrine.

d. An indication of the nurse's willingness to accept accountability for her actions was seen in the number of subjects who listed nursing interventions alone in response to the third part of the Case Presentation tool which asked what the subject would have done if she were the nurse. In Case I, 23 subjects listed actions the nurse should do. The other 27 subjects listed actions involding the

referral of responsibility, e.g., calling the physician or nursing supervisor. In Case II, 33 subjects listed nursing actions alone while 17 would have contacted the physician or nursing supervisor. In comparing responses in the two cases, referral of responsibility was listed by 12 of the 50 subjects.

CHAPTER 5

SUMMARY OF THE STUDY

This study was designed to identify the nurse's knowledge of the law as it relates to nursing practice, and to evaluate the nurse's ability to apply that knowledge to actual nursing care situations in which the patient or his family had brought legal action for injury. The problems of this study were (a) to determine the relationship between professional nurses' knowledge of the law governing professional practice and their application of this knowledge to specific nursing care situations, and (b) to determine if the professional nurse's level of basic nursing education had an effect upon her knowledge of and ability to apply the law to nursing practice.

The hypotheses, stated in the null form, were:

1. There is no relationship between the professional nurse's knowledge of the law as it relates to the practice of nursing and the application of this knowledge to specific nursing care situations.

2. There is no difference in professional nurses' knowledge of or ability to apply the law to nursing

practice that can be attributed to their level of basic nursing education. Both of the null hypotheses were accepted.

Summary

The population for this study consisted of 50 registered nurses who were currently licensed in the State of Texas and were actively employed in nursing. They were obtained through incidental sampling from nursing organization meetings and university classes where they were studying for their baccalaureate degrees. The two tools used in the study were designed by the investigator to measure (a) the nurse's knowledge of the law, and (b) the application of this knowledge to two actual nursing care situations in which allegations of negligence or malpractice had been made and the nurse defendant had been found liable.

Discussion of Findings

The findings of this study indicated that all nurses had some knowledge of the law as it relates to nursing practice. The object of the study was not to determine the level of that knowledge but to see if there was a relationship between knowledge scores and the nurse's ability to apply that knowledge to actual nursing care

situations in which legal action had been taken. Hemelt and Mackert (1978) stated that the application of the principles of law to a work situation will usually result in an appropriate legal response. In comparing knowledge scores with application scores there was no relationship, i.e., those who had high knowledge scores did not necessarily have high application scores. It was found that, as a group, nurses with 5 to 10 years working experience had higher scores in both areas. While nurses who had worked 5 years or less had the second highest knowledge scores, they were lowest in application of that knowledge.

There was little difference in the scores of the nurses when grouped according to basic education levels. The mean for the knowledge scores for the diploma group was the highest while the mean for the application scores for the baccalaureate degree group was highest. The associate degree group had the lowest means in both areas.

Of the 50 nurses in the study only 5 knew the definition of the term negligence. The 45 who responded incorrectly to this question did not know that harm must be done for an action to be considered negligent. In applying the law to the case presentations, 23 subjects

were able to identify the legal question in Case I and 48 in Case II as negligence. When asked to indicate who was at fault in each case, 23 correctly named the nurses in Case I and 30 correctly named the head nurse in Case II. The remaining subjects listed the hospital, physician, nursing supervisor, and/or the nurse as at fault. This would suggest that a significant number of nurses either did not see the nurse as accountable for her own actions, or felt that the doctrine of respondeat superior protected them from litigation.

Case I involved the issue of consent in that the patient did not wish to ambulate as the physician had ordered. Only 17 subjects stated that the patient had the right to refuse. In view of the importance of this issue today, every nurse should have recognized this as part of the nursing intervention for the patient.

Accountability for one's actions is an inherent part of safe nursing practice. Over half of the subjects stated that they would contact the physician or nursing supervisor in Case I and one-third would do so in Case II. This suggested that they would have preferred to have someone else make the decisions regarding their nursing actions and thereby reduce their responsibility or accountability. Paplau (1971) described

accountability in the legalistic sense as being held liable to the extent to which the actions taken were consistent with the responsibilities for which one contracted. Nurses must recognize that they alone are held legally accountable for their actions. Monnig's study (1976), examining the expanded role of the nurse, found that both nurses and physicians saw nurses as accountable to some degree but indicated they should be more accountable.

Conclusions and Implications

Based on the results of the study, the following conclusions and implications were drawn:

1. Nurse subjects drew from their past experience as well as their knowledge base in applying the law to nursing practice.

2. Age and experience influence accountability and autonomous behavior. The older a person, the more autonomous he is.

3. There is a perceived powerlessness among nurses. Their fear of going against the physician's orders is greater than the fear of a law suit.

4. Nurses continue to feel they are protected against legal action by the Doctrine of Respondeat Superior.

5. Hospitals' policies dictate nursing actions rather than an actual knowledge of the law.

6. There is a general fear of the power structure of the employing agency. Nurses are afraid they may lose their jobs if they disagree with policy or the system.

Recommendations for Further Study

The following are recommendations of the study:

1. Repeat the study using a larger population of registered nurses so as to obtain a more diverse sample in regard to age, level of basic education, area of work and position, and years of experience.

2. Conduct the study in other areas of the country and various sized communities to determine if there is a regional difference in outcome.

3. Study in greater depth the relationship between years of experience and knowledge and application of the law.

4. Repeat the study using hospital nurses and independent nurse practitioners to determine if there is a difference in findings between the two groups.

5. Try to identify barriers to application of the law to nursing practice such as socialization, role

perception, status of the hospital nurse, etc.

6. Identify the relationships and differences between accountability and autonomy.

APPENDIX A

ORAL DESCRIPTION OF THE STUDY

Prior to having the subjects sign the Consent Form B, the following information will be read:

This is a study designed to test first, the nurse's knowledge of the law as it relates to nursing practice and second, to evaluate the ability to apply that knowledge to actual nursing care situations in which the patient or his family have brought legal action for injury.

Information will be requested regarding your age range, educational background, work area and type of position, and number of years actively employed in nursing. This information will be used to determine if there is any difference in test scores that can be attributed to basic education.

You are being asked to follow the directions written on the two instruments. You may have as much time as you need to complete each section.

Participation in this study involves little risk or discomfort to you. It will take a period of time to read and complete each test. It may involve some personal inconvenience to you. Measures have been taken to protect anonymity and confidentiality. The two testing instruments have been coded numerically. It is specifically requested that you not use your name on any form

other than the consent form which has not been coded. You are asked to place the consent form in a box separate from the testing instruments.

The potential benefit of this study to you and others is the conscious awareness of the need for nurses to be knowledgeable of the law as it relates to nursing practice.

You may withdraw from this study at any time during the testing period or afterwards. I will now answer any questions you may have concerning the study or testing procedure.

APPENDIX B

TEXAS WOMAN'S UNIVERSITY

Human Research Committee

Name of Investigator: Tara Fedric Center: Dallas

Address: 409 Atherton Drive Date: 9/19/79

Garland, Texas 75043

Dear Ms. Fedric:

Your study entitled Legal Accountability in Nursing Practice has been reviewed by a committee of the Human Research Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education and Welfare regulations require that written consents must be obtained from all human subjects in your studies. These forms must be kept on file by you.

Furthermore, should your project change, another review by the Committee is required, according to DHEW regulations.

Sincerely,

Estelle D. Hurst

Chairman, Human Research
Review Committee

at Dallas.

Consent Form
TEXAS WOMAN'S UNIVERSITY
HUMAN RESEARCH REVIEW COMMITTEE

Title of Project: LEGAL ACCOUNTABILITY IN NURSING PRACTICE

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time.

_____ _____
Signature Date

_____ _____
Witness Date

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

_____ _____
Signature Date

_____
Position

_____ _____
Witness Date

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 74204

DALLAS INWOOD CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M.D. ANDERSON BLVD.
HOUSTON, TEXAS 77025

DALLAS PRESBYTERIAN CENTER
8194 WALNUT HILL LANE
DALLAS, TEXAS 75231

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO Tara Nedra Fedric
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Legal Accountability in Nursing Practice

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.

5. Other _____

_____

_____

Date: 4/14/80

[redacted]
Signature of Agency Personnel

_____
Signature of Student

Helen A. Bush
Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original - Student; First copy - agency; Second copy - TWU College of Nursing.

TEXAS WOMAN'S UNIVERSITY
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4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.

5. Other _____

_____

_____

Date: 10/19/79

[redacted]
Signature of Agency Personnel

Sara H. Jones
Signature of Student

Helen L. Bush
Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original - Student; First copy - agency; Second copy - TWU College of Nursing.

APPENDIX C

PROFESSIONAL BACKGROUND DATA SHEET

Check only one block for each category

Age: ☐ 20-29, ☐ 30-39, ☐ 40-49, ☐ 50 or over

Basic Education Preparation:

☐ Diploma

☐ Associate Degree

☐ Baccalaureate Degree

Year Graduated _____

Highest Level of Education Completed:

☐ Diploma

☐ Associate Degree

☐ Baccalaureate in Nursing

Year Graduated _____

☐ Baccalaureate in Other Field

☐ Master's in Nursing

☐ Master's in Other Field

☐ Doctorate

Work Area:

☐ Hospital

☐ Nursing Home

☐ Community Health Agency

☐ Nursing School

☐ Other (specify) _____

☐ Doctor's Office

☐ School Nurse

☐ Occupation Health Nurse

☐ Private Duty

Type of Position:

- ☐ Administrator or Assistant
- ☐ Supervisor or Assistant
- ☐ Instructor
- ☐ Head Nurse or Assistant
- ☐ Staff or General Duty
- ☐ Clinical Specialist (MS or above)
- ☐ Nurse Associate/Practitioner
- ☐ Other (specify) _____

Number of Years Actively Employed in Nursing: _____

APPENDIX D

THE LAW IN NURSING PRACTICE

Please mark ✓ either T (true) or F (false) under the appropriate column for each of the following statements:

True	False	
___	___	1. Even though no harm has come to the patient a nurse may be guilty of negligence if the care she gives that patient is not up to the standards of her profession.
___	___	2. A nurse is not expected to possess knowledge that has yet to be introduced in the community in which she works.
___	___	3. If a doctor orders a medication which may cause harm to the patient, the nurse may be held liable for the action if she gives it.
___	___	4. If, in having a consent form signed, a nurse finds that the doctor has failed to tell a patient all of the risks involved in a procedure, it is her duty to provide full disclosure before having the patient sign the form.
___	___	5. If a nurse administers an injection which causes damage to the patient's sciatic nerve, the physician who ordered the injection is also liable under the "Captain of the Ship" doctrine.
___	___	6. The blanket consent form signed by most patients at the time of admission is valid for virtually anything that is a necessary part of care for that patient.
___	___	7. A nurse has the legal authority to refuse to carry out a physician's order if in her judgment carrying out the order will harm the patient.
___	___	8. Whether a nurse acted with reasonable care in a given situation is judged mainly by her conduct compared with that of other nurses with similar training under comparable circumstances.

___ ___ 9. To be legally effective permission to perform surgery must be in writing.

___ ___ 10. If a doctor assumes personal responsibility for the acts of his nurse, that nurse cannot be held liable for her negligent acts.

___ ___ 11. In a life-threatening emergency a nurse may make a medical diagnosis and undertake whatever treatment is necessary until a physician arrives on the scene.

___ ___ 12. A health care practitioner who fails to act reasonably and prudently is considered to be negligent in the eyes of the law.

___ ___ 13. A competent adult patient has the right to refuse medication or treatment at any time.

___ ___ 14. It is unnecessary to obtain an informed consent to treat an unconscious patient brought to the emergency room.

___ ___ 15. Restraints applied against a patient's will constitutes false imprisonment.

___ ___ 16. Under the law every patient who fibrillates or goes into cardiac arrest must be defibrillated in an attempt to resuscitate him.

___ ___ 17. A nurse giving medication or treatment to a patient contrary to that patient's stated wishes could be liable for assault and battery.

___ ___ 18. If, in assessing a patient's pain, the nurse finds it milder than previously, it is permissible to reduce the dosage that is ordered.

___ ___ 19. Professional nurses who have the responsibility of caring for children are required by law to report suspected child abuse to the proper authorities.

___ ___ 20. If changes in a patient's condition are noted in the patient's chart, the nurse has no further responsibility to notify the attending physician.

The Law in Nursing Practice

Answers

1. false
2. false
3. true
4. false
5. false
6. false
7. true
8. true
9. false
10. false
11. true
12. true
13. true
14. true
15. false
16. false
17. true
18. false
19. true
20. false

APPENDIX E

June 8, 1979

408 Atherton Drive
Garland, Texas 75043

(Address)

Dear :

I am conducting a study entitled Legal Accountability in Nursing Practice as my thesis toward a Master's Degree in Nursing. The study involves testing the nurse's knowledge of the law as it relates to the practice of nursing and the application of that knowledge to two court cases involving malpractice.

Enclosed are the two testing instruments to be used in the study. I would appreciate it very much if you could review each of them for the following:

Instrument A--The Law in Nursing Practice

1. Please comment on the content, clarity, and phraseology of each question.

2. Are the answers correct?

3. Rank the questions as to importance from 1 to 30 (1 is best).

Instrument B--Case Presentation

1. Is the information adequate for making a determination of (a) the legal question in each case, (b) who is liable in each case, and (c) what the nurse's responsibility would be in each case?

2. Is the terminology appropriate for a lay person to understand?

3. Are the answers provided correct?

Thank you very much for your interest and cooperation in validating the content of these testing instruments.

Respectfully,

Tara N. Fedric

THE LAW IN NURSING PRACTICE

Please mark ✓ either T (true) or F (false) under the appropriate column for each of the following statements:

True	False	
___	___	1. The hospital assumes responsibility for errors made by auxiliary personnel working under your supervision.
___	___	2. If a side rail release has been signed, the nurse is no longer responsible if the patient falls while getting out of bed.
___	___	3. Even though no harm has come to the patient a nurse may be sued for negligence if the care she gives that patient is not up to the standards of her profession.
___	___	4. A nurse is not expected to possess knowledge that has yet to be introduced in the community in which she works.
___	___	5. If a doctor orders a medication which may cause harm to the patient, the nurse is liable for the action if she gives it.
___	___	6. If, in having a consent form signed, a nurse finds that the doctor has failed to tell a patient all of the risks involved in a

procedure, it is her duty to provide full disclosure before having the patient sign the form.

___ ___ 7. If a nurse administers an injection which causes damage to the patient's sciatic nerve, the physician who ordered the injection is also liable under the "Captain of the Ship" doctrine.

___ ___ 8. An accident victim must be examined by a physician in the E. R. even if he feels he has not been injured.

___ ___ 9. The blanket consent form signed by most patients at the time of admission is valid for virtually anything that is a necessary part of care for that patient.

___ ___ 10. A nurse has the legal authority to refuse to carry out a physician's order if in her judgment carrying out the order will harm the patient.

___ ___ 11. Whether a nurse acted with reasonable care in a given situation is judged mainly by her conduct compared with that of other nurses with similar training under comparable circumstances.

___ ___ 12. To be legally effective permission to perform surgery must be in writing.

___ ___ 13. Consent is not required when the patient is unconscious and the procedure is necessary to save his life.

___ ___ 14. The rule with respect to the giving of emergency care outside the nurse's normal work duties is that she has an ethical but not a legal obligation to render such care.

___ ___ 15. A nurse may make a diagnosis if she is required to evaluate the patient's condition to determine his needs for nursing care.

___ ___ 16. In an emergency a nurse is not held to the same standard of care expected of her under normal circumstances.

___ ___ 17. If a doctor assumes personal responsibility for the acts of his nurse, that nurse cannot be held liable for her negligent acts.

___ ___ 18. When a patient's failure to exercise reasonable care has contributed to an injury initially caused by a nurse's negligence, the patient will not be permitted to recover for damages in a lawsuit against the nurse.

___ ___ 19. In a life-threatening emergency a nurse may make a medical diagnosis and undertake whatever treatment is necessary until a physician arrives on the scene.

___ ___ 20. A health care practitioner who fails to act reasonably and prudently is considered to be negligent in the eyes of the law.

___ ___ 21. A competent adult patient has the right to refuse medication or treatment at any time.

___ ___ 22. It is unnecessary to obtain an informed consent to treat an unconscious patient brought to the emergency room.

___ ___ 23. A nurse who acts carefully and prudently will not be deemed negligent for any of her professional nursing activities.

___ ___ 24. A patient who fails to act in a reasonably prudent manner and is injured as a result may be considered to be negligent.

___ ___ 25. Restraints applied against a patient's will constitute false imprisonment.

___ ___ 26. Under the law every patient who fibrillates or goes into cardiac arrest must be defibrillated in an attempt to resuscitate him.

___ ___ 27. A nurse giving medication or treatment to a patient contrary to that patient's stated wishes could be liable for assault and battery.

___ ___ 28. If, in assessing a patient's pain, the nurse finds it milder than previously, it is permissible to reduce the dosage that is ordered.

___ ___ 29. Professional nurses who have the responsibility of caring for children are required by law to report suspected child abuse to the proper authorities.

___ ___ 30. If changes in a patient's condition are noted in the patient's chart, the nurse has no further responsibility to notify the attending physician.

APPENDIX F

CASE PRESENTATION

The following two situations actually happened. Both cases came before the courts and decisions were handed down.

Instructions:

After reading each case please discuss:

1. What is the legal question in each case? e.g., malpractice, false imprisonment, negligence, assault and battery, etc.

2. Who is liable in each case and why?

3. What is the nurse's responsibility in each case? (What would you have done? Please list as many alternatives as possible.)

Case I

On December 11, 1964, appellant, Mrs. Lucille A., age 41, entered the hospital operated by appellee. A hysterectomy was performed by Dr. R. B. During the following two days she was given the normal medication, including drugs to relieve pain. Mrs. A.'s physician left instructions at the hospital that she be exercised on December 12. When two nurses attempted to walk Mrs. A., she became violently ill and was immediately returned to her bed.

On December 13, after Dr. B. had examined Mrs. A., he again prescribed exercise for her which, he testified, was the usual and necessary treatment. Later that day when two nurses undertook to exercise Mrs. A. she protested and stated that she was sick and unable to walk. At the trial she described the events leading to her alleged injury thusly:

". . . I was laying in my bed and Mrs. L. and Mrs. R. came in and told me, said, 'Mrs. A., you haven't been walked today," and said, 'We have got to get you up.' I was really sick and I told them, I said, 'I don't believe I can walk, I'm so sick." Mrs. L. walked around to the foot of the bed and stood there. Mrs. R. took me by my left arm and gave it a jerk and she said, 'Get on up from there--doctor's orders, and you have got to do it.' They took me up and took me a few steps out in the hall and Mrs. L. said, 'Lucille, you're getting sick, aren't you?' I said, 'Noreen, I'm really sick,' and about that time I just completely collapsed and I hit the floor and when I did, I felt this sharp pain in my back and I have lived with this pain ever since."

Mrs. A. further testified that while she was being exercised there was a nurse on each side of her who had an arm around her.

Reference: Lucille A. v. The J. B. H. Memorial Hospital, 415 S.W.2d 844. (Regan 1976)

Case II

Willard B. H. was admitted to Niagara Falls Memorial Medical Center suffering from a fever of undetermined origin. It was subsequently diagnosed as pneumonia. At the

time of admission he was observed to be acutely ill. He was placed in a private room. It had a single window opening onto a small balcony which was encircled by a railing two to three feet high. During his hospitalization he fell from the window sustaining serious injuries. The nurses' notes on the day of the accident indicated that the patient "appears weak and dizzy, eyes unable to focus, left side of face twitching, confused at times." Mrs. H. visited her husband on the morning of the accident and found him vague, confused, and unresponsive to her questions. Mrs. H.'s mother stayed with him until he was given a hypo about 2:00 P.M. on the day of the accident. She testified that he was uncommunicative and restless. Mr. H. had no recollection of the events in the hospital prior to his fall. At about 3:30 P.M. on the day of the accident, Mr. H. was observed by construction workers, standing in his pajamas on the balcony outside his room. The workers notified the hospital nurses who returned Mr. H. to his room and placed a posey belt and cloth wrist restraints on him. The Charge Nurse on the floor called Mr. H.'s attending physician. The doctor told the nurse to keep an eye on the patient, to keep him restrained, and that if the patient caused any more trouble, he would have to be put in a secured room. The Charge Nurse then called Mrs. H. and suggested that she come to sit with Mr. H. Mrs. H. said that she would call her mother who lived only five to ten minutes distance from the hospital and ask her to go to the hospital immediately. She asked that someone watch Mr. H. until her mother arrived, but the nurse advised her that the hospital was understaffed and "we can't possibly do that." Mrs. H. called her mother, who hurried the four or five blocks from her home to the hospital and arrived just in time to see a group of construction workers and spectators surrounding Mr. H. He had fallen from the second-story window of his room. At the time of the accident all the personnel on the floor were engaged in routine duties, taking temperatures, or reviewing charts. Shortly before Mr. H. injured himself, the Aide assigned to this section was permitted to leave for supper.

Reference: H. v. Niagara Falls Med. Cntr., 380 N.Y.S.2d 116.

Answers and Scoring

CASE I

Legal Question:

Nurses were negligent in performing their duties. There is a duty owed to the patient to properly protect her from injury. The fact that Mrs. A. was being exercised in accordance with her physician's orders does not excuse the nurses from their duty to use proper care for her safety.

Fault:

The nurses were at fault. See above.

Scoring	Points
Question 1	3
Question 2	3
Question 3	
Assessment	4
Intervention	
Provide safety	3
Progressive activity	3
Confer with patient	1
Allow refusal	4
Referral of responsibility	1

CASE II

Legal Question:

Negligence in view of the fact that hospital personnel knew that the patient was confused and disoriented. The Court took the position that the Jury could find that the hospital had the personnel to provide continuous supervision for the 10-15 minutes required before Mr. H.'s mother-in-law arrived and that it was negligent in failing to do so.

The hospital and nurses have a legal responsibility separate and distinct from that of the attending physician to protect the patient from harm.

Fault:

The nurses were at fault. The hospital could be held liable as Respondeat Superior.

Scoring	Points
Question 1	3
Question 2	3
Question 3	
Assessment	1
Intervention	
Restraints	3

Move patient	3
Nursing/safety measures	2
Stay with patient	3
Referral of responsibility	1

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