INTRODUCTION

Patient injury incident to treatment can give rise to health care malpractice liability if, in addition to patient physical or mental injury, there exists a legal basis for imposing liability. The five legal bases for liability include professional negligence, breach of a treatment-related contractual promise, intentional care-related misconduct, and strict (non-fault-based) liability for injury from dangerously defective treatment-related products or for abnormally dangerous
Health care professionals face significant liability risk exposure primarily because they routinely interact with clients who are injured or ill and often in great physical pain and psychological distress. The concept of malpractice, as used in this course, refers to liability on the part of health care providers for patient injury. The traditional term medical malpractice only refers to the potential liability of physicians and surgeons for patient injury. In this course the more inclusive term health care malpractice is used to reflect and emphasize the fact that primary health care professionals other than physicians and surgeons are also exposed to malpractice liability incident to their professional practice. These primary health care professionals include advanced practice nurses, podiatrists, and rehabilitation professionals such as physical and occupational therapists and speech pathologists.

**Health care malpractice:** Liability of health care providers for patient injury.

### SIGNIFICANCE OF REPORTED LEGAL CASES

What is the significance of a “reported” legal case? A reported legal case is one that was appealed by one or both sides to at least one tier of appellate review or was deemed by legal scholars to be sufficiently significant at the initial trial court level of adjudication to warrant reporting.

Just because a legal case exists, is appealed, or is reported does not in any way infer that a finding of liability resulted against a defendant–health care professional. The exclusive burden to prove liability rests with patient-plaintiffs suing defendant–health care professionals. Health care malpractice plaintiffs (i.e., injured patients or their representatives) must prove their cases to the satisfaction of a judge (acting as fact-finder in a judge-alone trial) or jury by a preponderance (greater weight) of evidence in order to prevail.

At the end of a trial on the merits of a health care malpractice case, a patient-plaintiff may fail to convince a jury or judge that a defendant–physical or occupational therapist committed malpractice. If such is the case, the plaintiff loses his or her case, and the defendant prevails, or wins, and is vindicated in the case.

Even before a formal trial commences, a plaintiff may lose a health care malpractice case if the presiding trial judge concludes that there is not any material issue in (triable) dispute. In such a case the judge will normally dismiss the case against the defendant-provider through summary judgment, that is, a formal finding that the plaintiff’s case cannot proceed to trial because of insufficient or defective evidence.
FACTORS INCREASING HEALTH CARE PROFESSIONALS’ MALPRACTICE LIABILITY EXPOSURE

External Factors

Probably the most significant external factor leading to greater health care malpractice liability exposure is the litigious nature of the American public. With 16.5 million new civil lawsuits filed in the United States in 2004 (among them, perhaps 30,000 to 50,000 new health care malpractice lawsuits), Americans are clearly overly litigious. Adding to liability risk exposure is the myriad of new and complex governmental and accreditation agency regulations. In a business environment so regulated and so scrutinized by everyone, from administrative agencies to the media, providers can ill afford not to have on retainer, and proactively seek advice regularly from, personal legal counsel.

Another liability-generating factor is the nature of the ever-changing health care delivery system. The health care milieu is moving away from what heretofore has been primarily an altruistic, patient-welfare focused, informal, and friendly system of providing health care for patients toward an arms-length, business-like, cost-containment–focused, competitive, formal, and defensive system of client management. The U.S. Supreme Court declared, in the case of Pegram v. Herdrich, that the managed care health care delivery system has the blessing of the Congress and that patient care decisions made by health maintenance organization (HMO) physicians who receive variable incentive pay from their employers are not fiduciary decisions. The Supreme Court went on to rule in Aetna Health Inc. v. Davila and CIGNA Healthcare Corp. of Texas, Inc. v. Calad, that health insurers and managed care organizations are not liable under state tort laws for negligent health care decisions that injure patients. The American Medical Association labeled these decisions “the demise of managed care accountability.”

Internal Factors

Several factors internal to specific health care disciplines predispose to greater potential malpractice liability exposure. The broadening scope of practice for many nonphysician primary health care disciplines may lead to greater liability exposure. For physical therapy, for example, the fact that 42 states permit direct access practice, that is, without physician referral, may lead to greater liability exposure as more physical therapists serve as primary care providers. The trend toward clinical specialty certification in physician and nonphysician specialties may also lead to greater liability exposure—for certified specialists and nonspecialists—as the standard of care for specific practice specialties becomes more precisely articulated. Similarly, the trends toward postbaccalaureate professional-level entry to practice and advanced professional degrees and residencies may also alter the legal standard of care because more prospective expert witnesses who will establish the standard of care in court are educated beyond the baccalaureate level. Cross-training, acquisition of multiple skills, and the delegation of care (but not legal responsibility) to extenders also potentially creates greater malpractice liability exposure.
LEGAL BASES FOR IMPOSING LIABILITY FOR PATIENT INJURY

Malpractice liability occurs in the health care professional–patient relationship whenever a patient is injured during the course of care and there is a legally recognized basis for imposing malpractice liability. Health care professionals are bound to comply with the foundational ethical principle of, or “do no intentional malicious harm,” when caring for patients. However, the myth that malpractice liability occurs any time that a patient is injured in the course of patient care is simply inaccurate. Judges in malpractice cases are required to practice equity, or fairness, and would not allow a jury to award a sympathy verdict in favor of a patient-plaintiff merely because the plaintiff was injured in the course of treatment. One or more of the legally recognized bases for malpractice liability must also be present.

Traditionally, medical (physicians) or health care (all disciplines) malpractice has meant liability for patient injury caused by professional (treatment-related) negligence. However, by the mid-1980s, courts and legislatures broadened the scope of potential bases for malpractice-related liability to include other legal bases for liability associated with patient injury.4

Under this broader definition of health care malpractice, a defendant–health care professional may face fault-based malpractice liability for patient injury caused by professional negligence, breach (violation) of a contractual promise made to a patient, and intentional conduct resulting in patient injury. A defendant—health care professional may also face malpractice liability without regard to fault for patient injury from dangerously defective treatment-related products and from provider-controlled abnormally dangerous treatment activities (Box 3-1).

The first three fault-based bases for health care malpractice liability—professional negligence, breach of contract, and intentional conduct—involve the delivery of care that is adjudged as being objectively substandard. Substandard care means care that fails to meet at least minimally acceptable practice standards for the defendant-provider’s discipline.

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**BOX 3-1  Health Care Malpractice**

- Traditional definition: Liability of health care professionals for patient injury caused by professional negligence.
- Expanded definition: Liability of health care professionals for patient injury caused by the following:
  - Professional negligence
  - Breach of a contractual promise regarding treatment
  - Intentional conduct of the defendant–provider incident to care of a patient
  - Dangerously defectively designed or manufactured treatment-related products or modalities
  - Abnormally dangerous clinical activities

Adapted from Scott RW: Promoting legal awareness in physical and occupational therapy, St Louis, 1997, Mosby.
Substandard care: Care that fails to comply with legal and ethical standards; that is, care that fails to meet at least minimally acceptable practice standards for a defendant-provider’s specific discipline.

Liability for Professional Negligence

Health care professionals may be liable for malpractice when they fail to care for patients in ways that comply with legal standards of care. Negligent care may be rendered by the primary health care professional (primary liability) or by someone (an agent) under the supervision of the primary health care professional (vicarious liability). What the standard of care is, is most often established through expert testimony of health care professionals from the same discipline as a malpractice defendant by reference to authoritative texts and peer-reviewed publications or by reference to clinical practice protocols or guidelines.

The Concept of Negligence

Negligence can be considered legally actionable carelessness. The legal definition of negligence is conduct by a person who owes another a legal duty, which falls below a standard established by law for the protection of others against unreasonable risk of harm. In a health care malpractice scenario, a defendant–health care professional may be negligent in carrying out a duty owed to a patient, and the patient-plaintiff may be contributorily negligent if the patient acts in a manner that falls below a standard that the law imposes on the patient for self-protection against possible harm.5

“Conduct” that can form the basis for actionable negligence on the part of a health care provider may involve an act or an omission when the provider had a duty to act. An example of a negligent act might be the act of dislocating the shoulder of a patient with hemiplegia while carrying out passive mobility testing. An example of a negligent omission might be the failure to monitor a patient’s intravenous line.

Contributory negligence: Plaintiff-patient conduct that falls below a standard mandated by law for the patient’s own protection from unreasonable harm incident to treatment.

Elements of Proof for Professional Negligence

A patient bringing a claim or lawsuit alleging professional negligence on the part of a treating health care professional must fulfill a litany of proof, consisting of four elements: (1) that the defendant–health care provider owed a duty of care to the plaintiff-patient; (2) that the defendant-provider violated the duty owed through conduct that constitutes professional negligence; (3) that, as a direct cause and consequence of the defendant-provider’s negligent conduct, the plaintiff-patient sustained injury; and
(4) that the type of injuries that the plaintiff-patient sustained warrant the award of monetary damages. The plaintiff has the legal burden to prove each of these elements to a jury or judge (acting as trier of fact) by a preponderance, or greater weight, of evidence. Before an allegation of professional negligence ever becomes a formal claim or lawsuit, the lawyer representing the plaintiff-patient evaluates the merits of the case to satisfy himself or herself that these four elements can be proved in court by a preponderance of the evidence (Box 3-2).

Duty
When does a health care professional owe a special duty of care to a patient? Possible answers include (1) whenever a patient calls for an appointment for evaluation and treatment, (2) when a patient presents himself or herself for care, (3) when a patient signs in at the reception area and is awaiting evaluation and treatment, or (4) when a health care professional accepts a patient for care. Almost always, the special duty of professional care arises only when a health care professional agrees to accept a patient for care.

Occasionally, a health care professional will not know whether a patient’s diagnosis or problem falls within the professional’s legal scope of practice or ambit of personal competence until after a history and physical examination are completed. It is proper, and even required by legal and ethical standards, to decline to treat a patient whose problem falls outside a health care professional’s legal scope of practice or personal competence. In such instances, refusal to treat a patient does not constitute patient abandonment.

In the United States, unlike in some other countries, there is no general duty to help another person in need of assistance or in peril. Absent some special relationship, such as a preestablished health care provider–patient relationship, an attorney-client relationship, a minister-parishioner relationship, or a parent-child relationship, the general duty to aid another person does not apply. By way of example, consider the following hypothetical situation.

A man is standing on the roof of a tall building. Suddenly, a 3-year-old child walks through the door leading to the roof and ambles toward the edge of the roof, which does not have a protective fence. The toddler is walking relatively slowly, and the man has ample time to stop the toddler’s movement without any danger to himself. Instead, the man silently observes as the toddler walks off the edge of the building to his death.

**BOX 3-2 Four Required Elements of Proof in a Professional Negligence Lawsuit**

1. Duty owed by defendant
2. Duty violated by defendant
3. Causation, that is, the defendant’s negligent conduct caused the patient injury
4. Monetary damages are required to be awarded to make the injured patient “whole”
Is the man legally responsible for the young child’s demise? The answer depends on whether the man owed a legal duty of care to the child. Unless the man was a security guard or another type of employee of the building or somehow enticed the toddler onto the roof, he probably had no legal duty to come to the aid of the child, even though it was a clear, calm day, and he could have easily rescued the child from harm without exposing himself to any danger. Of course, it is beyond debate, under the facts of this scenario, that the man had a moral duty to help the unwitting toddler, but he probably could not be held legally accountable for his failure to act.

Under the same no-duty principle as the one presented in the hypothetical example, health care professionals generally are free to decline to accept patients for care. This commonly properly occurs, for instance, when a provider has a limited-scope practice, such as an exclusive adolescent or geriatric patient practice. In such circumstances, providers are normally free to reject patients for care who do not fall within the scope of their practice. Health care providers are not free, however, to decline to care for patients for illegal reasons, such as illegal discrimination based on a patient’s race, ethnicity, religion, gender, national origin, age, or disability.

**When Does “Duty” End? Issues Involving Patient Abandonment.** An allegation of improper patient abandonment may arise incident to health care delivery and may be brought as a negligent or intentional abandonment charge with different legal consequences. Legally actionable patient abandonment occurs when a treating health care professional improperly unilaterally terminates the professional-patient relationship.

**Abandonment:** Improper unilateral termination by a treating health care professional of a professional-patient relationship.

The widest imaginable range of variegated clinical treatment activities can give rise to an allegation of patient abandonment, from a clinician momentarily turning his or her back from a patient (with a resultant patient fall) to discharging a patient before the patient reaches the zenith of rehabilitative potential because of inability to continue to pay for care.

A patient is free unilaterally and summarily to terminate a health care professional–patient relationship at any time without legal consequence. The same is not true for a health care professional charged with responsibility for caring for a patient. A health care professional may unilaterally terminate a professional-patient relationship when, in the provider’s professional judgment, a cure has been effected or maximal recovery or progress has been achieved. Careful documentation of the patient’s status upon discharge is always required for the protection of provider and patient.

It may also be acceptable to discharge a patient for reasons unrelated to goal achievement, such as failure to pay for services or an irreconcilable personality conflict between provider and patient. In these and in similar circumstances, the freedom to discharge the patient is neither absolute nor without conditions. In the case of discharge for failure to pay for professional services, for example, a health care professional who is a preferred provider in a managed care network may have agreed contractually to treat patients for a fixed price and may not be free to discharge prematurely or to charge more than the agreed amount for whatever period treatment may entail. In the case of discharge because of an irreconcilable personality conflict, the provider must give advance notice of the intent to sever the professional-patient relationship and must also
give the patient a sufficient amount of time to locate a suitable substitute, competent care provider. It is highly recommended that a provider discharging a patient under this scenario also actively assist the patient in locating a substitute provider and consult with and transfer the patient’s health records expeditiously to the substitute provider to minimize the possibility of legal action by the patient for intentional abandonment.

In the case of negligent abandonment, the same four elements of proof as in any other professional negligence action must be established by the plaintiff-patient. These are (1) that the defendant–health care provider owed a duty of special care to the patient; (2) that in prematurely and improperly discharging the patient, the defendant-provider breached the legal standard of care; (3) that the breach of duty on the part of the defendant-provider caused injury to the plaintiff-patient; and (4) that the injuries that the plaintiff-patient sustained warrant the award of monetary damages in order to make the patient whole. The language used to present these four professional negligence elements is similar to language that a defendant–health care provider might see in a formal civil complaint in which the plaintiff-patient details the specifics of his or her lawsuit.

**Abandonment and Substitute Care Providers.** One of the special circumstances concerning patient abandonment involves whether health care professionals may temporarily transfer the care of patients to substitute health care providers of the same discipline when the primary provider is called away from the facility for additional duties, attends a continuing education course, or goes on vacation. The answer is usually yes. Just as it is legitimate to employ a substitute care provider when a primary health care professional becomes ill, it is normally acceptable to transfer a patient’s care to a substitute care professional when duty (or even scheduled vacation) takes the primary provider away from the facility. In hospital and HMO settings, patients do not always have a reasonable expectation of receiving professional care from a specific provider. Instead, patients are treated by staff (in the hospital and staff HMO models) or contract (in the group or network HMO models) providers.

In private practice or preferred provider organization settings, however, patients probably do have a reasonable expectation of being treated by specific providers of choice. In such environments, providers are advised to obtain written patient informed consent for substitution of specific primary providers by other professionals. In either situation, providers should always obtain patient consent for substitution and provide a detailed care summary and instructions to the substitute professional. When applicable, referring physicians should also be notified in advance of the substitution of providers. All of these details should be succinctly but thoroughly documented in the records of affected patients.

**Abandonment and the Limited-Scope Practice.** Another potential problem area involves health care professionals who work only in specific, limited practice settings. What happens when a current patient asks for treatment for problems unrelated to areas in which the provider offers services? Although it would probably still be acceptable to deny care for areas outside of one’s specialty practice—even for existing patients—it is recommended that specialty providers clearly delineate their scope of professional practice to patients at the outset of care so that subsequent misunderstandings (and patient dissatisfaction) do not arise.

**Duties Owed to Third Parties.** Although health care professionals clearly owe a special duty of care to patients under their care, an additional duty may be owed to third parties associated with patients under care. Specifically, providers may have an
The Law of Health Care Malpractice

affirmative duty to warn third parties, law enforcement, or other authorities of specific danger incident to threats of harm made by patients. Clearly, this duty to warn others about things that patients reveal during confidential examination or treatment sessions seems to be in direct contravention of the legal and ethical duties to maintain patient diagnostic and treatment-related information in confidence.

The lead case in the area of duty to warn third parties of potential harm from patients is Tarasoff v. Regents of the University of California. In that California State case, a psychotherapist employed by the University of California was treating a mentally ill patient named Poddar. During therapy sessions, Poddar threatened bodily harm to his former girlfriend. Neither the psychotherapist nor his supervisors reported the threats to the potential victim, social services, or law enforcement authorities. Poddar carried out his threat and killed his former girlfriend. Her parents sued the University of California, alleging professional negligence on the part of the psychotherapist and vicarious liability on the part of the university. In ruling in favor of the victim’s parents, the California Supreme Court held that a psychotherapist owes an affirmative duty to take reasonable steps to warn identifiable third parties of foreseeable danger of serious bodily harm from patients under their care. This legal duty has been extended to physicians and other primary health care professionals by statutes or regulations in many or most states.

A psychotherapist owes an affirmative duty to take reasonable steps to warn identifiable third parties of a foreseeable danger of serious bodily harm from patients under their care. This legal duty has been extended to physicians and other primary health care professionals.

EXERCISE

Research the practice act, code of ethics, and other practice standards of your discipline to determine whether the concept of duty to warn third parties of threats by patients of death or serious bodily harm is addressed. Share your findings with fellow students and professional colleagues.

Health care professionals may also have a duty to correct obvious errors made by other providers caring for patients. A major area of concern is medication errors. Who is responsible? This multidisciplinary problem has recently resulted in Food and Drug Administration (FDA) action in the form of a new regulation designed to minimize such errors. The regulation, effective June 30, 2006, requires FDA-approved patient labeling on prescription medications and preempts specific failure to warn lawsuits in state courts against drug manufacturers that comply with the law.

DISCUSSION QUESTION

What are the relative roles and responsibilities of primary health care professionals—including physicians, pharmacists, registered nurses, occupational and physical therapists, and others—in minimizing drug administration errors? What responsibilities do patients and their significant others have in reducing such errors?
Breach of Duty
The second element that a plaintiff-patient in a professional negligence health care malpractice case must prove is that the defendant–health care professional violated a legal duty owed to the plaintiff by providing substandard care. Although every person in society owes a duty to foreseeable others to conduct himself or herself in a reasonable manner (e.g., to drive a car safely), health care professionals, because of their special knowledge, training, and experience, owe an even higher **duty of due care** to patients and others.

In establishing whether a health care professional’s conduct met or violated the required professional standard of care, courts do not typically refer to a standard “cookbook” for a list of acceptable versus unacceptable procedures and interventions. Instead, courts analyze on a case-by-case basis whether what a defendant-provider did in a specific case would have been done or could have been considered acceptable by an ordinary, reasonable professional peer of the defendant acting under the same or similar circumstances.

The legal standard of care may be established in court by many sources. The most common way to establish what the standard of care is, is to ask experts from the same discipline as a defendant-provider. This usually takes place during pretrial interviews and (formal) depositions and during trial testimony. Attorneys and judges also commonly refer to official definitions of professional practice and official practice standards published by state licensure administrative agencies, professional associations, or other groups. Institutional and professional practice guidelines and protocols are also relied upon to establish the legal standard of care, as are professional journals, periodicals, and authoritative books.

**Parameters of the Duty Owed.** The nature of the duty owed to patients depends in part on what is permissible practice under the practice act of a profession. When a health care professional carries out treatment that is not permitted under the applicable practice act, the offender is held to the legal standard of the profession upon which the offender’s practice is encroaching.

Certainly, evidence-based, peer-reviewed journals qualify as **learned works** upon which health care professional witnesses in malpractice cases may rely to formulate expert opinions on the professional standard of care. Standard textbooks for the health care professional disciplines qualify as **learned treatises**, from which opinions on the professional standard of care may also be based.

**Expert Witness Testimony on the Standard of Care.** Most health care malpractice legal cases are settled well before formal trials occur, through settlement, abandonment of a case, or other disposition. How and whether a case is settled often turns on the strength of expert testimony given at pretrial depositions. Health care professionals may qualify to serve as experts for a wide range of purposes, from vocational rehabilitation experts to ergonomic experts. In health care malpractice cases, however, they frequently testify as clinician-experts who establish the legal standard of care and render expert opinions on whether a defendant-provider-peer met or breached the standard of care in treating a plaintiff-patient.

Health care professional experts may serve as expert witnesses for plaintiff-patients or defendant–health care providers in malpractice cases. These experts may be asked to testify about patient care evaluation or treatment practices, the use of therapeutic
equipment and modalities, informed consent practices, referral and consultation customary practice, and many other practice parameters.

In all cases in which expert witnesses are called to testify, experts establish the legal standard of care for the defendant-provider’s profession and comment on whether the care rendered by the defendant met or violated legal practice standards, based on one of three geographical frames of reference:

- In the vast majority of states, what fits within acceptable legal standards is care that passes as at least minimally acceptable in the same community, or in communities similar to the area in which a defendant–health care professional practices (same or similar community standard, majority rule).
- In as many as 13 states, health care professionals are held to a statewide or nationwide standard of comparison, meaning that experts from anywhere within the state or from across the nation may testify on the applicable standard of care (trend).

The locality rule, which was the rule of law in the majority of jurisdictions earlier in this century, tended to cause unjust results in medical malpractice cases and was gradually supplanted by the same or similar community standard in a majority of states. Under the locality rule, there was often an actual or perceived conspiracy of silence in which professional colleagues in small (or even large) communities refused to come forward to testify as experts for patients against their friends and associates. This conspiracy of silence often resulted in the dismissal of clearly meritorious legal cases, which did not further the primary purpose of the tort legal system: to make whole the deserving victims injured by the negligence or misconduct of others (Box 3-3).

Irrespective of the geographical frame of reference from which an expert testifies, the expert must testify, when commenting on a defendant-provider’s care, whether the defendant acted as an ordinary, reasonable professional peer would have acted under the same or similar circumstances. Experts are not allowed to testify about what they themselves would have done under circumstances similar to those at issue in a trial. The legal system is not interested in what an expert would do in practice nor in what average or best practice is among providers. What is pertinent is whether what a defendant-provider did constituted at least minimally acceptable clinical practice.

To be legally competent to testify as an expert, a witness must meet two basic requirements:

- Possess in-depth knowledge about the treatment procedure at issue in the trial
- Be familiar with the applicable legal standard of care in the place where the alleged professional negligence took place at the time of alleged patient injury

**BOX 3-3 = Geographical Frames of Reference for Expert Witness Testimony on the Legal Standard of Care**

| 1. Majority rule: Expert practices in a similar community (or the same community) as the defendant–health care professional. |
| 2. Minority rule and trend: Expert practices in any community, statewide or nationwide. |
Because an expert’s qualifications are subject to challenge through **impeachment** by opposing legal counsel, an expert must also demonstrate how he or she acquired the special knowledge that makes him or her an expert, that is, through formal or continuing education, clinical experience, or other training. When, as often is the case, a jury or judge is faced with competing expert testimony on both sides about whether a defendant-provider met or violated the standard of care, the verdict often turns on which expert is most convincing in his or her presentation.

Who may testify as an expert for or against a defendant-provider of a specific health care discipline, on the legal standard of care of that discipline? In many states, courts require that expert witnesses be of the same academic discipline as the defendant. This is often referred to as the **same school doctrine**. A number of courts, however, allow others to qualify and testify as experts in health care malpractice cases based on their personal knowledge about the procedure in issue and of the applicable standard of care for the defendant’s profession obtained through formal or informal training or experience.

In one reported physical therapy malpractice case, *Novey v. Kishwaukee Community Health Services*, in which a postoperative hand surgery patient sustained a tendon rupture during physical therapy care, an occupational therapist was called at trial by the plaintiff-patient as an expert witness to establish the physical therapy standard of care for postoperative hand patients. In the case, the plaintiff, who had severed his middle finger flexor tendons in an industrial accident, underwent surgical repair of the lacerations and was casted. When the cast was removed, the patient was sent to the defendant’s physical therapist–employee for rehabilitation. The plaintiff alleged that his tendons were retorn during physical therapy.

At trial the patient won his case and was awarded $12,127.67 in monetary damages. On appeal, the defendant-hospital’s attorney successfully argued that the occupational therapist was unqualified to testify as an expert on the physical therapist standard of care because she was not from the same “school” as the defendant’s physical therapist–employee. Because of the finding by the appeals court that the occupational therapist–witness was not a proper expert in the case, the case was remanded to the trial court for reconsideration. (The case was not reported again in the legal literature, meaning that it might have been settled upon its remand.)

What is troubling about this case? The Illinois appellate court, like many other courts (and lawyers), apparently had incomplete knowledge about the professions of physical and occupational therapy. A common professional standard exists for hand therapists certified by the American Hand Society, which includes occupational and physical therapists. Physical and occupational therapists also probably share a common standard—based on similar knowledge, training, and experience—in areas such as ergonomics, functional capacity assessments, pediatrics practice, and stroke rehabilitation, among many other areas of practice. Because of incomplete knowledge about these professions on the part of attorneys, primary health care professionals are urged to educate their legal counsel about their professions for any type of legal representation.

Specialty certification also has an impact on the legal standard of care. The standard used to assess board-certified clinical specialists’ conduct is normally a national, rather than local or statewide, standard. Are nonspecialists permitted to testify as expert witnesses in legal cases involving defendant–clinical specialists? Yes. Just as with clinicians having different degrees, qualification as an expert witness does not
on certification but on demonstrated knowledge about a treatment procedure in issue—whether that knowledge is derived from formal or informal training.

Direct access practice may have a profound effect on the legal standard of care for nonphysician health care professionals. For advanced practice nurses, physical therapists in independent practice, and others, an allegation that the provider in direct access practice exceeded the legal scope of practice under the state practice act may result in that professional being held to the legal standard of a professional to whom the clinician should have referred the patient for consultation—probably a physician’s standard of care.

Klein reported that 6 percent of professional negligence claims and lawsuits involving nurse practitioners involve issues of practice beyond scope of legal authority. According to Klein, nurse practitioners may practice independently in 14 states, through collaboration with referring entities in 23 states, and exclusively under physician supervision in 13 states.

In lawsuits involving allegations of exceeding permissible scope of primary health care practice, same-discipline expert witnesses may not be legally competent to testify about the standard of care because the medical standard of care may apply. The legal ramifications of misdiagnosis and failure to refer patients appropriately to physicians and other appropriate professionals, therefore, make it imperative to practice squarely within the boundaries of state practice acts and individual competency levels, whether physician extenders are practicing independently, with collaboration, or under supervision.

Primary health care professionals should consider it an honor to be called upon to serve as expert witnesses. Whether sought out because of professional publications, noteworthy clinical practice, or for another reason, it is a civic duty to serve as an expert witness when called upon. The duty is akin to voting and jury duty. If health care professionals do not come forward in future legal cases to establish their own standards of care, other professionals from disparate disciplines will continue to do so for these professions.

Clinical Practice Guidelines. Primary health care professionals are no doubt familiar with federal government–issued clinical practice guidelines for stroke rehabilitation, treatment of pressure ulcers, and low back pain care, published by the Agency for Healthcare Research and Quality, formerly the Agency for Health Care Policy and Research. The agency was created by Congress as part of the Omnibus Budget Reconciliation Act of 1989 and is housed within the U.S. Public Health Service.

Between 1992 and 1996, the Agency for Healthcare Research and Quality published 19 popular clinical practice guidelines for primary and support health care professionals and their patients. The agency ceased such issuance of guidelines, in part, because of their unintended use by attorneys in health care malpractice legal proceedings as evidence of the legal standard of care.

What are clinical practice guidelines, and how do they mesh into the legal standard of care? Clinical practice guidelines are different from clinical practice protocols. Protocols are relatively rigid decision matrices that call for fairly specific compliance with treatment regimens and are customarily seen in emergency and perioperative care.

Clinical practice guidelines, however, rely more on qualitative clinical reasoning and offer clinicians a number of acceptable treatment options for particular patient presentations. Valid clinical practice guidelines should address all reasonable practice options and potential outcomes of these interventions (and their likelihood
of occurrence). Whether or not relative values are assigned to practice options presented, the names of the authors or panels formulating the guidelines and recommendations should be delineated, and the guidelines should clearly state that the process of formulating options and assigning values has been peer reviewed. The date of publication should reflect that the guidelines are clinically current.

What, if any, legal precedent do clinical practice guidelines have in establishing the standard of care? To the extent that guidelines are inclusive of all reasonable clinical practice options, they represent the legal standard of care, although they are not prescriptive like protocols are. Just as with clinical protocols, however, deviation from acceptable practice standards may shift the legal burden of persuasion to a defendant—health care professional to justify why the clinician deviated from collectively established practice standards. Although the burden of proof remains with a patient-plaintiff in such cases, clearly the defendant who deviates from clinical protocols or guidelines encumbers himself or herself with a trial burden that normally a defendant does not have—the burden to justify why the clinician disregarded collective wisdom enunciated in standards or to leave it to the jury or judge to guess why.

Advantages of clinical practice guidelines include standardizing treatment processes, memorializing collective professional judgment on the validity and efficacy of treatment options, possibly reducing the number of health care malpractice claims, and providing a framework for clinical decision making. Disadvantages include limiting available options for clinicians, creating “cookbook” health care, and causing the burden of persuasion to shift to defendant—health care clinicians in malpractice cases to justify deviation from clinical practice guidelines.

Clinicians and administrators should do everything possible to communicate that clinical practice guidelines are intended merely to guide clinical decision making and not to represent the legal standard of care. Facilities and professional associations may attempt to include a disclaimer with their clinical practice guidelines, indicating that such guidelines are not intended to represent the legal standard of care. These kinds of disclaimers may have limited effect, however, because the judges in courts of law decide what evidence is permitted at trial to represent the legal standard of care.

### Causation

The third element of proof that a plaintiff-patient bears in a health care malpractice professional negligence case is to show, by a preponderance of evidence, that any breach of duty (i.e., violation of the legal standard of care) by a defendant-provider caused injury to the plaintiff-patient. The two elements of legal causation are actual cause and proximate cause.

Actual causation means that “but for” the defendant’s substandard care delivery, the plaintiff-patient would not have sustained any injury incident to care. The “but for” designation is also frequently referred to as *sine qua non* (Latin for “without which not”).

For a patient-plaintiff in a health care malpractice professional negligence case to establish actual causation is fairly simple. Any direct causal link between a health care professional’s conduct (action or failure to act) and a patient’s alleged injuries establishes actual causation. This is true even if the defendant-provider’s conduct was only a substantial factor (along with other possible causes) in the plaintiff-patient’s injuries.

Proximate causation poses a more difficult hurdle for plaintiffs in health care malpractice litigation. Under proximate, or legal, causation a court may choose not to
hold a defendant-provider liable for professional negligence, even where a breach of
duty and actual causation have been established by the plaintiff.

The definition of proximate causation is elusive, even for legal scholars. In one
reported physical therapy malpractice case, Greening by Greening v. School District of
Millard, the court described proximate causation in detail. In Greening, a state-
employed physical therapist designed an exercise regimen for a student-patient with
myelodysplasia. The program was carried out with the patient wearing leg braces, by
an aide, under supervision of the physical therapist. During a treatment session the
patient sustained a femoral fracture. The school district (sued by the patient’s parents
for vicarious liability) prevailed in the case at trial and on appeal. The appellate judge
in the case described proximate cause as a natural, direct result of a breach of duty on
the defendant-provider’s part, with no superseding intervening act breaking the
“chain” of causation.

When harm is not reasonably foreseeable, courts may refuse to hold health care
professional–defendants liable for unforeseeable results, as a matter of fundamental
fairness. Note, however, that a patient’s preexisting medical conditions do not neces-
sarily equate to superseding causes of injury that absolve a provider of liability for
injuries incident to treatment, if the provider could have learned about the preexist-
ing conditions through the taking of a thorough history or through other reasonable
means, such as a thorough physical examination. Only for the reasonably unforesee-
able harm may a court be willing to cut off liability under proximate causation.

**Damages**

The final element of proof in a professional negligence lawsuit is damages. To warrant
the award of monetary damages, a plaintiff must show that he or she sustained the
kinds of injuries, as a direct result of a defendant-provider’s breach of duty, that re-
quire the payment of money in order to make the plaintiff “whole” again (or as whole
as possible).

What kinds of losses warrant the award of monetary damages in a professional
negligence health care malpractice case? Monetary outlays for additional medical care
to correct or minimize the injury caused by the defendant constitute one element of
damages. So do lost wages or salary (from one or more employment sources) result-
ning from time away from work because of rehabilitation. Economic losses, such as
telephone, Internet, and traveling expenses, are also recoverable, as are (in some
states) loss of a reasonable chance of recovery or survival incident to a defendant-
health care professional’s negligent care. These actual out-of-pocket losses specific to
the plaintiff-patient are known as special damages.

Finally, damages may be awarded for the monetary value of pain and suffering
incident to the defendant-provider’s substandard care. Because of the difficulty in
quantifying the monetary value of pain and suffering, a majority of states now cap
pain and suffering damages at a statutory maximum amount. Pain and suffering dam-
ages and damages paid for the loss of enjoyment of life and the fear of contracting a
disease related to a defendant’s negligence are known as general damages.

Immediate family members directly and adversely affected by the plaintiff-patient’s
injuries may also recover monetary damages for loss of consortium. For spouses,
loss of consortium damages include the monetary value of lost services, society, and
companionship (including sexual relations) incurred over some definite period. For
parents, the value of a plaintiff-child’s lost economic contribution to the family unit is recoverable in some states.5

**Other Tort Bases for Malpractice Liability**

The two other tort bases for health care malpractice liability are intentional conduct causing patient injury and strict liability without regard for fault. Intentional tort liability is addressed in course 204. A brief description of the two forms of strict liability in tort follows.

Strict, or absolute, liability in tort involves a socially important, but abnormally dangerous, activity that results in patient injury or patient injury from a dangerously defective commercial product. The first form of strict liability is called **strict liability for abnormally dangerous activities** (formerly called **strict liability for ultrahazardous activities**); the second is strict product liability. An issue of strict liability for abnormally dangerous activity seldom, if ever, should arise in health care clinical practice because of the emphasis on patient safety and quality management associated with health care delivery. Factors used by courts to assess whether an activity is abnormally dangerous include the following:

- Whether the activity involves a high risk of foreseeable harm
- The severity of the risk of harm
- Whether the risk of harm can be eliminated through stringent quality control or safety precautions
- Whether the activity that causes injury falls within customary practice
- The social worth or value of the activity to patients and society

Hypothetical examples of activities that could be bases for strict liability for abnormally dangerous activities include high-velocity, rotary cervical manipulative thrust procedures by chiropractors, osteopaths, and physical therapists. Few cases appear in the legal literature based on strict liability for abnormally dangerous clinical activities.

**EXERCISE**

Brainstorm and identify at least five clinical activities from your discipline that might give rise to strict (non-fault-based) liability for abnormally dangerous clinical activities. What steps can you undertake to minimize the risk of patient harm associated with these activities?

Regarding strict product liability, courts will impose liability upon commercial distributors of unreasonably dangerously defective products that injure buyers or other foreseeable persons. According to the Restatement of Torts (Second) [a model for adoption as law by the states], Section 402A(1):

*One who sells any product in a defective condition unreasonably dangerous to the user or consumer … is subject to liability … if the seller is engaged in the business of selling such a product.*

Strict product liability was first imposed in the United States in California in 1944, in *Escola v. Coca-Cola Bottling Co.,* a *res ipsa loquitur* (presumptive negligence) case.
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involving an exploding soda bottle that injured a consumer. All other states soon followed the lead of California in establishing strict product liability as a viable cause of action in tort.

The philosophy behind strict product liability is that, between two potentially innocent parties—a commercial seller and a consumer of a dangerously defective product—the seller is the logical party to bear the risk of liability for injuries from the product because the seller is in the better position to insure against such liability and to monitor product safety. Dangerous product defects can be of three types: design defects, manufacturing defects, and inadequate warnings about potential hazards associated with a possibly dangerous product. The FDA classifies medical devices into three categories: Classes I (generally safe), II (safe with special controls; e.g., mercury thermometers), and III (necessary, but inherently unsafe, requiring premarket approval).18

Courts traditionally have been reluctant to impose strict product liability on health care professional–defendants because health care delivery is primarily the delivery (sale) of a professional service and not the sale of a product. This qualified immunity of health care professionals from strict product liability means that patients injured by defective medical products normally are required to claim against or sue product manufacturers.

Courts, however, will allow patients to sue health care clinicians (also classified under law as learned intermediaries19 for strict product liability when health care clinicians are regularly in the business of selling products to patients, such as transcutaneous electrical nerve stimulation devices, home traction units, and exercise equipment. The professions of optometry, orthotics, and prosthetics are more vulnerable to strict product liability malpractice lawsuits because these health disciplines are co-primary service and products professions.

Primary and support health care professionals must exercise caution when asked by patients to modify care-related equipment. Product manufacturers have in place disclaimers of liability for unauthorized major modifications of equipment, which may lead to unintended strict product liability exposure for health care clinical professionals.

Ordinary Negligence Incident to Health Care Delivery

Ordinary negligence differs from professional negligence in several key respects. Any person owing a duty of care to others may face liability for ordinary negligence. Professional negligence, however, deals with liability of members of learned (licensed or registered) professions. Professionals are rightfully held to a higher standard of care vis-à-vis their clients than are members of the public at large. The reason is that learned professionals possess superior knowledge and skills gained through advanced formal and informal education, training, and professional development. (Along the same continuum, doctoral and board-certified professional specialists may be held to even a higher standard because of their higher-level credentials.)

Premises liability: Potential liability for monetary damages on the part of owners or occupiers of land for injuries incurred by patrons and others coming onto their premises.
**Premises liability** concerns potential liability for monetary damages on the part of owners or occupiers (e.g., lessees [“tenants”]) of land for injuries incurred by patrons and others coming onto the premises. A duty of due care may be owed even to those persons entering or remaining on the premises without authorization, for example, trespassers and burglars.

In a majority of states, the law classifies the degree of duty owed to persons entering onto premises based on their status as invitees, licensees, and trespassers. For trespassers, the duty owed under this classification scheme is the lowest, often involving only the duty to post warnings about hidden constructed dangers that pose a substantial risk of serious bodily harm or death. As with most laws, there are exceptions to this bare-bones requirement, particularly for children (age 12 or under) who might be drawn onto hazardous premises by an “attractive nuisance,” such as ladders and scaffolding.

A higher duty is normally owed to business licensees, such as delivery persons and vendors. In addition to the aforementioned duty to warn about hidden hazards, there is usually a duty owed to use all reasonable measures to protect licensees from injuries resulting from operation of the facility. For example, an occupational therapist using work simulation machinery in the clinic would be required to take reasonable steps to prevent a FedEx delivery person from being injured by that machinery while traversing the clinic on the way to the office to make a delivery.

For states using the “bright-line” duty standard based on victim status, the highest duty owed is toward invitees, including in the case of physical and occupational therapist–clinic owners the patients and their families and significant others who are allowed into the clinic. In this case the duty owed is to take all reasonable steps to protect the invitees from any foreseeable harm from their exposure to the premises. This includes an affirmative duty to undertake regular inspections of the premises to seek out potential hazards.

A minority of states have abolished the bright-line rules for duty owed to persons coming onto premises based on their status. In these states the law simply universally requires owners and occupiers of premises to act reasonably under all circumstances to protect all persons coming onto their property from foreseeable harm. The status of the entrant, then, becomes only one factor to be considered in deciding the extent of the duty owed.

What is the significance of the legal distinction between ordinary and professional negligence to health care professionals? The difference is important to all parties and their attorneys. If a case is filed as an ordinary negligence case, the tort reform measures applicable only to health care malpractice legal actions do not apply. A longer statute of limitations (time line for commencing legal action) for ordinary negligence cases may exist than for professional negligence cases. In ordinary negligence cases the health care professional standard of care is not normally at issue, and often, expensive, contradictory, and confounding expert witness testimony is not needed. In some jurisdictions, such testimony is not even permitted because juries are perfectly capable of discerning common premises negligence without it. In the event of a finding of liability in an ordinary negligence case—even if it arises in a health care setting—the defendant’s name is not be reportable to the National Practitioner Data Bank (which is defined and discussed later in this course).

So it appears that a case brought as an ordinary negligence case, rather than as a professional negligence case, can inure to the benefit of all parties. Such a case can
also be of great benefit to courts because trial time may be decreased because less expert witness testimony may be required. Finally, ordinary versus professional case designation may benefit society as a whole because cases will probably cost less to bring to trial.

Vicarious Liability for Others’ Conduct

The term *vicarious liability* refers to the circumstances under which an employer bears indirect legal and financial responsibility for the conduct of another person, usually of an employee. The concept of vicarious liability dates back to ancient times and in legal circles is often referred to as *respondeat superior* (Latin for “let the master answer”).

**Vicarious liability:** Indirect legal and financial responsibility for the conduct of another person, such as an employee or a clinic volunteer.

The basic rule of vicarious liability is that an employer is financially liable for the negligent conduct of an employee when that employee-wrongdoer (tortfeasor) is acting within the scope of his or her employment at the time the act or omission occurred. Therefore, when a hospital-based health care clinician is alleged to have negligently caused injury to a patient during the course of care, the hospital employing the person directly responsible for the patient’s injury may be required to pay the monetary judgment if the employee’s negligence is proved in court. Vicarious liability, like strict liability, is non-fault-based liability.

An employer’s indirect responsibility for an employee’s conduct does not in any way excuse from financial responsibility the employee who is directly responsible for negligent patient injury. A tortfeasor is always personally responsible for the consequences of his or her own conduct. Vicarious liability, however, gives a tort victim another party against which to make a claim or to sue for monetary damages incident to wrongful injury. If an employer is required to pay a settlement or judgment for the negligence of one of its employees, the employer retains the legal right to seek indemnification from the employee for this outlay.

Is it fair to impose liability on an employer who is innocent of any wrongdoing? In balancing the equities between an innocent victim of negligence and an innocent employer of the party directly responsible for negligence, the legal system weighs in favor of the innocent victim of negligence. Several good reasons exist for this public policy favoring victims over employers. First, it is the employer, not the patient-victim, who has the exclusive right (and duty) to control the quality of patient care rendered in the facility by all providers. Second, because the employer earns a profit from the activities of its employees, it is only fair that the employer should be held responsible for patient injuries caused by employees. Third, the employer is normally in a much better position than the patient to bear the financial risk of loss—through economic loss allocation (i.e., purchase of liability insurance)—as part of the overall cost of doing business.
An employer may be held vicariously liable for the conduct of nonemployees and for employees. In the relatively few reported cases addressing the issue, courts have universally imposed vicarious liability on hospitals for the negligence of their volunteers; in essence, equating unpaid volunteers with employees. For this reason, health care facilities using the services of volunteers should carry liability insurance for volunteers’ activities.

Another area of vicarious liability involves general partnership business arrangements, wherein each general partner is considered legally to be the agent of all other general partners. Each general partner, then, is vicariously liable for negligent acts committed by other general partners when those acts are within the scope of activities of the partnership.

Several important exceptions to vicarious liability exist. Although an employer may be vicariously liable for employees’ negligence, the employer typically is not liable for malicious intentional misconduct committed by employees. Such misconduct is normally unforeseeable, so it would be unfair to hold an employer financially responsible for such conduct.

Another exception to vicarious liability involves independent contractors: for example, contract nurses working in a health care facility. The legal system generally distinguishes between employees (for whom an employer is vicariously liable) and contract workers (for whom the employer generally is not vicariously liable). This distinction is based primarily on the permissible degree of control the employer may exercise over the physical details of the professional work product of these two classes of workers.

In some states, courts hold employers vicariously liable for the negligence of independent contractors under the theory of apparent agency, or ostensible agency (also called “agency by estoppel”). When a contract professional worker in a clinic setting is indistinguishable from an employee-clinician, for example, a court may hold the employer vicariously liable for contractor negligence. Therefore, it is prudent risk management for employers to take appropriate steps to ensure that patients know when they are being treated by contract workers instead of employees. Methods to accomplish this include requiring contractors to wear name tags identifying them as contractors, posting an informational memorandum about workers’ status, and displaying cameo photographs of contract staff in clinic reception or waiting areas.

In some cases an employer may be not only vicariously liable for its employees’ negligence but also primarily, or directly, liable for its workers’ conduct under a concept known as corporate liability. Until the mid-twentieth century, nonprofit hospitals were virtually immune from any liability under a concept known as charitable immunity, granted in large part because of the benevolent character of these institutions. Since that time, courts in many states have imposed direct liability on hospitals and health care organizations under the theory of corporate liability. In essence, courts are treating hospitals like any other ordinary business. The U.S. Supreme Court validated this status for health care organizations in its landmark managed care (non) liability case in 2000, Pegram v. Herdrich. In essence, courts are treating hospitals like any other ordinary business. The U.S. Supreme Court validated this status for health care organizations in its landmark managed care (non) liability case in 2000, Pegram v. Herdrich.23

Corporate liability may attach under at least four theories. Hospitals have been found liable for the negligent screening and hiring of professional employees, such as physicians, nurses, and allied health care professionals. Hospitals have also been held liable for the negligent credentialing and privileging of staff professionals. Hospitals have also been held directly liable for negligent failure to monitor safety adequately
in their facilities. Finally, hospitals have been held liable under corporate liability for failing to establish effective quality management programs to monitor systematically the quality of health care delivered by all providers within the facility, including employees, contractors, consultants, volunteers, and others.

The 2005 Harvard University Leape study of medical mistakes attributed primary culpability for patient deaths to poor leadership within complex medical systems. The study recommended a systems approach to quality management to minimize the propensity for perinatal, medication, and ventilator errors that lead to patient injuries and deaths.

**Defenses to Health Care Malpractice Actions**

Although a defendant in a health care malpractice case normally bears no particular burden of proof in the case, the defendant probably will put forward one or more affirmative defenses in opposition to a plaintiff-patient’s *case-in-chief*. Affirmative defenses are ones that normally must be stated in the defendant’s *answer*, the first responsive *pleading* to a plaintiff’s *complaint*. By its apparent meaning, an affirmative defense is one in which the defendant bears the legal burden of proving the defense to the plaintiff’s allegation by a preponderance of evidence.

Two key defenses available to health care malpractice defendants are expiration of the statute of limitations and comparative patient fault in causing injury. Other potential defenses include assumption on the patient’s part of the attendant risks associated with a treatment and immunity and release from liability.

**Statutes of Limitations**

For purposes of health care malpractice litigation, the statute of limitations is a time line that begins at a point at which a patient knows (or should reasonably know) that he or she was injured at the hands of a health care provider and ends some months or years later at a time fixed by state or federal statute. The alleged victim of malpractice must file a formal civil lawsuit within the confines of that time line or be forever barred from later bringing legal action. The statute of limitations is considered a procedural, rather than a substantive, law.

Statute of limitations: Period after injury during which an injured person must file a civil lawsuit or be forever barred from later initiating legal action.

The statute of limitations has several key purposes. First, the statute of limitations affords an injured person sufficient time to investigate the source and nature of an injury, consult with and retain legal counsel (if desired), file a complaint with the responsible party (and/or that party’s employer and/or insurer), and attempt to settle the matter short of resorting to trial. Second, the statute of limitations creates a state of certainty (except when its exceptions apply, discussed later) and finality. Under the statute of limitations, legal cases must be commenced and brought to trial within a reasonable time frame so that witnesses to an event are still alive and available, documents and physical evidence are preserved for inspection, and parties and insurers can anticipate the resolution of pending legal disputes and their likely consequences.
A number of exceptions to the statute of limitations apply in many jurisdictions. If one of these exceptions applies, the statute of limitations is said to be tolled, or suspended until the exception is no longer applicable. Some exceptions concern what is termed a legal disability involving an alleged victim. For example, in some jurisdictions, the statute of limitations is tolled for minors and mentally incompetent victims for varying periods. Now, many jurisdictions do not suspend the statute of limitations because of a victim’s minority or incompetency. This is the case in the federal civil legal system.\(^{25}\)

Other exceptions that toll the statute of limitations include the continuous treatment doctrine and the discovery rule. Under the continuous treatment doctrine a court may suspend the running of the statute of limitations during the time in which the alleged victim of malpractice and the responsible health care professional maintain an active patient-professional relationship for treatment of the same condition from which injury resulted. The public policy purpose for this exception is that a tort victim should not be expected to interrupt necessary health care intervention for an active condition in order to bring legal action for malpractice.

The principle exception to the statute of limitations is the discovery rule. Under this exception, the statute of limitations may be suspended for the period during which an injured person cannot reasonably be expected to discover the injury upon which a malpractice claim may be based. The discovery rule has been invoked for conditions such as surgical sponges, needles, or instruments left inside of a surgical patient. Consider the following hypothetical example:

> A patient is referred to physical therapy by an orthopedic surgeon with a diagnosis of cervical degenerative joint disease with mild right C5 radiculopathy. The treatment order reads, “Evaluate and treat. Consider traction and/or appropriate mobilization techniques.” After taking a thorough history and conducting a comprehensive physical examination, the physical therapist makes evaluative findings and formulates a physical therapy diagnosis. The therapist then treats the patient using manual cervical distraction and manipulation techniques. The patient does not improve, and after several treatments, appears to have worsened. The physical therapist then ceases treatment, and refers the patient back to the orthopedist for reevaluation. Nine months later, it is discovered through diagnostic imaging study, that the patient sustained bony injury to the cervical spine, probably from the physical therapist’s manipulation treatments. The statute of limitations would probably not begin to run until the date of discovery by the patient of the existence and source of the injury.

Some states, pursuant to tort reform legislation, have placed absolute time limits, called statutes of repose, on certain types of civil actions, particularly for strict product liability actions.\(^{26}\) This means that, regardless of legal disability or plaintiff inability to discover the source of an injury, the outside time limit for initiating affected legal actions covered under statutes of repose is cut off after a set statutory period. Statutes of repose are considered to be an equitable way to solve the problems of perpetual litigation involving products produced long ago and incidents resulting in injury that have become stale because of lost or destroyed evidence or unavailable witnesses.
Comparative Fault

The right of a patient to collect monetary damages for injury incident to health malpractice is not absolute. In many cases, defendant–health care professionals raise the issue of patient contributory negligence or comparative fault in cases brought against them. Just like health care professionals treating patients have a duty of due care owed to patients under their care, patients themselves have a legal duty incident to care. That duty is to conduct themselves so that their actions do not fall below a standard imposed by law for their own safety and protection. When a patient’s conduct falls below the standard imposed by law for the patient’s own protection, that careless conduct constitutes contributory negligence.

Courts assess plaintiff-patient conduct in two ways, depending on the state in which a health care malpractice trial takes place. Before the first era of patient-oriented tort reform earlier in the last century, most or all jurisdictions used a pure contributory negligence formula for assessing plaintiff-patient conduct. Under this formula, if a patient is at all responsible—even 1 percent or less—for his or her own injuries incident to treatment, then the patient loses a health care malpractice case brought against a defendant–health care professional or defendant-organization. This harsh rule of “all or nothing” was tempered over time with numerous exceptions that permitted meritorious lawsuits brought by plaintiffs to proceed. One of those exceptions is last clear chance. Under the doctrine of last clear chance, application of all-or-nothing contributory negligence is prevented when a defendant has the last clear opportunity to act reasonably to prevent plaintiff injury but negligently fails to prevent it. Consider the following hypothetical example.

A patient who has recently undergone lumbar laminectomy is undergoing an occupational therapy work capacity evaluation. While preparing to lift a 10-lb weight from one table to another, the patient suddenly moves toward a 75-lb weight that is on the floor and states, “Let’s see how much I can lift.” Even though it would otherwise be pure contributory negligence for the patient to attempt to lift the heavy weight from the floor without authorization, the patient’s harm to himself might not preclude legal action for professional negligence. A legal action might be viable if the occupational therapist failed to take reasonable steps to attempt to halt the patient from attempting to lift the heavy box, under the equitable doctrine of last clear chance.

In most states a newer method of assessing potential plaintiff fault in a malpractice case applies—comparative negligence. Under the doctrine of comparative negligence, plaintiff-patient contributory negligence or wrongdoing does not necessarily eliminate any possibility of a professional negligence malpractice lawsuit against a health care professional. Instead, courts assess proportional patient culpability and assign a percentage of fault to it. In most states, if the patient’s percentage of fault is 50 percent or less, the patient can proceed with a lawsuit and have monetary damages reduced by the patient’s proportional degree of fault. In 13 states, patients can proceed to trial and win a monetary judgment, even if plaintiff comparative fault is greater than 50 percent.27 This subcategory of comparative negligence is called pure comparative fault. Consider the following hypothetical case.
A patient undergoing outpatient surgery for a sebaceous cyst intentionally removes an intravenous line from her arm, under a drape and out of the view of the surgeon and physician’s assistant carrying out the procedure. Soon after, the patient has a mild seizure, and the physician and assistant attempt to administer medication intravenously. A 10-minute delay ensues while the assistant establishes a new intravenous line. Assuming that the state in which the patient files a health care malpractice lawsuit uses the doctrine of comparative fault to assess damages, at what level would you quantify patient comparative fault? Justify your assessment. Would the patient be permitted to proceed to trial and win any monetary damages under your assessment?

The defensive comparative fault concepts of contributory negligence and comparative negligence apply in most cases only to health care malpractice cases brought as professional negligence cases. Because, under strict liability cases, culpability on the part of a defendant is not in issue, comparative fault principles are likewise not applied in these types of cases. As always, of course, there are exceptions in the legal literature. Contributory negligence and comparative fault are not valid defenses in cases involving intentional misconduct by defendants, as a matter of public policy.

Assumption of Risk

Assumption of the risk is a theoretically possible defense to a health care malpractice lawsuit. A plaintiff is considered to have assumed the risk of an activity under a defendant’s control if the plaintiff (1) fully appreciates the nature and extent of the risk of injury associated with the activity, and (2) makes a knowledgeable, intelligent, voluntary, and unequivocal choice to encounter that risk. Assumption of the risk applies, for instance, when a pregnant patron voluntarily elects to ride a tumultuous roller coaster at an amusement park, despite clear, posted warnings of its potential dangers.

As with comparative fault, assumption of the risk is theoretically a defense in health malpractice litigation that should be available only in professional negligence malpractice cases. Assumption of risk is not available in cases involving alleged intentional misconduct by a defendant-provider, nor can it normally be raised as a defense in cases in which a plaintiff is a member of a statutorily protected class of persons, such as those persons who are mentally incompetent or minors. Finally, no health care professional may compel a patient to waive liability (indirectly causing a patient to assume the risks of health care interventions) through a contractual exculpatory release.

In one reported legal case, Schneider v. Revici, involving a female patient who contractually agreed with her physician to waive any liability on the physician’s part for a novel form of breast cancer therapy, the federal court ruled that assumption of the risk is potentially an available defense to a health care malpractice lawsuit in which the intervention at issue is “unconventional.”

The better rule to follow is that patients assume the risk of nothing in the course of health care intervention that would excuse professional negligence on the part of a health care provider owing a duty of special care toward that patient. Therefore, except theoretically, assumption of the risk is inapplicable as a defense in health care delivery.
Assumption of the risk is inapplicable as a defense in health care malpractice litigation in conventional health care delivery.

**Immunity**

Until recently, nonprofit religious-based health care institutions enjoyed immunity from legal actions under an equitable legal doctrine called *charitable immunity*. This immunity was granted because of the great public service rendered on behalf of the sick and dying patients who otherwise had no place of refuge in society. As health care delivery became equated with ordinary business during this century, however, the charitable immunity exception to tort liability died.

Immunity from legal actions is also a privilege enjoyed by governments under an ancient concept known as *sovereign immunity*. States and the federal government enjoy sovereign immunity from liability (i.e., cannot be sued or compelled to pay out a monetary judgment) unless they expressly waive, or give up, their sovereign immunity. The federal government, in 1946, partially relinquished its sovereign immunity from liability under a statute known as the Federal Tort Claims Act. Under this statute, in the federal-sector health care setting, most patients (except active-duty military service members and their family members, when suing the federal government derivatively for wrongdoing against active-duty service members) may bring lawsuits against the federal government for professional and ordinary negligence and for a limited number of intentional wrongs. Many states have adopted waiver of sovereign immunity statutes similar to the Federal Tort Claims Act.

Under litigation brought pursuant to the Federal Tort Claims Act, individual federal health care employees are personally immune from suit under the Federal Liability Reform and Tort Compensation Act, provided that their conduct falls within official federal scope of duty. State-employed health care professionals may enjoy similar personal immunity from liability under state statutes that mirror the Federal Tort Claims Act. Health care professionals engaging in *pro bono publico* (Latin for “for the public good”) health care services may also enjoy limited tort immunity from liability based on state law.

**Releases from Liability**

The release from liability is a standard legal instrument in civil law. For instance, when an insurance company settles a claim with a claimant, release from liability is used to absolve the insurance company forever of further liability resulting from the incident in question. The release from liability is also used in health care malpractice litigation to absolve a defendant or defendants of further liability exposure in exchange for a monetary settlement made to a plaintiff. These uses of a release are well-established and not generally subject to nullification, except in cases of fraud, duress, undue influence, or other overreaching by a party or by the party’s agent.

The attempted prospective use of releases in the health care setting is what is legally problematic. As a general rule, an attempted exculpatory release that is made a *condition precedent* (precondition) of receiving treatment is invalid as violative of
public policy. The lead reported legal case involving exculpatory releases from liability is *Tunkl v. Regents of the University of California.* In that seminal case a terminally ill patient was admitted to a state-run charity research hospital for treatment. As a condition of admission, the hospital required the patient to sign a release from liability, which was purportedly justified because the facility was a charity hospital. The patient died and his wife, as *executrix* (personally appointed legal representative) of his estate, brought suit challenging the exculpatory release and claiming professional negligence regarding her late husband’s care. In invalidating the exculpatory release, Justice Tobriner of the California Supreme Court held that California statutory law stated that “all contracts which have for their object, to exempt anyone from responsibility for his own fraud, or willful injury to the person or property of another … whether willful or negligent, are against the policy of the law.” The court ruled that there could be no exception for hospitals, even charity or research hospitals, and allowed the executrix’s legal action for malpractice to proceed.

In some instances a waiver of liability may be appropriate and enforceable. Consider the case in which a competent, hospitalized inpatient voluntarily elects to leave the facility midway through care “against medical advice.” Before such a patient leaves the facility, a physician, nurse, or administrative official will discuss the adverse consequences of leaving against medical advice and attempt to have the patient sign a release from further liability. Such a risk management measure is appropriate. Similarly, when a patient declines what health care professionals deem to be necessary care because of religious or personal beliefs, it is appropriate to seek a limitation of liability agreement from the patient. What is repugnant to the courts are exculpatory health care releases from liability that are general. Consider the following hypothetical example.

*A postoperative finger flexor tendon surgical patient is receiving outpatient rehabilitation by an occupational therapist. Suddenly one day, the patient states that she is going to quit attending rehabilitation and exercise her hand on her own. Objectively, she is still in need of professional care. As the treating therapist, explain how you would protect the patient’s interests and your own interests in this situation.*

**Answer:** (1) Fully explain to the patient the consequences of discontinuing therapy prematurely. Ensure that the patient’s decision to discontinue treatment is knowing, intelligent, voluntary, and unequivocal. Make sure that there is no point of dissatisfaction regarding your care that can be remedied to the patient’s reasonable satisfaction. (2) Notify the referring physician of the patient’s action, and carefully document the patient’s statements, your counseling of the patient, and your communication with the referring physician. (3) Consult with your legal advisor, and consider asking the patient to sign a release from further liability. Be careful that the release does not attempt to absolve you of any liability incident to care because such a release would probably be unenforceable as a violation of public policy.

**NATIONAL PRACTITIONER DATA BANK**

The National Practitioner Data Bank was established pursuant to a federal statute, the Health Care Quality Improvement Act of 1986. Congress enacted this law with several purposes in mind:
• To promote effective professional peer review by the health professions by providing “qualified immunity” from defamation or other bases of liability for statements made during these processes

• To require reporting by hospitals and other health care organizations having peer review of adverse credentialing actions affecting clinical privileges involving physicians, dentists, and other licensed health care professionals

• To require the reporting of adverse licensure action against a licensed health care professional by a state licensure board

• To require the reporting of health care malpractice payments made on behalf of health care professionals to patients or their representatives by settlement or judgment

Before the advent of the National Practitioner Data Bank, unscrupulous and incompetent health care providers were often able to “skip” from state to state to avoid adverse licensure disciplinary action with impunity. The data bank was intended to prevent these kinds of injustices by making available to employers and licensure agencies critical information about adverse actions taken against licensed health care professionals.

The implementation of the data bank was delayed for several years after the effective date of the Health Care Quality Improvement Act, in part because of strong opposition by health care professional associations. The data bank was debated in Congress, with substantial lobbyist intervention, until its implementation on September 1, 1990. Regarding health care malpractice payments, any amount, even a nominal, so-called “nuisance” settlement amount, must be reported by payers to the data bank.

In its first year of operation (September 1, 1990, to August 31, 1991), the Data Bank recorded 15,782 malpractice payments made by insurers and health care organizations on behalf of licensed health care professionals. Of that number, 11,721 involved physician malpractice payments, 2360 involved payments made on behalf of dentists, and 1701 payments were made on behalf of other licensed health care professionals, including physical and occupational therapists. There were 2779 adverse administrative action reports for the first-year period: 2285 involving physicians, 470 involving dentists, and 24 involving other licensed health care professionals. The total number of reports made to the data bank in the first year was 18,561.

Who has access to the National Practitioner Data Bank? Hospitals and other health care organizations required to query the data bank about newly licensed health care professional–employees, state licensing entities, and licensed health care professionals themselves. In limited circumstances (such as when employers fail to query the data bank as required about new health care professional–employees), plaintiff attorneys have access to information in the National Practitioner Data Bank. Note that employers are also required to query the data bank for information about employed or otherwise privileged licensed health care professionals on a regularly recurring basis—every 2 years. Currently, no provisions exist under the Health Care Quality Improvement Act for public access to information about health care professional adverse administrative actions or malpractice payments.

Democratic Senator Ron Wyden of Oregon, author of the legislation behind the data bank, is critical of recently publicized underreporting of health care malpractice payment data to the data bank. According to Wyden, the data bank is only as good as the information it contains. Daniel Levinson, inspector general of the Department
of Health and Human Services, specifically cited 474 malpractice cases from federal health agencies that went underreported to the data bank. Perhaps because of this problem, the Joint Commission has expressed a lack of confidence in the data bank and called for its redesign or replacement.44

**PATIENT CARE DOCUMENTATION MANAGEMENT**

Patient care documentation has malpractice implications just as affirmative care delivery does. Communication of pertinent information about the patient to other providers who are simultaneously treating that patient, therefore, is the principal purpose of patient care documentation. Concise, objective, timely documentation of a provider’s evaluation, diagnosis, and treatment of a patient conveys to other health care professionals who treat that patient—now or in the future—insight into the patient’s specific needs. Standards for formats and frequency of patient care documentation are established by statutes; licensure regulations; institution, group, or network standards; accreditation and third-party payer mandates; and professional association guidelines.

Because communication through patient care documentation is so critically important to a patient’s well-being, the failure to document vital care information in the patient’s record accurately, clearly, objectively, and in a timely manner constitutes professional negligence, which may be legally actionable, depending on the consequences of an omission. This type of professional negligence action for the negligent failure to communicate vital patient information to others having a need to know exists independently of any other legal action based on the quality of care rendered.

Many other legitimate purposes exist for patient care documentation, including the risk management purpose of memorializing important facts about an event for possible use in subsequent litigation. Patient care documentation is also used as a basis for planning and continuity of care, as a primary source of information for quality measurement and evaluation of patient care activities, to provide information necessary for reimbursement decisions and utilization review, to identify staff training needs, as a resource for patient care research and education, and to memorialize informed consent to treatment and patient wishes concerning advance directives, among other purposes (Box 3-4).

Documentation of patient care is as important as the rendition of patient care itself.

The patient treatment record is a legal document, referred to as a business document, which is admissible in court as evidence in health care malpractice and other civil and criminal legal proceedings. As part of the legal duty owed to a patient, a treating health care professional is responsible and accountable for accurate, clear, objective, and timely documentation of the patient’s chief complaint(s), relevant history, physical examination, evaluative findings, informed consent to intervention, intervention, referral, home care instructions, and follow-up care on discharge.

Information documented about a patient serves simultaneously to protect the patient and the treating clinician. If a patient brings a malpractice lawsuit against the clinician—often years after care is rendered—what is documented in the treatment record about the patient’s care may well be the best or even only objective evidence of what transpired between the patient and the health care professional at the time of
When expert witnesses take the stand for or against defendant–health care providers to testify about whether care rendered to plaintiff-patients met or violated the legal standard of care, they rely primarily on what is documented in treatment records to formulate their professional opinions. From the standpoint of health care malpractice, documentation of patient care serves as the primary basis for expert testimony about whether the standard of care was breached or met in a given case, the standard of care being the benchmark that delineates negligent and nonnegligent care.

When a treating health care clinician is required to testify as a defendant or witness in a legal proceeding, how can the clinician recall a given patient’s relevant history, evaluative findings, treatment plan, disposition, and follow-up care when the event occurred months or years earlier? Although attorneys often try to jog the memories of percipient (fact) or expert witnesses through leading questions (where not objected to or where allowed by judges), more often than not, reference to patient health records is often indispensable in order to refresh lapsed memories regarding past events.

When a treating health care clinician’s memory (as a witness) is incomplete, patient care documentation in the treatment record can be relied upon in one of two ways during direct testimony in a legal proceeding. The preferred way is for the clinician first to review the treatment record while on the witness stand, as a stimulus to jog the witness’s present memory. After reviewing the documentation, the treatment record is taken away from the witness, and the witness testifies. This form of recall is called present recollection refreshed.
If a clinician’s present recollection cannot be refreshed by reviewing the treatment record, then the treatment record itself may have to be admitted into evidence as substantive evidence of the care rendered to the patient under an exception to the hearsay rule.\textsuperscript{45} This exception is called \textbf{past recollection recorded}. To substitute the treatment record for live testimony, however, the clinician must swear or affirm that the treatment record was accurate at the time it was written.

A health care professional should always document in a patient’s treatment record as if the entry were being prepared for court because this may in fact occur. A health care professional will be more inclined to document more carefully if he or she imagines the documentation being blown up to giant size in a courtroom. The following simple, common-sense documentation tips will help clinicians avoid legal dilemmas concerning patient care documentation:

- Always write on every line in the record (to avoid the temptation to correct an entry after the fact).
- Write with one pen, using black (or blue) ink. In the rare case in which a pen runs out of ink midway through documenting an entry, indicate in a brief parenthetical that the first pen ran out of ink and continue with a second pen.
- Correct mistaken entries by drawing a single, straight line through the error and initialing (and dating, if this is customary practice) the correction. (Do not add words such as “error” or “mistaken entry” because such words may give rise to an inference in the eyes of a jury of negligent care delivery.)
- Except when correcting contemporaneous mistakes, do not edit prior documentation entries.
- Do not back-date an omission in a patient treatment record. Once an omission is noted, document critical omitted information in a new entry with today’s date.
- Write legibly. Print, type, or dictate as required to help you to communicate clearly. Remember that the failure to communicate vital patient information clearly and in a timely manner constitutes professional negligence.
- Do not express negative personal feelings about a patient in the treatment record, such as “Patient is an obvious malingerer.” Lack of objectivity in documenting patient evaluation and treatment can give rise to an inference of noncompliance with the legal standard of care.
- Do not argue with or disparage other health care professionals in the treatment record. Again, such behavior gives rise to an inference of uncoordinated and negligent care.
- Avoid including in patient care documentation extraneous verbiage not related to diagnosis or treatment of patients. Information such as “Patient is a pleasant, 55-year-old Beatles record collector” probably has no place in a general patient treatment record.
- Avoid using terms and abbreviations not universally understood by all health care professionals caring for the patient. Use of cryptic, esoteric terminology constitutes a negligent failure to communicate patient information.
- Avoid documenting patient status using ambiguous terminology, such as “tolerated treatment well,” without specifying the parameters of the meaning of the phrase. Health care malpractice insurers caution that such ambiguous phraseology is too vague to be useful in defending a health care malpractice charge.\textsuperscript{46}
Even innocent corrections of prior treatment entries may be construed by courts as intentional alteration of treatment records, which can have profound adverse legal consequences for health care professionals who become defendants in malpractice cases. A court may rule that altered treatment records are inadmissible or that a jury may infer or must presume negligence against a defendant–health care provider. Intentional alteration of treatment records may also give rise to the awarding of punitive damages against a defendant-provider should be plaintiff prevail in the case. Punitive damages are not normally payable by a provider’s malpractice liability insurer. The legal term for intentional treatment record loss or alteration is spoliation.

Although specific rules concerning the use of adverse incident reports vary from facility to facility, certain universal rules apply when documenting adverse, potentially compensable events involving patients. Potentially compensable events that warrant the generation of incident reports include patient injury or expression by a patient of serious dissatisfaction with care.

An incident report serves two purposes: (1) to alert management to possible safety hazards requiring investigation and possible correction, and (2) to memorialize important facts about an adverse event for the purpose of preventing liability on the part of the organization.

**Spoliation:** The intentional loss or destruction of patient treatment records.

Always document adverse patient incidents concisely and objectively. Do not assign blame or speculate as to the cause of injury in the incident report. Document as fact only those things that you personally perceive. What others related to you, as recorder, constitute hearsay and should be bracketed in quotation marks to identify the hearsay statements clearly as emanating from someone other than the recorder.

Normally, information documented in an incident report is immune from discovery by a plaintiff-patient and his or her attorney. This qualified immunity normally requires that incident reports be clearly labeled as “quality assurance/improvement/management documents” or a “report prepared at the direction of the organization’s attorney for possible use in litigation.”

Do not file a copy of an incident report or mention its creation in the treatment record. The information contained in its does not relate to patient evaluation or treatment. Do create a concurrent treatment entry in the record detailing patient injury and provider interventions on the patient’s behalf. Consider the following hypothetical example.

You are a licensed practical nurse entering a patient room on a nursing unit. The patient’s diagnosis is “status-post left cerebrovascular accident, with right upper limb hemiplegia.” As you enter the room, you observe the patient on the floor beside his bed, in the fetal position, and moaning. You notice that the side rails are down on the side where the patient is found. The patient’s wife is sitting in a chair next to the bed. She states, “The side rails were down, and he fell out of bed. The nurses always leave the damn side rails down!” You quickly come to the patient’s aid, and examine and stabilize him in a supine position. There is no apparent injury. You then go to the door and call for help from other nurses and doctors on the unit.

How do you document (1) the narrative portion of the incident report and (2) the progress note in the patient’s treatment record?
1. The narrative portion of the incident report might read as follows: “Upon entering the patient’s room, I observed the patient on the floor next to his bed. The patient was in the fetal position and was moaning. The side rails were down. The patient’s wife, who was seated in a chair next to the patient’s bed, stated, ‘The side rails were down, and he fell out of bed. The nurses always leave the damn side rails down!’ I examined and stabilized the patient in the supine position, after noting no apparent injury. Nurses and physician notified.”

2. The progress note might read as follows: “Upon entering the patient’s room, I observed the patient on the floor next to his bed. The patient was in the fetal position and was moaning. Patient examined and stabilized in the supine position, after noting no apparent injury. Nurses and physician notified.”

SUMMARY

The term health care malpractice encompasses civil legal actions initiated by patients or their representatives against health care providers and/or health care organizations for patient injury incident to the delivery of professional care services. However, patient injury alone is insufficient to allow a patient to prevail against a health care professional or organization. The injury must be coupled with a recognized legal basis for imposing health care malpractice liability.

The legal bases for imposing health care malpractice liability consist of professional negligence; intentional, treatment-related conduct resulting in patient injury; breach of a treatment-related contractual promise made by a health care provider; and strict liability (without regard to fault) for injuries from abnormally dangerous clinical procedures or from dangerously defective treatment-related products.

The overwhelming majority of health care malpractice legal cases are based on allegations of professional negligence. A plaintiff-patient alleging professional negligence by a defendant-health care professional must prove a litany of four elements, each by a preponderance, or greater weight, of evidence at trial. These elements are (1) that the defendant-provider owed a legal duty of special care toward the plaintiff-patient, (2) that the provider breached the duty owed by delivering care that was objectively substandard, (3) that the breach of duty directly caused the patient injury, and (4) that the award of monetary damages is appropriate and necessary to make the patient “whole.”

Defenses available to defendant-health care professionals and organizations in malpractice cases are of two general types: technical (procedural) and substantive. Technical defenses, demonstrated in many of the reported malpractice cases lodged against physical and occupational therapists include plaintiff-patient noncompliance with the applicable statute of limitations, failure to comply with procedural requirements for affidavits and other pleadings and documents submitted to courts, and personal immunity from liability (as when the federal government is responsible for official conduct of federal workers under the Federal Tort Claims Act). Substantive defenses include plaintiff-patient contributory negligence or comparative fault and proof by the defendant of compliance with the legal standard of care, making a plaintiff-patient’s injuries merely an unfortunate adverse event without legal recourse.
Health care professionals—individually and collectively, and health care organizations, systems, and networks—can and must develop and implement effective risk management strategies to minimize malpractice exposure and liability. Such measures include patient care documentation skills and management, effective communications with patients and professional colleagues, empathy and respect for patients, systematic quality and risk management, continuing and continuous professional education, training and development for staff. 47

**CASES AND QUESTIONS**

1. Patient A is an outpatient in nurse practitioner B’s private practice. A ambulates using a four-legged cane. On his way from the reception area to the treatment area, A trips on a frayed edge of carpeting and falls and breaks a tooth. A expresses an intention to file a claim against the clinic for malpractice. Is A’s claim for malpractice valid? If so, under what theory of liability? What steps should the nurse practitioner take immediately after injury?

2. Patient C, an outpatient in a sports physical therapy clinic, is being treated for an anterior cruciate ligament deficiency with closed-chain functionally focused exercise. Z, the clinic owner and treating physical therapist, promised C that her involved (dominant) knee strength would be equal to the uninvolved leg after 6 to 8 weeks of rehabilitation. During a session, C falls, twisting and injuring her involved knee. The incident was clearly no one’s fault. Does C have a valid claim for physical therapy malpractice? Under which theory or theories might she proceed?

3. D, a general practice physician in private practice, treats patient E, an outpatient with a diagnosis of mechanical low back pain, with back extension exercises. At the end of the treatment session, E suddenly complains of increased left lower limb radicular symptoms and severe low back pain. A subsequent magnetic resonance imaging study reveals an intervertebral disk herniation at L4-L5. E undergoes a surgical diskectomy the next day. On these facts alone, is D liable for malpractice? From which disciplines might health care professionals testify as experts in a subsequent health care malpractice trial?

**SUGGESTED ANSWERS TO CASES AND QUESTIONS**

1. Patient A’s case is probably an ordinary premises negligence case and not a professional treatment-related negligence case. This is so because the source of injury was a frayed rug, causing the same kind of fall that could occur in a retail store, a private home, or anywhere else.

   The main advantage for the plaintiff of the case being labeled as ordinary negligence is that the plaintiff avoids the many administrative hurdles that attach to professional negligence legal actions, such as submission of the case to an administrative merit panel and submission of expert opinions along with court pleadings. In an ordinary premises negligence case, expert testimony on the nurse practitioner’s standard of care is inapplicable. Experts are unnecessary because the nature of an ordinary fall is within the common knowledge of lay jurors, without the need for clarification by experts.

   For the defendant, the main advantage of the case being labeled as ordinary negligence is that a finding of liability does not result in the health care professional’s name being reported for inclusion in the National Practitioner Data Bank. For both parties, an ordinary negligence case should be less time-consuming, less intense, and less expensive than a health care malpractice case.
Promoting Legal and Ethical Awareness

The first step that the nurse practitioner should take after injury is to ensure that the patient is safe and stable. After injuries are ascertained, emergency consultation with a physician or dentist should be accomplished, and the patient should be transferred for care by these professionals. Express empathy with the patient’s situation, and show that you care.

Complete an incident report. (This applies even for private practice clinics.) In addition to accurate documentation of administrative data, such as time, place, lighting, and other relevant details about the incident, carefully complete the narrative part of the report objectively and completely. Attribute any hearsay statements made by others to their source. Do not file or mention the incident report in the patient’s treatment record.

Complete an entry in the patient’s treatment record regarding injuries incurred by the patient and actions taken by you and your staff on the patient’s behalf. Be sure to send a copy of the patient’s record with the patient for emergency medical treatment.

2. The problem states that patient C’s knee injury was no one’s fault. This, however, does not prevent the filing of a health care malpractice claim or lawsuit. Some persons erroneously believe that malpractice liability automatically attaches anytime a patient is injured during treatment. Such is not the case. Malpractice liability requires patient injury, plus the presence of one of the recognized legal bases for imposing liability. In this case, one of these bases for liability—breach of contract—may seem to be present because a therapeutic promise was made to the patient by the physical therapist. However, the accidental fall that caused the patient injury probably would excuse the physical therapist from the contractual promise to achieve a therapeutic result under the contractual defense of “impossibility of performance.”

3. As was explained in the answer to problem 2, patient injury during treatment alone does not create health care malpractice liability. The patient must also prove, by a preponderance of evidence, the existence of one of the legal bases for imposing liability. If such a connection can be established, a malpractice case may proceed to trial.

If the case proceeds to pretrial depositions and to trial, expert witnesses for the plaintiff and defendant may be physicians, physical or occupational therapists, chiropractors, or other health care professionals from related disciplines having similar knowledge, training, and experience about low back care as the defendant, and knowledge of the applicable standard of care in effect in the community in which the defendant practices.

SUGGESTED READINGS

Freeman J: Medical negligence and the locality rule: that’s how medicine is practiced here, Iowa Med 96(3):10, 2006.
Fusion K: ‘Patient’ says it all: ER waits vary widely from state to state, USA Today p 8D, June 1, 2006. (Low: Iowa, 138.3 minutes; high: Arizona, 297.3 minutes)


REFERENCES

10. 21 C.F.R. Parts 201, 314 and 601 (Jan 24, 2006).
18. C.F.R. 880.2920 (April 1, 2006). The administrative Code of Federal Regulations (21 C.F.R. Ch. 1, Section 801.109) requires that all prescription medical devices have the statement: “Federal law restricts this device to sale by or on the order of a physician, dentist, veterinarian, or other appropriate health care professional.”
23. *Pegram v. Herdrich.* 530 U.S. 211 (2000). [ERISA, the Employee Retirement Income Security Act of 1974, preempts imposition of health care malpractice liability in state courts against health maintenance organizations that treat patients pursuant to employer-provided health insurance benefit plans. ERISA cases are tried exclusively in federal courts, and liability is limited to the monetary value of health benefits denied to patients. Compensatory and punitive damages are disallowed.]


28. Under the Restatement (Second) of Torts, Section 524, contributory negligence is a viable defense in a strict liability case when a plaintiff knowingly and unreasonably subjects himself or herself to risk of harm. Similarly, intentional, unreasonable misuse of a product by a plaintiff may create a valid defense to a strict product liability legal action. *Daly v. General Motors Corp.*, 20 Cal. 3d 725 (1978).


31. Federal Tort Claims Act, 28 United States Code Sections 1346(b) and 2671-2680.

32. Federal Employees Liability Reform and Tort Compensation Act, 28 United States Code Section 2679, reads in pertinent part:

(b)(1) The remedy against the United States provided by Sections 1346(b) and 2672 of this title for injury or loss of property, or personal injury or death arising or resulting from the negligent or wrongful act or omission of any federal employee of the Government while acting within the scope of his office or employment is exclusive of any other civil action or proceeding for monetary damages by reason of the same subject matter against the employee whose act or omission gave rise to the claim or against the estate of such employee. Any other civil action or proceeding for monetary damages arising out of or relating to the same subject matter against the employee or the employee’s estate is precluded without regard to when the act or omission occurred.


35. California Civil Code Section 1668.


37. Subchapter 1—Promotion of Professional Review Activities

(1) Limitation on damages for professional review actions

If a professional review action … of a professional review body meets all the standards specified …

(A) the professional review body,

(B) any person acting as a member or staff to the body, and

(C) any person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States (or political subdivision thereof) with respect to the action …

(2) Protection for those providing information to professional review bodies

Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competency or professional conduct of a physician shall be held, by reason of having provided such information,
to be liable in damages under any law of the United States or of any State (or political subdivision) unless such information is false and the person providing it knew that such information was false.

38. Section 11131. Requiring reports on medical malpractice payments
   (a) In general:
   Each entity (including an insurance company) which makes payments under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report … information respecting the payment and circumstances thereof.
   (b) Information to be reported
   The information to be reported under subsection (a) of this section includes:
   (1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,
   (2) the amount of the payment,
   (3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,
   (4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based …

41. Using the National Practitioner Data Bank, Medical Staff Briefing pp 9-10, Dec 1991.
42. 42 United States Code Section 11135(a)(2).
45. Black’s Law Dictionary, ed 5, St Paul, Minn, 1979, West Publishing Company. Hearsay evidence includes out-of-court statements offered as evidence in legal proceedings for the truth of the matter asserted in them. The hearsay rule, in effect in every state and in the federal legal system, prevents hearsay evidence from being admitted in legal proceedings, absent a recognized exception, such as a confession (in a criminal case) or admission (in a civil case), or a dying declaration (statement made by someone near to the time of death).