

# HEALTH CARE PROFESSIONALS LEGAL–ETHICAL ISSUES

*Ethics is nothing else than reverence for life.*

–ALBERT SCHWEITZER

## LEARNING OBJECTIVES

Upon completion of this chapter, the reader will be able to:

- Identify a variety of ethical and legal issues that arise in selected health care professions (e.g., nursing, emergency services, laboratory, pharmacy, radiology).
- Explain how practicing one’s professional code of ethics can assist in resolving day-to-day issues that arise during patient care.
- Explain the difference between the certification and licensure of a health care professional.
- Identify helpful suggestions that help caregivers provide high-quality care.

## INTRODUCTION

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*My life is my message.*

–MAHATMA GANDHI

This chapter presents an overview of how ethics and the law affect a variety of health care professions. The ethical codes for each profession demand a high level of integrity, honesty, and responsibility. Codes of ethics are designed to facilitate the resolution of common ethical dilemmas that arise in one's profession.

The contents of codes of ethics vary depending on the risks associated with a particular profession. Ethical codes for psychologists, for example, define relationships with clients in greater depth because of the personal one-to-one relationship they have with their clients. Laboratory technicians and technologists, on the other hand, generally have little or no personal contact with patients but can have a significant impact on their care. Laboratory technologists in their ethical code pledge accuracy and reliability in the performance of tests. The importance of this pledge was borne out in a March 11, 2004, report by the *Baltimore Sun* wherein state health officials discovered that a hospital's laboratory personnel overrode controls in testing equipment showing results that might be in error and then mailed them to patients anyway.<sup>1</sup> The various codes of ethics for each health care profession are accessible by profession on the Internet.

## NURSES—ETHICS AND LEGAL ISSUES

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*To Be a Nurse: Swedish Hospital, Seattle, Washington*

- *In memory of all those patients that have enriched my life and blessed me with their spirit of living—while they are dying.*
- *Nursing is the honor and privilege of caring for the needs of individuals in their time of need. The responsibility is one of growth to develop the mind, soul, and physical well-being of one-self as well as the one cared for.*
- *Excellence is about who we are, what we believe in, what we do with everyday of our lives. And in some ways we are a sum total of those who have loved us and those who we have given ourselves to.*
- *I have been with a number of people/patients when they die and have stood in awe. Nursing encompasses the sublime and the dreaded. We are regularly expected to do the impossible. I feel honored to be in this profession.*
- *To get well I knew I had to accept the care and love that were given to me—when I did healing washed over me like water.*
- *Through all of this I was never alone.*
- *In the caring for one another both are forever changed.*
- *A friend takes your hand and touches your heart.*
- *To all of you whose names were blurred by the pain and the drugs.*
- *Don't ever underestimate your role in getting patients back on their feet.*
- *Will I lose my dignity? Will someone care? Will I wake tomorrow from this nightmare?*
- *You exist as women living between heaven and hell. Inside a machine that demands absolute vigilance. I hated every minute of my stay with you; however, I totally realize the value of your efforts. Please accept my heartiest thank you.*

–UNKNOWN AUTHORS

The nurse is generally the one medical professional the patient sees more than any other. Consequently, the nurse is in a position to monitor the patient's illness, response to medication, display of pain and discomfort, and general condition. This section provides an overview of the ethical responsibilities and legal issues of nursing practice. Although nurses traditionally have followed the instructions of attending physicians, physicians realistically have long relied on nurses to exercise independent judgment in many situations.<sup>2</sup> Patients in hospitals, nursing homes, or at home learning to manage a chronic condition are often at their most vulnerable moments. Nurses are the health care providers they are most likely to encounter; spend the greatest amount of time with; and often depend on for care. Research is now beginning to document what physicians, patients, other health care providers, and nurses themselves have long known: how well we are cared for by nurses affects our health and sometimes can be a matter of life or death.<sup>5</sup>

The more than a decade old nursing shortage continues to require hospitals to search for foreign-trained registered nurses. New immigration laws have complicated the hiring and immigration process. Many countries are facing similar shortages, thus raising ethical dilemmas when recruiting foreign nurses from countries with shortages of their own.

Higher salaries and incentives have done little to resolve the nursing shortage. The unemployment rate would be expected to provide some incentive for students to enter the nursing profession, but the shortage persists. The Secretary of Health and Human Services (HHS), Kathleen Sebelius, announced that \$55.5 million in funding was awarded in FY 2013 to strengthen training for health professionals and increase the size of the nation's health care workforce.

These grants and the many training programs they support have a real impact by helping to create innovative care delivery models and improving access to high-quality care," Secretary Sebelius said.

More than 270 grants will address health workforce needs in nursing, public health, behavioral health, health workforce development, and dentistry. The grants are managed by HHS' Health Resources and Services Administration (HRSA).

A majority of the funding, \$45.4 million, will support nursing workforce development in the following areas:

- Increasing the number of nurse faculty (\$22.1 million)—provides low-interest loans to nurses to train to become faculty and loan cancellation for service as faculty.
- Improving nursing diversity (\$5.2 million)—expands educational opportunities for students from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented among registered nurses.
- Increasing nurse anesthetist traineeships (\$2.2 million) —supports nurse anesthetist programs to provide traineeships to licensed registered nurses enrolled as full-time students in a master's or doctoral nurse anesthesia program.
- Promoting interprofessional collaborative practice (\$6.7 million)—brings together interprofessional teams of nurses and other health professionals to develop and implement innovative practice models for providing care.
- Supporting advanced nursing education (\$9.2 million)—funds advanced nursing programs that support registered nurses in becoming nurse practitioners, nurse midwives and other practice nurses.<sup>4</sup>



### 50 and You Lived Your Life?

I recall teaching an ethics course to nurses in a master’s degree program in New York. As we were discussing care for the elderly, a young nurse, about 23 years of age, said, “I think we should not be providing expensive tests and treatments for patients over 50 years of age. People at that age have basically lived their lives.” Although most of the nurses in the class were in their late 40s and early 50s, there was silence across the room. My assumption is the nurse was unaware of the age group in the class, as she was the youngest nurse. As to the older nurses, I am not sure as to why they remained so silent. To my surprise, no one uttered a word and the class moved on as though nothing was said. I must say that I, being 33, was speechless.

*Anonymous*

#### Discussion

1. Discuss the ethical issues here that concern you.
2. Describe how you might have responded if you were instructing the class.

### REGISTERED NURSE

A *registered nurse* is one who has passed a state registration examination and has been licensed to practice nursing. The scope of practice of a registered professional nurse includes patient assessment, analyzing laboratory reports, patient teaching, health counseling, executing medical regimens, and operating medical equipment as prescribed by a physician, dentist, or other licensed health care provider. The nursing profession “is in a period of rapid and progressive change in response to the advances in technology, changes in patterns of demand for health services, and the evolution of professional relationships among nurses, physicians and other health professions.”<sup>5</sup> Although most states have similar definitions of nursing, differences generally revolve around the scope of practice permitted.

### ADVANCED PRACTICE NURSES

An *advanced practice nurse* (APRN) is a registered nurse having education beyond that of a registered nurse. APRNs include nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives. They often play a critical role as primary care providers for patients who live in remote areas or have difficulty obtaining a primary care physician. APRNs are certified by a nationally recognized professional organizations in their nursing specialty or meet other criteria established by a board of nursing that sets education, training, and experience requirements.

## Nurse Practitioner



### The Role of Nurses Extends Beyond the Hospital Ward

**Nurse practitioners** . . . Studies have found that their ability to diagnose illnesses, order and interpret tests, and treat patients is equivalent to that of primary-care physicians. They also tend to spend more time with patients during routine office visits than physicians, and they are more likely to discuss preventative health measures. As of 2010, 140,000 NPs were working in the United States.

Nurse practitioners are poised to become even more visible with the passage last year of the Patient Protection and Affordable Care Act, which could add nearly 35 million people to the ranks of the insured.

*Consumers Union of United States Inc., The Washington Post, May 30, 2011*

A *nurse practitioner* (NP) is a registered nurse who has completed the necessary education to engage in primary health care decision making. The NP is trained in the delivery of primary health care and the assessment of psychosocial and physical health problems, such as performing routine examinations and ordering routine diagnostic tests. The NP provides primary health care services in accordance with state nurse practice laws.

### Clinical Nurse Specialist

The *clinical nurse specialist* (CNS) is a professional registered nurse with an advanced academic degree, experience, and expertise in a clinical specialty (e.g., obstetrics, pediatrics). The clinical nurse specialist functions in a leadership capacity as a clinical role model, assisting the nursing staff to continuously evaluate patient care. The CNS acts as a resource for the management of patients with complex needs and conditions, participates in staff development activities related to his or her clinical specialty, and makes recommendations for establishing standards of care for patients. The CNS functions as a change agent by influencing attitudes, modifying behavior, and introducing new approaches to nursing practice, and collaborates with other members of the health care team to develop and implement the therapeutic plan of care for patients.

### Nurse Anesthetist

Administration of anesthesia by a *nurse anesthetist* requires special training and certification. Nurse-administered anesthesia was the first expanded role for nurses requiring certification. Oversight and availability of an anesthesiologist are required by most organizations. The major risks for nurse anesthetists include improper placement of an airway, failure to recognize significant changes in a patient's condition, and the improper use of anesthetics (e.g., wrong anesthetic, wrong dose, wrong route).

## Nurse Midwife

*Nurse midwives* provide comprehensive prenatal care, including delivery for patients who are at low risk for complications. For the most part, they manage normal prenatal, intrapartum, and postpartum care. Provided that there are no complications, normal newborns are also cared for by a nurse midwife. Nurse midwives often provide primary care for women’s health issues from puberty to postmenopause.

## SPECIAL DUTY NURSE

A *special duty nurse* is a nurse employed by a patient or patient’s family to perform nursing care for the patient. An organization is generally not liable for the negligence of a special duty nurse unless a master–servant relationship can be determined to exist between the organization and the special duty nurse. If a master–servant relationship exists between the organization and the special duty nurse, the doctrine of respondeat superior may be applied to impose liability on the organization for the nurse’s negligent acts. Although the patient employs the special duty nurse and the organization has no authority to hire or fire the nurse, the organization does have the responsibility to protect the patient from incompetent or unqualified special duty nurses.

## FLOAT NURSE

*Float nurses* are designated as such because they are rotated from unit to unit based on staffing needs. They often cover nursing units with unusually burdensome workloads that often involve complex patients. Float nurses can present a liability to the organization if they are assigned to work in an area where they are not qualified and competent to perform the assigned duties. Failure to match skills with work assignments can be risky business for both the patient and the health care professional. Behavioral health nurses, for example, usually does not have the skills or competencies to cover for surgical nurses in the operating room. Failure to make assignments based on a nurse’s skills presents a legal risk if a patient is injured as the result of a nurse’s negligent act. The standard of care required in order to establish negligence would be based on the skills and competencies required of the assigned task. In addition to legal implications, it is clear that assignment of a professional to a task he or she is not competent to perform is ethically and morally wrong. The New York State Nurses Association in a position statement on float nurses states in part:

Adequate staffing (appropriate number, mix and competency of nursing staff) is critical to ensure quality patient care.

The nursing profession has an obligation to evaluate and monitor patient assignments to ensure the delivery of safe, quality care.

The state has a responsibility to hold healthcare employers accountable for the provision of appropriate and timely orientation and training for staff expected to float to unfamiliar units.

The optimum solution to emergency staffing, such as in a sudden fluctuation in census or unexpected increase in absenteeism, is the establishment of an internal pool

of competent personnel whose credentials have been reviewed and who have been oriented to the facility's units and current policies.

All professional nurses must continually assess their own knowledge, ability, and experience and access appropriate resources when needed.

RNs have the right and responsibility to express their concerns and protest an assignment if placed in a potentially unsafe practice situation.<sup>6</sup>

Joint Commission standards require that, "Those who work in the hospital are competent to complete their assigned tasks."<sup>7</sup> It is the responsibility of the hospital's leadership to ensure that nurses are competent to perform the duties and responsibilities to which they are assigned. Not only is the employee responsible for a negligent act, the hospital can be found liable for assigning an employee to a duty that he or she is not competent to perform. This applies not strictly to float nurses but to all staff members.

## AGENCY PERSONNEL

Health care organizations are at risk for the negligent conduct of agency personnel. Because of this risk, it is important to ensure that agency workers have the necessary skills and competencies to carry out the duties and responsibilities assigned by the organization.

## NURSING ASSISTANTS

A *nursing assistant* is an aide who has been certified and trained to assist patients with activities of daily living. The nursing assistant provides basic nursing care to nonacutely ill patients and assists in the maintenance of a safe and clean environment under the direction and supervision of a registered nurse or licensed practical nurse. The nursing assistant helps with positioning, turning, and lifting patients and performs a variety of tests and treatments. The nursing assistant establishes and maintains interpersonal relationships with patients and other hospital personnel while ensuring confidentiality of patient information. Common areas of negligence for nursing assistants include failure to follow or improperly perform procedures; failure to assist patients and prevent falls, unsafe placement, or positioning of equipment; failure to maintain equipment properly; failure to observe a patient and take vital signs at appropriate intervals; failure to chart pertinent information regarding a patient's changing condition (e.g., vital signs); and failure to respond to a patient's call for help (e.g., call bells).

## STUDENT NURSES

Student nurses are entrusted with the responsibility of providing nursing care to patients. When liability is being assessed, a student nurse serving at a health care facility is considered an agent of the facility. Student nurses are personally liable for their own negligent acts, and the facility is liable for their acts on the basis of *respondeat superior*.

A student nurse is held to the standard of a competent professional nurse when performing nursing duties. The courts have taken the position that anyone who performs duties customarily performed by a professional nurse is held to the standard of care required of a

professional nurse. Every patient has the right to expect competent nursing services even if students provide the care as part of their clinical training.

### NEGLIGENT ACTS IN NURSING

The following cases illustrate some of the acts or omissions constituting negligence that all nurses should be aware of. They are by no means exhaustive and merely represent the wide range of potential legal pitfalls in which nurses might find themselves.

#### Nurse Assessments and Diagnosis Valid

The defendant physicians in *Cignetti v. Camel*<sup>8</sup> ignored a nurse's assessment of a patient's diagnosis, which contributed to a delay in treatment and injury to the patient. The nurse had testified that she told the physician that the patient's signs and symptoms were not those associated with indigestion. The defendant physician objected to this testimony, indicating that such a statement constituted a medical diagnosis by a nurse. The trial court permitted the testimony to be entered into evidence. Section 335.01(8) of the Missouri Revised Statutes (1975) authorizes a registered nurse to make an assessment of persons who are ill and to render a nursing diagnosis. On appeal, the Missouri Court of Appeals affirmed the lower court's ruling, holding that evidence of negligence presented by a hospital employee, for which an obstetrician was not responsible, was admissible to show the events that occurred during the patient's hospital stay.

#### Ambiguous Medication Order

A nurse is responsible for making an appropriate inquiry if there is uncertainty about the accuracy of a physician's medication order in a patient's record. The medication order in *Norton v. Argonaut Insurance Co.*,<sup>9</sup> as entered in the medical record, was incomplete and subject to misinterpretation. Believing the order to be incorrect because of the dosage, the nurse asked two physicians present on the patient care unit whether the medication should be given as ordered. The two physicians did not interpret the order as the nurse did and therefore did not share the same concern. They advised the nurse that the attending physician's instructions did not appear out of line. The nurse did not contact the attending physician but instead administered the misinterpreted dosage of medication. As a result, the patient died due to a fatal overdose of the medication.

The nurse was negligent by failing to consult with the attending physician before administering the medication. The nurse was held liable, as was the physician who wrote the ambiguous order that led to the fatal dose. In discussing the standard of care expected of a nurse who encounters an apparently erroneous order, the court stated that not only was the nurse unfamiliar with the medication in question, but she also violated the rule generally followed by members of the nursing profession in the community, which requires that the prescribing physician be called when there is doubt about an order. The court noted that it is the duty of a nurse to make absolutely certain what the physician intended regarding both dosage and route.



## Wrong Dosage of a Medication



### State Cites Safety Drug Lapses at Cedars-Sinai

Cedars-Sinai Medical Center’s handling of high-risk drugs placed its pediatric patients in immediate jeopardy of harm, the state said Wednesday in its response to an overdose involving the newborn twins of actor Dennis Quaid.

In a 20-page report, the California Department of Public Health said the prestigious Los Angeles hospital gave the twins and another child 1,000 times the intended dosage of the blood thinner heparin Nov. 18.

“This violation involved multiple failures by the facility to adhere to established policies and procedures for safe medication use,” state inspectors wrote.

*Charles Ornstein, Los Angeles Times, January 10, 2008*



### More Heparin Overdoses, This Time in Texas

Add at least 17 Texas infants to the number of children mistakenly given overdoses of heparin in the hospital. At least one of those infants died, and an autopsy is planned to determine whether the blood thinner played a role. Another is still in critical condition.<sup>10</sup>

*Tami Dennis, Los Angeles Times, July 9, 2008*

The nurse in *Harrison v. Axelrod*<sup>11</sup> administered the wrong dosage of Haldol to the patient on seven occasions while employed at a nursing facility. The patient’s physician had prescribed a 0.5-mg dosage of Haldol. The patient’s medication record indicated that the nurse had been administering doses of 5 mg, which were being sent to the patient care unit by the pharmacy. The nurse had admitted that she administered the wrong dosage and that she was aware of the facility’s medication administration policy, which she breached by failing to check the dosage supplied by the pharmacy against the dosage ordered by the patient’s physician. The commissioner of the Department of Health made a determination that the administration of the wrong dosage of Haldol on seven occasions constituted patient neglect.

## Medicating the Wrong Patient

A patient’s identification bracelet must be checked before administering any medication. To ensure that the patient’s identity corresponds to the name on the patient’s bracelet, the nurse should address the patient by name when approaching the patient’s bedside to administer any medication. Should a patient unwittingly be administered another patient’s medication, the attending physician should be notified and appropriate documentation placed in the patient’s chart.

### Failure to Note an Order Change

Failure to review a patient’s record before administering a medication to ascertain whether an order has been modified may render a nurse liable for negligence. The physician in *Larriamore v. Homeopathic Hospital Association*<sup>12</sup> wrote an instruction on the patient’s order sheet changing the method of administration from injection to oral medication. The nurse mistakenly gave the medication by injection. Perhaps the nurse had not reviewed the order sheet after being told by the patient that the medication was to be given orally; perhaps the nurse did not notice the physician’s entry. Either way, the nurse’s conduct was held to be negligent. The court went on to say that the jury could find the nurse negligent by applying ordinary common sense to establish the applicable standard of care.

### Failure to Follow Instructions

Failure of a nurse to follow the instructions of a supervising nurse to wait for her assistance prior to performing a procedure can result in the revocation of the nurse’s license. The nurse in *Cafiero v. North Carolina Board of Nursing*<sup>13</sup> failed to heed instructions to wait for assistance before connecting a heart monitor to an infant. The incorrect connection of the heart monitor resulted in an electrical shock to the infant.

[6] Ms. Cafiero put the leads on Jami’s [sic] chest, and inserted the end of the leads into a cord attached to the back of the monitor. Ms. Cafiero then plugged the machine into the wall. A click was heard, and Jami [sic] was noted to be balled up in a fetal position, trembling, with a red color, and “looked hard.” Mrs. Moss screamed and told Ms. Cafiero to turn the monitor off, that she was shocking her baby. Ms. Cafiero told her everything would be o.k. in a minute. Mrs. Moss then saw a black cord on the bed next to Jami [sic] and she unplugged the leads from this black cord. Jami [sic] then fell back on the bed. Ms. Moss went into the hall calling for assistance from a physician.

Gretchen Baughman, RN, Charge Nurse on this shift, came to the room and initiated cardio-pulmonary resuscitation. Jami [sic] was successfully resuscitated, and transferred to the Pediatric Intensive Care Unit (PICU). She did sustain two burns on her chest and one burn on her stomach from this incident. Jamie’s parents were later told by the Risk Manager that Jami [sic] was electrocuted by the Neonatal Monitor . . . .<sup>14</sup>

The board of nursing, under the Nursing Practice Act, revoked the nurse’s license. The board had the authority to revoke the nurse’s license even though her work before and after the incident had been exemplary. The dangers of electric cords are within the realm of common knowledge. The record showed that the nurse failed to exercise ordinary care in connecting the infant to the monitor.

### Failure to Report Physician Negligence

An organization can be liable for the failure of nursing personnel to take appropriate action when a patient’s personal physician is clearly unwilling or unable to cope with a situation that threatens the life or health of the patient. In a California case, *Goff v. Doctors General Hospital*,<sup>15</sup> a patient was bleeding seriously after childbirth because the physician failed to suture her properly. The nurses testified that they were aware of the patient’s dangerous condition

and that the physician was not present in the hospital. Both nurses knew the patient would die if nothing was done, but neither contacted anyone except the physician. The hospital was liable for the nurses' negligence in failing to notify their supervisors of the serious condition that caused the patient's death. Evidence was sufficient to sustain the finding that the nurses who attended the patient and who were aware of the excessive bleeding were negligent and that their negligence was a contributing cause of the patient's death. The measure of duty of the hospital toward its patients is the exercise of that degree of care used by hospitals generally. The court held that nurses who knew that a woman they were attending was bleeding excessively were negligent in failing to report the circumstances so that prompt and adequate measures could be taken to safeguard her life.

### Failure to Question Patient Discharge

A nurse has a duty to question the discharge of a patient if he or she has reason to believe that such discharge could be injurious to the health of the patient. Jury issues were raised in *Koeniguer v. Eckrich*<sup>16</sup> by expert testimony that the nurses had a duty to attempt to delay the patient's discharge if her condition warranted continued hospitalization. By permissible inferences from the evidence, the delay in treatment that resulted from the premature discharge contributed to the patient's death. Summary dismissal of this case against the hospital by a trial court was found to have been improper.

### Failure to Observe Patient's Changing Condition

Failure to observe changes in a patient's condition can lead to liability on the part of the nurse and the organization. The recovery room nurse in *Eyoma v. Falco*<sup>17</sup> (who had been assigned to monitor a postsurgical patient) left the patient and failed to recognize that the patient had stopped breathing. Nurse Falco had been assigned to monitor the patient in the recovery room. She delegated that duty to another nurse and failed to verify that the other nurse accepted that responsibility.

Nurse Falco admitted she never got a verbal response from the other nurse, and, when she returned, there was no one near the decedent. She acknowledged that Dr. Brotherton told her to watch the decedent's breathing but claimed that she was not told that the decedent had been given narcotics. She maintained that on her return she checked the decedent and observed his respirations to be eight per minute.

Thereafter, Brotherton returned and inquired about the decedent's condition. Falco informed the doctor that the patient was fine; however, on his personal observation, Brotherton realized that the decedent had stopped breathing. Decedent, because of oxygen deprivation, entered a comatose state and remained unconscious for over a year until his death.<sup>18</sup>

The jury held the nurse to be 100% liable for the patient's injuries. The court held that there was sufficient evidence to support the verdict.

### Charting Observations

The patient's care, as well as the nurse's observations, should be recorded on a regular basis. The nurse should comply promptly and accurately with the physician orders written in the record. Should the nurse have any doubt as to the appropriateness of a particular order, he or she is expected to verify with the physician the intent of the prescribed order.

### Failure to Remove Endotracheal Tube

The court in *Poor Sisters of St. Francis v. Catron*<sup>19</sup> held that the failure of nurses and an inhalation therapist to report to the supervisor that an endotracheal tube had been left in the plaintiff longer than the customary period of 3 or 4 days was sufficient to allow the jury to reach a finding of negligence. The patient experienced difficulty speaking and underwent several operations to remove scar tissue and open her voice box. At the time of trial, she could not speak above a whisper and breathed partially through a hole in her throat created by a tracheotomy. The hospital was found liable for the negligent acts of its employees and the resulting injuries to the plaintiff.

## CHIROPRACTOR

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*Chiropractors* are required to exercise the same degree of care, judgment, and skill exercised by other reasonable chiropractors under like or similar circumstances. They are expected to maintain the integrity, competency, and standards of their profession, as well as avoid even the appearance of professional impropriety.

Chiropractors have a duty to determine whether a patient is treatable through chiropractic means and to refrain from chiropractic treatment when a reasonable chiropractor would or should be aware that a patient's condition will not respond to chiropractic treatment. Failure to conform to the standard of care can result in liability for any injuries suffered.



### CASE: POOR JUDGMENT

The chief medical officer of the Nebraska Department of Health and Human Services Regulation and Licensure in *Poor v. State*<sup>20</sup> entered an order revoking Poor's license to practice as a chiropractor in the state of Nebraska.

Poor engaged in a conspiracy to manufacture and distribute a misbranded substance and introduced into interstate commerce misbranded and adulterated drugs with the intent to defraud and mislead. He was arrested for driving under the influence and was convicted of that offense. In addition, Poor knowingly possessed cocaine. He conceded that these factual determinations were understood as beyond dispute.

The district court's determination that Poor had engaged in "grossly immoral or dishonorable conduct" was not based on "trivial reasons." The appeals court found that Poor's conduct clearly fell within the plain and ordinary meaning of grossly immoral or dishonorable conduct. In its order finding Poor to be unfit, the district court relied in part on Poor's denial of conduct underlying a previous felony conviction. The court stated, "Poor's denial now, after taking advantage of a plea bargain, that he committed any of the acts he admitted to in the United State[s] District Court is disturbing and is not consistent with the integrity and acceptance of responsibility expected by persons engaged in a professional occupation."

Chiropractic medicine is a regulated health care profession. Patients necessarily rely on a chiropractor's honesty, integrity, sound professional judgment, and compliance with applicable governmental regulations. Poor argued that there was absolutely no testimony or evidence to the effect that anything he did constituted a threat of harm to his patients.

The Supreme Court of Nebraska determined that due to the seriousness of Poor's felony conviction and its underlying conduct, his subsequent lack of candor with respect to that conduct, as well as his lack of sound judgment demonstrated by his driving-under-the-influence conviction, revocation of Poor's license was an appropriate sanction.

### Ethical and Legal Issues

1. Did the chiropractor in this case violate his professional code of ethics? Explain your answer.
2. Describe how an individual's personal life can affect one's professional career.

## DENTISTRY



### Hawaii Family Sues Dentist for Root Canal that Left 3-Year-Old Girl BRAIN DEAD

A Hawaii family has sued a dentist for root canal gone horribly wrong that left a 3-year-old girl brain dead.

The lawsuit brought by the Boyle family against Island Dentistry in Honolulu alleges staff bungled the Dec. 3 procedure on little Finley Boyle and were unprepared for the emergency 26 minutes into her multiple root canal, local news station KITV reported.

The child "went into respiratory and cardiac arrest due to an overdose given to her during her treatment," Finley's family wrote on an online fundraiser.

*Stephen Rex Brown, New York Daily News, January 3, 2014*

*Dentists* are expected to respect patient rights and to avoid harm to their patients. They are expected to treat patients within their scope of practice. Such did not occur in the following cases.



### CASE: PRACTICING OUTSIDE THE SCOPE OF PRACTICE

Practicing outside one's scope of practice involves both ethical and legal issues. For example, plaintiff Brown, in *Brown v. Belinfante*,<sup>21</sup> sued a dentist for performing several elective cosmetic procedures, including a facelift, eyelid revision, and facial laser resurfacing. He was licensed to practice dentistry in Georgia. Brown claims that after the cosmetic procedures, she could not close her eyes completely, developed chronic bilateral eye infections, and required remedial corrective surgery. Brown alleged that the dentist's performance of the cosmetic procedures constituted negligence because he exceeded the scope of the practice of dentistry.

The primary purposes of the Georgia Dental Act are to define and regulate the practice of dentistry. The statute limits the scope of the practice of dentistry. Such limitation protects the health and welfare of patients who submit themselves to the care of dentists by guarding against injuries caused by inadequate care or by unauthorized individuals. Brown falls within that class of persons the statute was intended to protect, and the harm complained of was of the type the statute was intended to guard against. In performing the elective cosmetic procedures, the dentist violated the Dental Practice Act by exceeding the statutory limits of the scope of dentistry.

### Ethical and Legal Issues

1. Describe the ethical issues presented here.
2. Describe the legal issues in this case.



### CASE: INAPPROPRIATE SEXUAL CONDUCT

Revocation of a dentist's license on charges of professional misconduct was properly ordered in *Melone v. State Education Department*<sup>22</sup> on the basis of substantial evidence that while acting in a professional capacity the dentist had engaged in physical and sexual contact with five different male patients within a 3-year period. Considering the dentist's responsible position, the extended time period during which the sexual contacts occurred, the age and impressionable nature of the victims (7 to 15 years of age), and the possibility of lasting effects on the victims, the penalty was not shocking to the court's sense of fairness.

### Ethical and Legal Issues

1. Describe the ethical and legal issues of this case.
2. Describe what procedures could be implemented in a dentist's office to help reduce the likelihood of sexual abuses.

## DENTAL HYGIENIST

Dental hygienists are expected to treat patients with respect and to disclose all relevant information so that they can make informed choices about their care. Patient information must be kept confidential. Dental hygienists have an obligation to provide services in a manner that protects all patients and minimizes harm to them.



### CASE: UNLAWFUL ADMINISTRATION OF NITROUS OXIDE

This case<sup>23</sup> arises from a complaint by a dental hygienist against a former employer, Lowenberg and Lowenberg Corporation. The dental hygienist alleged that the defendant allowed dental hygienists to administer nitrous oxide to patients. Under state law, dental hygienists may not administer nitrous oxide. The Department of Education's Office of Professional Discipline investigated the complaint by using an undercover investigator. The investigator made an appointment for teeth cleaning. At the time of her appointment, she requested that nitrous oxide be administered. Agreeing to the investigator's request, the dental hygienist

administered the nitrous oxide. There were no notations in the patient's chart indicating that she had been administered nitrous oxide.

A hearing panel found the dental hygienist guilty of administering nitrous oxide without being properly licensed. In addition, the hearing panel found that the dental hygienist had failed to record accurately in the patient's chart that she had administered nitrous oxide.

The New York Supreme Court, Appellate Division, held that the investigator's report provided sufficient evidence to support the hearing panel's determination. There is adequate evidence in the record to support a finding that the dentist's conduct was such that it could reasonably be said that he permitted the dental hygienist to perform acts that she was not licensed to perform.

### Ethical and Legal Issues

1. Discuss how the ethical values listed in the Pillars of Moral Strength were violated in this case.
2. Explain how both legal and ethical issues are intertwined in this case.



### CASE: PATIENT INJURED DURING PROCEDURE

The plaintiff in *Hickman v. Sexton Dental Clinic*<sup>24</sup> brought a malpractice action against a dental clinic for a serious cut under her tongue. The dental assistant, without being supervised by a dentist, placed a sharp object into the patient's mouth, cutting her tongue while taking impressions for dentures. The court of common pleas entered a judgment on a jury verdict in favor of the plaintiff, and the clinic appealed. The court of appeals held that the evidence presented was sufficient to infer without the aid of expert testimony that there was a breach of duty to the patient. The testimony of Dr. Tepper, the clinic dentist, was found pertinent to the issue of the common knowledge exception in which the evidence permits the jury to recognize breach of duty without the aid of expert testimony. Tepper presented the following testimony regarding denture impressions:<sup>25</sup>

Q. You also stated that you have taken, I believe, thousands?

A. Probably more than that.

Q. Of impressions?

A. Yes, sir.

Q. This never happened before?

A. No, sir, not a laceration.

Q. Would it be safe and accurate to say that if someone's mouth were to be cut during the impression process, someone did something wrong?

A. Yes, sir.

### Ethical and Legal Issues

1. Do you see any ethical issues in this case? Explain your answer.
2. Describe the legal issues of this case.

## DIETARY

Good nutrition is crucial to the recovery of the patient. A nurse performs nutritional screenings at the time of a patient’s hospital admission. A screening tool is used to help determine when a full assessment is necessary. The screenings are based on specific questions asked of the patient. The results of a screening can trigger a more thorough nutritional assessment, which is conducted by a registered dietitian. A patient’s nutritional needs are often neglected because of poorly designed screening tools that often fail to trigger a full assessment. A patient’s short hospital stay also contributes to poor screenings and assessments.



### Patient’s Diet Order Inappropriate

Mom had colon cancer and was told she would be placed on a soft diet following surgery. One evening following surgery I was visiting mom. The diet aide entered the room, laid down mom’s food tray on her bedside table, and left the room. Mom lifted the cover off her plate. There on her plate laid a dried-out pork chop with mashed potatoes and broccoli. She looked up at me and said, “Do you want my meal? I can’t eat that.” I walked to the nurses’ station and asked, “Why does my mom have pork chops on her plate. She was told she would be on a soft diet following surgery.” The nurse said, “Let me look at her record. After a few moments searching the record, the nurse looked up at me and said, “Yes, it’s right here written by the doctor. ‘Regular diet for Mrs. Dively.’ I can’t change her diet. I will have to get an order change from her physician.” The nurse continued, “Your mom will have to remain on a regular diet until the doctor writes a new order.” I asked, “And how long will that take?” The nurse replied, “When he comes in to visit her on rounds. Probably tomorrow because he just saw her earlier.” I then asked to speak to the dietitian. She came to the floor and said, “I understand your dilemma, but I can’t change your mom’s diet without an order from the physician.” I asked for the evening nursing manager, who eventually talked to me on the nursing station phone. She was eventually able to get an order change from the physician who had not returned her call until later that evening.

*Anonymous*

*Dietitians* are expected to exercise professional judgment and practice dietetics based on scientific principles and current practice. Yet few health care organizations have fully integrated them into their *patient care teams*. Although the participation of pharmacists in the patient care setting is becoming the norm on patient care units, participation of dietitians is yet to be at an optimal level.



### CASE: PATIENT SUFFERS MALNUTRITION

Health care organizations must provide each patient with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each patient. Failure to do so can lead to negligence suits. The deceased patient’s daughter in *Lambert v. Beverly Enterprises, Inc.*,<sup>26</sup> filed an action claiming that her father had been mistreated. The notice of



intent to sue indicated that the deceased suffered various injuries and malnutrition as a direct result of the acts or omissions of dietary personnel and that the plaintiff's father suffered actual damages that included substantial medical expenses and mental anguish because of the injuries he sustained. A motion to dismiss the case was denied.

### Ethical and Legal Issues

1. Identify the ethical issues in this case.
2. How might the dietitians' professional ethical code have been violated in this case?

The inability of hospitals and ambulatory care centers to provide adequate staff to address the nutritional needs of patients is due in part to financial constraints. Rural outpatient centers are generally understaffed and barely have time to address the patient's presenting complaints. Staffing to address the unique nutritional needs of many patients often goes unchecked. Frequently patients with poor nutritional habits often return over the years with more severe, costly, and debilitating medical conditions (e.g., diabetes and heart disease), as discussed in the following *reality check*.



### Patient's Nutritional Status Not Addressed

Jeb, a 12-year-old 175-pound boy came with his mother to General Hospital's ambulatory care clinic to be treated for poison ivy. When Brad, a physician's assistant, was completed with his assessment, he provided Jack's mother with a prescription and gave instructions for caring for her son. He then asked, "Do you have any questions?" She replied that she had none. After she and her son left the treatment room I asked, as a resident assigned to the clinic for training, "Brad, do you know if anyone ever discussed Jack's nutritional status with his mother and the future risks associated with his weight."

Brad looked in Jack's medical record and noted that he had been a patient in the clinic since birth. He could not find any notations indicating there was any discussion over the years regarding his weight. He did note that there was a height and weight chart in the record by age and that Jack's height was in the norm for his age, however, his weight was as he put it, "Off the scale." He looked at me and said, "The problem here is, the mother, as you may have observed, has a weight problem as well. We have been asking for a registered dietitian to schedule a morning once a week for referral purposes. It like singing in the wind and nobody is listening."

*Anonymous*

### Discussion

1. Balancing the financial constraints of the clinic and the long-term health risks that Jeb faces, discuss what creative action you would take in order to provide nutritional consultations for clinic patients, assuming the hospital has no available resources to provide for nutritional counseling.
2. What are the ethical issues of treating poison ivy and seemingly ignoring Jeb's risks of developing diabetes and/or heart disease?

## INCIDENCE AND RECOGNITION OF MALNUTRITION

The importance of diet is often not given sufficient consideration in health care settings, which was noted by J. P. McWhirter and C. R. Pennington in a study conducted to determine the incidence and recognition of malnutrition in a hospital. The results of the study were printed in the *British Medical Journal*.<sup>27</sup> Although not totally conclusive of what the findings would be in a larger sampling, the results of this study are somewhat perplexing. The abstract of the McWhirter and Pennington study is presented here.

### Abstract

**Objectives:** To determine incidence of malnutrition among patients on admission to hospital, to monitor their changes in nutritional status during stay, and to determine awareness of nutrition in different clinical units.

**Design:** Prospective study of consecutive admissions.

**Setting:** Acute teaching hospital.

**Subjects:** 500 patients admitted to hospital: 100 each from general surgery, general medicine, respiratory medicine, orthopaedic surgery, and medicine for the elderly.

**Main Outcome Measures:** Nutritional status of patients on admission and reassessment on discharge, review of case notes for information about nutritional status.

**Results:** On admission, 200 of the 500 patients were undernourished (body mass index less than 20) and 34% were overweight (body mass index >25). The 112 patients reassessed on discharge had mean weight loss of 5.4% with greatest weight loss in those initially most undernourished. But the 10 patients referred for nutritional support showed mean weight gain of 7.9%. Review of case notes revealed that, of the 200 undernourished patients, only 96 had any nutritional information documented.

**Conclusion:** Malnutrition remains a largely unrecognized problem in hospital and highlights the need for education on clinical nutrition.

*J. P. McWhirter and C. R. Pennington, "Incidence and Recognition of Malnutrition in Hospital," BMJ 308:945, April 9, 1994*

## EMERGENCY SERVICES



### Wait Times Lengthen at Emergency Rooms

Emergency-room patients are waiting ever longer to see a doctor, a potentially dangerous development as rising numbers of uninsured and underinsured Americans turn to ERs for medical care.

*Theo Francis, The Wall Street Journal, January 15, 2008*



**FIGURE 9-1** Teamwork in Action (© ChameleonsEye/Shutterstock, Inc.)

Federal and state statutes impose a duty on hospitals to provide emergency care. The statutes require hospitals to provide some degree of emergency service. If the public is aware that a hospital furnishes emergency services and relies on that knowledge, the hospital has a duty to provide those services to the public.

Treatment rendered by hospitals is expected to be commensurate with that available in the same or similar communities or in hospitals generally. In *Fjerstad v. Knutson*,<sup>28</sup> the South Dakota Supreme Court found that a hospital could be held liable for the failure of an on-call physician to respond to a call from the emergency department. An intern, who attempted to contact the on-call physician and was unable to do so for 3 1/2 hours, treated and discharged the patient. The hospital was responsible for assigning on-call physicians and ensuring that they would be available when called. The patient died during the night in a motel room as a result of asphyxia resulting from a swelling of the larynx, tonsils, and epiglottis that blocked the trachea. Testimony from the laboratory director indicated that the emergency department's on-call physician was to be available for consultation and was assigned that duty by the hospital. Expert testimony also was offered that someone with the decedent's symptoms should have been hospitalized and that such care could have saved the decedent's life. The jury could have believed that an experienced physician would have taken the necessary steps to save the decedent's life.



#### **CASE: ON-CALL PHYSICIAN FAILS TO RESPOND**

Hospitals are expected to notify specialty on-call physicians when their particular skills are required in the emergency department. An on-call physician who fails to respond to a request to attend a patient can be liable for injuries suffered by the patient because of his or her failure to respond. In *Thomas v. Corso*,<sup>29</sup> a Maryland court sustained a verdict against the hospital and physician. The patient had been brought to the hospital emergency department after being struck by a car. A physician did not attend to him even though he had dangerously low

blood pressure and was in shock. There was some telephone contact between the nurse in the emergency department and the physician who was providing on-call coverage. The physician did not act on the hospital's call for assistance until the patient was close to death, and the patient did die. The court reasoned that expert testimony was not even necessary to establish what common sense made evident: that a patient who had been struck by a car may have suffered internal injuries and should have been evaluated and treated by a physician. Lack of attention in such cases is not reasonable care by any standard. The concurrent negligence of the nurse, who failed to contact the on-call physician after the patient's condition had worsened, did not relieve the physician of liability for his failure to come to the emergency department at once. Rather, under the doctrine of *respondeat superior*, the nurse's negligence was a basis for holding the hospital liable as well.

### Ethical and Legal Issues

1. Describe how both the physician and nurse failed in their ethical responsibilities to the patient.
2. Describe what actions the hospital can take to prevent future occurrences of this nature.
3. What are the legal and ethical concerns for the physician, nurse, and hospital?

### TIMELY RESPONSE MAY REQUIRE A PHONE CALL

Hospitals are not only required to care for emergency patients but also required to do so in a timely fashion. In *Marks v. Mandel*,<sup>30</sup> a Florida trial court was found to have erred in directing a verdict against the plaintiff. It was decided that the relevant inquiry in this case was whether the hospital and the supervisor should bear ultimate responsibility for failure of the specialty on-call system to function properly. Jury issues had been raised by evidence that the standard for on-call systems was to have a specialist attending the patient within a reasonable time of being called.

Emergency rooms are aptly named and vital to public safety. There exists no other place to find immediate medical care. The dynamics that drive paying patients to a hospital's emergency rooms are well known. A sudden injury occurs, a child breaks his arm, an individual suffers a heart attack, an existing medical condition worsens, a diabetic lapses into a coma, demanding immediate medical attention at the nearest emergency room. The catchphrase in legal nomenclature "time is of the essence" takes on real meaning. Generally, one cannot choose to pass by the nearest emergency room, and after arrival, it would be improvident to depart in hope of finding one that provides services through employees rather than independent contractors. The patient is there and must rely on the services available and agree to pay the premium charged for those services.<sup>31</sup>

The public not only relies on the medical care rendered by emergency departments but also considers the hospital as a single entity providing all of its medical services. A set of commentators observed:<sup>32</sup>

[T]he hospital itself has come to be perceived as the provider of medical services. According to this view, patients come to the hospital to be cured, and the doctors who practice there are the hospital's instrumentalities, regardless of the nature of the

private arrangements between the hospital and the physician. Whether or not this perception is accurate seemingly matters little when weighed against the momentum of changing public perception and attendant public policy.

The change in public reliance and public perceptions, as well as the regulations imposed on hospitals, has created an absolute duty for hospitals to provide competent medical care in their emergency departments.

Given the cumulative public policies surrounding the operation of emergency departments and the legal requirement that hospitals provide emergency services, hospitals must be accountable in tort for the actions of caregivers working in their emergency departments.



### Emergency Department Lifeline

Emergency departments are the lifelines for millions of people around the nation each day. For those with and those without insurance, each day we know someone out there cares. Often forgotten is the compassion that caregivers show each day. One such occurrence was observed when a young man walked into the emergency room at General Hospital. He described symptoms of severe chest pain. He was afraid but was soon rushed to a room where he was attended to by a physician, a nurse, an EKG technician, and a laboratory technician. He had blood drawn, an EKG, and a history and physical. As I watched, his fear turned to gratitude as treatment was administered and his pain alleviated. Fear faded away and the young man left with instructions for follow-up care. Fear turned to happiness for this young man. His smile spoke a million words.

*Anonymous*

## PARAMEDICS

Many states have enacted legislation that provides civil immunity to *paramedics* who render emergency lifesaving services. In *Morena v. South Hills Health Systems*,<sup>53</sup> the Pennsylvania Supreme Court held that paramedics were not negligent in transporting a victim of a shooting to the nearest available hospital, rather than to another hospital located 5 or 6 miles farther away where a thoracic surgeon was present. The paramedics were not capable, in a medical sense, of accurately diagnosing the extent of the decedent's injury. Except for the children's center and the burn center, no emergency trauma centers are specifically designated for the treatment of particular injuries.

The plaintiff, in *Riffe v. Vereb Ambulance Service, Inc.*,<sup>54</sup> alleged that, while responding to an emergency call an emergency medical technician began administering lidocaine to the patient, as ordered over the telephone by the medical command physician at the defendant hospital. While en route to the hospital, the patient was administered 44 times the normal dosage of lidocaine. Consequently, normal heart function was not restored, and the patient was pronounced dead at the hospital shortly thereafter. At trial, the superior court held that the liability of medical technicians could not be imputed to the hospital. The court noted the

practical impossibility of the hospital carrying ultimate responsibility for the quality of care and treatment given patients by emergency medical services.

## LABORATORY

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*Laboratory medical technologists* are expected to protect the welfare of patients and the tests conducted above all else. They are expected to avoid dishonest and unethical conduct. An organization's laboratory provides data that are vital to a patient's treatment. Among its many functions, the laboratory monitors therapeutic ranges, measures blood levels for toxicity, places and monitors instrumentation on patient units, provides education for the nursing staff (e.g., glucose monitoring), provides valuable data used in research studies, supplies data on the most effective and economical antibiotic for treating patients, serves in a consultative role, and provides important data as to the nutritional needs of patients.

### ETHICS AND INACCURATE LAB RESULTS

Ethics codes for both health care organizations and their professionals are written to protect patients, as well as, employees and their employers. The American Society for Clinical Laboratory Science in its code of ethics states as to the duty owed to patients:

Clinical laboratory professionals are accountable for the quality and integrity of the laboratory services they provide. This obligation includes maintaining individual competence in judgment and performance and striving to safeguard the patient from incompetent or illegal practice by others.

Clinical laboratory professionals maintain high standards of practice. They exercise sound judgment in establishing, performing and evaluating laboratory testing.

Clinical laboratory professionals maintain strict confidentiality of patient information and test results. They safeguard the dignity and privacy of patients and provide accurate information to other health care professionals about the services they provide.<sup>35</sup>

Lab tests are not always accurate, sometimes due to human error or faulty test results. According to an article in the *Baltimore Sun* on March 11, 2004, approximately 640 patients at Maryland General Hospital may have received incorrect HIV and hepatitis test results. Some patients might have been told they were HIV-negative when in fact they were positive and vice versa, and the hospital failed to notify the patients of the problem. A former hospital employee had apparently filed a complaint. State health officials discovered in January that the hospital's laboratory personnel overrode controls in the testing equipment that showed the results might be in error and then mailed them to patients anyway.<sup>36</sup> Licensure and certification of laboratory staff is necessary in order to help prevent incidents of this nature. The American Society for Clinical Pathology in a policy statement on State Licensure of Laboratory Personnel, Policy (Number 05-02) states that:

Due to the complexity of laboratory medicine and its importance in quality patient care, it is imperative that medical laboratory personnel possess the qualifications necessary to ensure their professional competence. Licensure and certification programs

not only set minimum standards for medical laboratory personnel working in clinical laboratories; they also help ensure quality laboratory testing and proper patient care.<sup>37</sup>

Inaccurate lab tests are not uncommon occurrences and the headlines of inaccurate reporting continue to come to public attention, as noted in the next news clipping.



### Spokane Woman Suing over False HIV Diagnosis

A Spokane woman is suing a Pennsylvania-based plasma donation company saying she was falsely told she had hepatitis and HIV after donating plasma at a clinic in Hayden, Idaho.

Melissa Bloom filed the lawsuit against BioLife Plasma Services alleging the clinic acted negligently when employees informed her she had the viruses after a combination of blood samples from several donors tested positive.

Bloom is seeking damages for emotional stress and punitive damages, saying she was informed of the positive test in April and went immediately to her doctor's office for tests that determined she did not have the viruses.

*KOMONEWS.com, Associated Press, December 26, 2013*<sup>38</sup>

### REFUSAL TO PERFORM HIV TESTING

Stepp, a laboratory staff technician, refused to perform tests on AIDS-contaminated fluids for which she was eventually terminated by the hospital. The Review Board of the Indiana Employment Security Division upheld the hospital's decision to terminate the technician. The technician appealed the board's decision. The Court of Appeals of Indiana, in *Stepp v. Review Board of the Indiana Employment Security Division*,<sup>39</sup> held that the technician was dismissed for just cause and that the laboratory did not waive its right to compel employees to perform assigned tasks. The technician had been warned, suspended, and discharged for her refusal to perform the tests. She told her supervisors that she refused to perform the tests because "AIDS is God's plague on man and performing the tests would go against God's will."<sup>40</sup> The technician argued that the employer hospital failed to provide a safe place to work. Under Section 11(c)(1) of the Occupational Safety and Health Act of 1970 (OSHA) an employer is prohibited from discharging any employee who exercises any right afforded by OSHA, which provides "the right of an employee to choose not to perform his assigned task because of a reasonable apprehension of death or serious injury coupled with a reasonable belief that no less drastic alternative is available." The Supreme Court in *Whirlpool Corp. v. Marshall*, 445 U.S. 1 (1980) laid out a two-part test. "First, an employee must reasonably believe the working conditions pose an imminent risk of serious bodily injury, and second, the employee must have a reasonable belief there is not sufficient time or opportunity either to seek effective redress from his employer or to apprise OSHA of the danger."<sup>41</sup> Stepp failed to successfully argue both parts of this test.

Although Stepp's case involved legal issues for the courts to decide, there are a variety of moral issues for health care professionals to consider when refusing to perform tests that are required to determine a patient's diagnosis. Of major applicability in this case is the principle of *nonmaleficence*—first, do no harm. Suppose for a moment that a technician was working alone at night on a weekend and was the only hospital employee that could perform cardiac enzyme blood tests to determine if the patient had a cardiac event. The blood sample arrives in the laboratory with an AIDS warning label attached. Should the laboratory technician refuse to perform the test, the legal and moral principles of ethics and applicable codes would not support the technician's refusal to perform the tests so urgently needed to determine the patient's treatment regimen.

## MEDICAL ASSISTANT

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A *medical assistant* is an unlicensed person who provides administrative, clerical, and/or technical support to a licensed practitioner. A licensed practitioner is generally required to be physically present in the treatment facility, medical office, or ambulatory facility when a medical assistant is performing procedures.<sup>42</sup> Employment of medical assistants is expected to continue to grow over time. This growth is due in part to technological advances in medicine and a growing and aging population. Increasing use of medical assistants in the rapidly growing health care industry will most likely result in continuing employment growth for the occupation.<sup>43</sup>

Medical assistants work in physicians' offices, clinics, nursing homes, and ambulatory care settings. The duties of medical assistants vary from office to office, depending on the location and size of the practice and the practitioner's specialty. In small practices, medical assistants usually are generalists, handling both administrative and clinical duties. Those in large practices tend to specialize in a particular area, under supervision. Administrative duties often include answering telephones, greeting patients, updating and filing patients' medical records, filling out insurance forms, handling correspondence, scheduling appointments, arranging for hospital admission and laboratory services, and handling billing and bookkeeping. Clinical duties vary according to state law and include assisting in taking medical histories, recording vital signs, explaining treatment procedures to patients, preparing patients for examination, and assisting the practitioner during examinations. Medical assistants collect and prepare laboratory specimens or perform basic laboratory tests on the premises, dispose of contaminated supplies, and sterilize medical instruments. They instruct patients about medications and special diets, prepare and administer medications as directed by a physician, authorize drug refills as directed, provide telephone prescriptions to a pharmacy, prepare patients for X-rays, perform electrocardiograms, remove sutures, and change dressings.

Medical assistants who work in the various medical specialties often have additional duties. Podiatric medical assistants, for example, make foot molds and assist podiatrists in surgery. Ophthalmic medical assistants help ophthalmologists provide eye care. They conduct diagnostic tests, measure and record vision, and test eye muscle function. They also teach patients how to insert, remove, and care for contact lenses. Under the direction of the physician, ophthalmic medical assistants may administer eye medications. They also maintain optical and surgical instruments and may assist the ophthalmologist in surgery.<sup>44</sup>





### CASE: LOOKING FOR HELP

On July 12, Jill had severe pain in the left side of her head while at work. She was not speaking coherently and eventually lost consciousness for a few moments. She was taken to her physician's office by a coworker. Jill's physician ordered some tests at the hospital's outpatient imaging center to rule out a transient ischemic attack (TIA). A medical assistant at the imaging center explained to Jill that her tests could not be scheduled until July 14.

Dan drove his wife Jill to her appointment. They arrived early on July 14 for her imaging test. On their arrival at the imaging center, Dan dropped Jill off at the front entrance while he searched for a parking space. Meanwhile Jill went into the center and handed her prescription to Carol, a medical assistant at the front desk. Carol said to Jill, "I am sorry, but we cannot perform your test. Your doctor faxed us an unsigned and undated order sheet. It is confusing as to what imaging studies he wants. He checked a box on the physician's order sheet indicating that he wanted a CT scan of the head. In addition, there was a handwritten note on the form indicating that your physician wants an MRI to rule out a TIA. We are not sure if he wants one or both tests. You will have to get clarification from the physician as to exactly what procedure he wants." Dan, after having parked his wife's car, arrived at the front desk and saw his wife somewhat distressed. Carol explained the problem to Dan. He asked Carol, "Could you please contact the physician and ask him to clarify and fax back to the center what tests he wants?" Carol replied, "We are very busy; however, you can use our phone and ask the physician to clarify his order and have him fax us a new order." Jill interrupted, appearing somewhat agitated, and asked, "What is your fax number?" Carol (pointing to a wall) replied, "It is posted there on the wall by the phone. You can use that phone." Carol suggested to Jill that she complete the patient intake paperwork while Dan contacted Jill's physician. Dan was able to get a new faxed order. As they waited for Jill to be called for her tests, with her eyes tearing up, she turned to Dan and said, "This is how my last 6 years of life have been, fighting this horrendous disease. What would I do without you?"

### Ethical and Legal Issues

1. Should the medical assistant have clarified the physician's order prior to the patient's arrival? Consider in your answer how Carol might have reacted if she was the patient, or her spouse, parent, or child was the patient?
2. Discuss what ethical issues you would be concerned with and what action would you take if you were a member of the governing body sitting in the waiting room observing this incident.



### CASE: UNTIMELY DIAGNOSIS

The patient–plaintiff in *Follett v. Davis*<sup>45</sup> discovered a lump in her right breast in the spring of 1988. She made an appointment to see Dr. Davis, her obstetrician/gynecologist, to see if she should be concerned about the breast lump she had discovered. The clinic had no record of her appointment. The clinic's employees directed her to radiology for a mammogram. A technician examined the plaintiff's breast and confirmed the presence of a lump in her right

breast. Neither Dr. Davis nor any other physician at the clinic offered the plaintiff an examination. In addition, she was not scheduled for a physician’s examination as a follow-up to the mammogram. The plaintiff was instructed that she would hear from Dr. Davis if there were any concerns with her mammogram.

The radiologist explained in his deposition that the mammogram was not normal. Dr. Davis received and reviewed the mammogram report and considered it to be negative for malignancy. He did not know this was a new breast lump because none of the clinic employees had informed him about it. Neither clinic staff nor Dr. Davis contacted the plaintiff about her lump or the mammogram. The plaintiff called the clinic on April 6, 1990. She was told that there was nothing to worry about unless she heard from Dr. Davis. On September 24, 1990, the plaintiff returned to the clinic after she had developed pain associated with the same lump. A mammogram performed on that day gave results consistent with cancer. Three days later, Dr. Davis made an appointment for the plaintiff with a clinic surgeon for a biopsy and treatment. She kept her appointment with the surgeon. Nevertheless, this was her last visit with the clinic, as she subsequently transferred her care to other physicians. In October 1990, the biopsy confirmed the diagnosis of cancer.

In August 1992, the plaintiff filed a lawsuit. The evidence showed that after the patient found a lump in her breast, she went to Dr. Davis, and clinic for help. Dr. Davis and the clinic, through the clinic’s employees and agents, undertook to treat her ailment. That undertaking ended when the clinic’s surgeon performed the biopsy and therefore was continuous in nature. The evidence demonstrated that had clinic procedures been followed, Dr. Davis or another physician at the clinic would have made a more timely diagnosis.

### **Ethical and Legal Issues**

1. Describe the legal and ethical issues presented in this case.
2. Discuss what action the clinic’s leadership should take in order to prevent similar incidents in the future.

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## **MEDICAL RECORDS**

Health care organizations are required to maintain a medical record for each patient in accordance with accepted professional standards and practices. The main purposes of the medical record are to provide a planning tool for patient care; to record the course of a patient’s treatment and the changes in a patient’s condition; to document the communications between the practitioner responsible for the patient and any other health care professional who contributes to the patient’s care; to assist in protecting the legal interests of the patient, the organization, and the practitioner; to provide a database for use in statistical reporting, continuing education, and research; and to provide information necessary for third-party billing and regulatory agencies. Medical records must be complete, accurate, current, readily accessible, and systematically organized.

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## **PHARMACY**

The practice of pharmacy essentially includes preparing, compounding, dispensing, and retailing medications. These activities may be carried out only by a pharmacist with a state license

or by a person exempted from the provisions of a state's pharmacy statutes. The entire stock of drugs in a pharmacy is subject to strict government regulation and control. The pharmacist is responsible for developing, coordinating, and supervising all pharmacy activities and reviewing the drug regimens of each patient.

Because of the immense variety and complexity of medications now available, it is impossible for nurses or physicians to keep up with all of the information required for safe medication use. The *pharmacist* has become an essential resource in modern hospital practice.<sup>46</sup>

Medication errors are considered a leading cause of patient injury. Antibiotics, chemotherapeutic drugs, and anticoagulants are the three categories of drugs responsible for most drug-related adverse events. The prevention of medication errors requires recognition of common causes and the development of practices to help reduce the incidence of errors. With thousands of drugs, many of which look alike and sound alike, it is understandable that medication errors are so common. The more common types of medication errors include prescription errors, transcription errors (often caused by illegible handwriting and improper use of abbreviations), dispensing errors, and administration errors. As noted in the following news clippings, medication errors are all too common occurrences.


**NEWS**

### Hospital Errors Common and Underreported

Sorrel King's 18-month-old daughter Josie was recovering from second degree burns at Johns Hopkins Hospital in Baltimore when a communication breakdown caused a deadly misstep.

As King watched, a nurse gave Josie a methadone injection despite verbal orders to the contrary, assuring King that the order had been changed. Josie, who was about to be released from the hospital, went into cardiac arrest. "I took one look at her, ran into the hallway, and screamed for help," King said. Josie died 2 days later . . .

As many as one-third of hospital visits leads to hospital-related injuries, according to a report published today in *Health Affairs*.

*Katie Moisse, ABC News Medical Unit, April 7, 2011*<sup>47</sup>


**NEWS**

### Drug Overuse Threatens Nursing Home Residents

More than five years after the federal government warned that drugs routinely prescribed to nursing-home residents posed serious threats, including an increased risk of death, inappropriate use remains high, according to a recent analysis by the American Society of Health-System Pharmacists (ASHP).

Consumer Reports, *December 2010*



**FIGURE 9-2** Prescription Errors Reviewed (© Scott Maxwell/LuMaxArt/Shutterstock, Inc.)

### DISPENSING AND ADMINISTRATION OF DRUGS

The dispensing of medications is the processing of a drug for delivery or for administration to a patient pursuant to the order of a health care practitioner. It consists of checking the directions on the label with the directions on the prescription or order to determine accuracy; selecting the drug from stock to fill the order; counting, measuring, compounding, or preparing the drug; placing the drug in the proper container; and adding to a written prescription any required notations.

The administration of medications is the act of giving a single dose of a prescribed drug to a patient by an authorized person in accordance with federal and state laws and regulations. The complete act of administration includes removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container); verifying it with the physician's order; giving the individual dose to the proper patient; and recording the time and dose given.

Licensed persons, in accordance with state regulations, may administer medications. Each dose of a drug administered must be recorded on the patient's clinical records. A separate record of narcotic drugs must be maintained. The record must contain a separate sheet for each narcotic of different strength or type administered to the patient. The narcotic record must contain the following information: date and time administered, physician's name, signature of person administering the dose, the balance of the narcotic drug on hand, and the proper recording of any drugs wasted/destroyed.

In the event that an emergency arises requiring the immediate administration of a particular drug, the patient's record should be documented properly, showing the necessity for administration of the drug on an emergency basis. Procedures should be in place for handling emergency situations.

## DRUG SUBSTITUTION

Drug substitution may be defined as the dispensing of a different drug or brand in place of the drug or brand ordered. “All states permit generic interchange to one extent or another.”<sup>48</sup> Health care organizations use a “formulary system” whereby physicians and pharmacists create a formulary listing drugs used in the institution. The formulary contains the brand names and generic names of drugs. Under the formulary system, a physician agrees that his or her prescription calling for a brand name drug may be filled with the generic equivalent of that drug (e.g., a drug that contains the same active ingredients in the same proportions). When a formulary system is in use, the prescribing physician can request the use of a particular brand name drug, when he or she deems it necessary or desirable for patient safety, by expressly prohibiting the use of the formulary system.

Hospitals are watchful for any abuses by physicians who circumvent the formulary for no valid patient safety reason. The ever-escalating costs of pharmaceutical products necessitates that hospitals become more vigilant in order to rein in costs.

## EXPANDING ROLE OF THE PHARMACIST

Historically, the role of the pharmacist was centered on management of the pharmacy and accurate preparation and dispensing of drugs. The duties and responsibilities of pharmacists have, however, moved well beyond the scope of filling prescriptions and dispensing medications. Pharmacists do much more than this. They are increasingly playing an ever-expanding clinical role on various hospital specialty units (e.g., cardiology and oncology). They provide patient and staff education, consultation, and evaluation and selection of medications for placement in the hospital formulary; review medication errors; and report adverse drug reactions. Schools of pharmacy, recognizing the ever-expanding role of pharmacists in the clinical aspects of patient care have raised the educational requirements for new graduates by requiring a Doctor of Pharmacy (Pharm.D.) degree.

### Duty to Monitor Patient’s Medications

In *Baker v. Arbor Drugs, Inc.*,<sup>49</sup> a Michigan court imposed a duty on a pharmacist to monitor a patient’s medications. Three different prescriptions were prescribed by the same physician and filled at the same pharmacy. The pharmacy maintained a computer system that detected drug interactions. The pharmacy advertised to consumers that it could, through the use of a computer monitoring system, provide a medication profile of a customer for adverse drug reactions. Because the pharmacy advertised and used the computer system to monitor the medications of a customer, the pharmacist voluntarily assumed a duty of care to detect the harmful drug interaction that occurred.

### Warning Patients About Potential for Overdose

A Pennsylvania court held that a pharmacy failed to exercise due care and diligence because the patient was not warned about the maximum dosage of a medication.<sup>50</sup> This failure resulted in an overdose, causing the patient permanent injuries. Expert testimony focused on the fact that a pharmacist who receives inadequate instructions as to the maximum recommended dosage of a medication has a duty to ascertain whether the patient is aware of the limitations

concerning the use of the drug or, alternatively, to contact the prescribing physician regarding the inadequacy of the prescription.

### Refusal to Honor a Questionable Prescription

In *Hooks v. McLaughlin*,<sup>51</sup> the Indiana Supreme Court held that a pharmacist had a duty to refuse to refill prescriptions at an unreasonably faster rate than prescribed pending directions from the prescribing physician. The Indiana Code provides that a pharmacist is immune from civil prosecution or civil liability if he or she, in good faith, refuses to honor a prescription because, in his or her professional judgment, honoring of the prescription would aid or abet an addiction of habit.<sup>52</sup>

### BILLING FRAUD

Pharmacists have a duty to act with honesty and integrity in their professional relationships as noted in the following excerpt from their Code of Ethics for ethical behavior.

*IV. A pharmacist acts with honesty and integrity in professional relationships.*

A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.<sup>53</sup>

The following legal cases illustrate how not only did the pharmacists break the law; they also failed to adhere to their own code or professional ethics.

The court of appeals in *State v. Beatty*<sup>54</sup> upheld a lower court's finding that the evidence submitted against the defendant pharmacist was sufficient to sustain a conviction for Medicaid fraud. The state was billed for medications that were never dispensed, for more medications than some patients received, and in some instances, for the more expensive trade name drugs when cheaper generic drugs were dispensed.

The pharmacists in *People v. Kendzia*<sup>55</sup> were convicted of selling generic drugs in vials with brand name labels. Investigators, working undercover, were provided with Medicaid cards and fictitious prescriptions requiring brand name drugs to be dispensed as written. Between April and October 1979, the investigators had taken the prescriptions to the pharmacy, where they were filled with generic substitutions in vials with the brand name labels.

### PHYSICAL THERAPY

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*Physical therapy* is the art and science of preventing and treating neuromuscular or musculoskeletal disabilities through the evaluation of an individual's disability and rehabilitation potential and the use of physical agents—heat, cold, electricity, water, and light—and neuromuscular procedures that, through their physiologic effect, improve or maintain the patient's optimum functional level. Because of different physical disabilities brought on by various injuries and medical problems, physical therapy is an extremely important component of a patient's total health care. As the following cases illustrate, there can be both ethical and legal issues when a therapist incorrectly interprets a physician's orders for physical therapy.

## INCORRECTLY INTERPRETING PHYSICIAN'S ORDERS

Pontiff, in *Pontiff v. Pecot & Assoc.*,<sup>56</sup> filed a petition for damages against Pecot and Associates and Morris. Pontiff alleged that Pecot and Associates had been negligent in failing to train, supervise, and monitor its employees properly, including Morris, and that Pecot and Associates was otherwise negligent. Pontiff alleged that employee Morris failed to exercise the degree of care and skill ordinarily exercised by physical therapists, failed to heed his protests that he could not perform the physical therapy treatments she was supervising, and failed to stop performing physical therapy treatments after he began to complain he was in pain. Pontiff claimed he felt a muscle tear while he was exercising on the butterfly machine, a resistive exercise machine.

Pontiff's expert, Boulet, a licensed practicing physical therapist, testified that Pecot deviated from the standard of care of physical therapists by introducing a type of exercise that, according to her, was not prescribed by Dr. deAraujo, the treating physician. She stated that Pecot had added resistive or strengthening exercises to Pontiff's therapy and that these were not a part of the physician's prescription. Pecot argued that resistive exercises were implicitly part of the prescription, even if her interpretation of the prescription was not reasonable.

*Legally*, under Louisiana law, a physical therapist may not treat a patient without a written physical therapy prescription. *Ethically*, the Physical Therapists' Code of Ethics, Principle 3.4, states "any alteration of a program or extension of services beyond the program should be undertaken in consultation with the referring practitioner." Because resistive exercises were not set forth in the original prescription, Boulet stated that consultation with the physician was necessary before Pontiff could be advanced to that level. Only in the case where a physician has indicated on the prescription that the therapist is to "evaluate and treat" would the therapist have such discretion. There was no such indication on the prescription written by Dr. deAraujo.

Davis, a physical therapist in private practice and Pecot's expert witness, testified that the program that Pecot designed for Pontiff was "consistent with how she interpreted the prescription for therapy that the physician wrote." Davis, however, did not at any time state that Pecot's interpretation was a reasonable one. In fact, Davis herself would not have interpreted the prescription in the manner that Pecot did. Davis testified only that Pecot's introduction of resistive exercises was reasonable based on her interpretation of the prescription.

It is clear that Pecot, as a licensed physical therapist, owed a duty to Pontiff, her client. Pecot's duty is defined by the standard of care of similar physical therapists and the American Physical Therapy Association. If Pecot found the prescription to be ambiguous, she had a duty to contact the prescribing physician for clarification. The appeals court found that the trial court was correct in its determination that Pontiff presented sufficient evidence to show that this duty was breached and that Pecot's care fell below the standard of other physical therapists.

## RESIDENT NEGLIGENCE

The physical therapist in the following case not only fail the legal system but also failed to adhere to the professional code of ethics for physical therapists, which provides:

2B. Physical therapists shall provide physical therapy services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/clients.

In *Zucker v. Axelrod*,<sup>57</sup> a physical therapist had been charged with resident neglect for refusing to allow an 82-year-old nursing facility resident to go to the bathroom before starting his therapy treatment session. Undisputed evidence at a hearing showed that the petitioner refused to allow the resident to be excused to go to the bathroom. The petitioner claimed that her refusal was because she assumed that the resident had gone to the bathroom before going to therapy and that the resident was undergoing a bladder-training program. The petitioner had not mentioned when she was interviewed after the incident or during her hearing testimony that she considered bladder training a basis for refusing to allow the resident to go to the bathroom. It is uncontroverted that the nursing facility had a policy of allowing residents to go to the bathroom whenever they wished to do so. The court held that the evidence supported resident neglect.



### Multidisciplinary Approach to Patient Care

Do patients believe that care is always well coordinated? Are patients at times treated based on short “handwritten notes” by the prescribing physician? Are mistakes sometimes made because of illegible handwriting? Is it helpful to the radiologist if the ordering physician notes on the order sheet why a particular imaging study is required? Do nurses sometimes find it necessary to clarify medication orders? Do pharmacists find it necessary to contact the physician when there are dosing questions? Would it be helpful for the prescribing physician to discuss a patient’s needs with the treating therapist? Would it be helpful if the physician reviewed the imaging studies of his or her patient with serious neck injuries, prior to treatment by a therapist? Does understaffing affect the quality of care?

Jill recently visited a pain center where the medical director had integrated a pain therapist into the hospital’s pain management program. After several visits to the hospital’s pain management program, Jill complimented the staff as to their multidisciplinary approach to her care.

The medical director stated that the success of the hospital’s pain management program was due to the multidisciplinary approach practiced in the hospital. He stated that pain management is often poorly practiced because of the failure of the treating physician to become more involved in the patient’s therapy. A patient’s pain is often exacerbated because of a superficial treatment plan that fails to include the physician, and the failure to provide the images to the treating therapist. Both the physician and treating therapist, and most important the patient’s care, are optimized when there is ongoing communication among caregivers. The medical director further stated that professionalism and satisfaction among caregivers improve when communications flow freely.

Jill again complimented the staff and stated that she would not hesitate to recommend the hospital’s pain management program to her family and friends.

The next time a caregiver treats a patient, the patient should ask: What records have you seen? Have you discussed my treatment plan with my physician? What were my physician’s specific orders? May I see them? What precautions have you been asked to follow with me? Have you seen my imaging studies? Has anyone discussed them with you?



My pledge as a patient: I will ask myself, am I being treated in an assembly-line fashion, assembled in a room like cattle, without privacy in cramped corridors by a caregiver who, because of understaffing, is frantically moving from patient to patient, or am I truly getting individualized care and treatment in a style worthy of the words “I am receiving good quality care”?

### Discussion

1. Regardless of your profession or health care setting, discuss how the multidisciplinary approach to patient care might be improved in your organization.
2. Consider and discuss what questions you might ask if you were the patient undergoing treatment.

## PHYSICIAN ASSISTANT

*Physician assistants* (PAs) are health care professionals who “practice medicine on a team under the supervision of physicians and surgeons. “There are more than 90,000 nationally certified PAs, according to the National Commission on Certification of Physician Assistants.”<sup>58</sup> They are formally educated to examine patients, diagnose injuries and illnesses, and provide treatment. PAs work in physicians’ offices, hospitals, and other health care settings.”<sup>59</sup> They are subject to the licensing laws within the state they are qualified to practice. As the role of PAs continues to expand, it is mandatory that they review and understand applicable state licensing laws. In addition, PAs must work within the scope of practice as defined by their employers.

PAs are responsible for their own negligent acts. Further, an employer of a PA can be held liable for a PA’s negligent acts on the basis of *respondeat superior*. Physicians who delegate tasks to PAs that licensing laws stipulate a physician must perform can be held liable for assignment of an unauthorized task that results in an injury to a patient. If there is no proof that a PA breached the applicable standard of care for a PA, liability will not accrue to the PA. However, if the physician was negligent in making the assignment to the PA that led to the injury, liability could accrue to the physician.

The plaintiff in *Cox v. MA Primary and Urgent Care Clinic*<sup>60</sup> sued for injuries she allegedly suffered as a result of a PA’s failure to diagnose her condition accurately. The patient was eventually diagnosed with cardiomyopathy. A mitral valve repair and mitral valve replacement were ultimately performed. The patient sued the PA for failure to readily diagnose her condition. The Tennessee Supreme Court after reviewing the case held:

The professional standard of care applicable to physician assistants is distinct from that applicable to physicians. Because Plaintiff introduced no expert proof as to any violation of the applicable standard of care, the trial court was correct in its ruling that Defendants are entitled to summary judgment.<sup>61</sup>

To limit the potential risk of liability for a PA’s negligent acts, PAs should be monitored and supervised by a physician. Moreover, guidelines and procedures should also be established to provide a standard mechanism for reviewing a PA’s performance.

## PSYCHOLOGY

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*Psychologists* are expected to safeguard the welfare and rights of those with whom they interact professionally. They must establish relationships of trust with those with whom they work. They must uphold professional standards of conduct, clarify their professional roles and obligations, and accept responsibility for their behavior.

### UNETHICAL CONDUCT

Sturm, a licensed psychologist who has taught professional ethics since 1985 and who served on the ethics committee of the Oregon Psychological Association for 6 years, testified that testimony about the best interests of children in a custody dispute by a therapist who had not observed both parents' interactions with the children was unethical. Sturm further stated that a psychologist has an obligation to adopt an impartial stance and to avoid actions that would escalate an adversarial nature of the relationship between the parents. Sturm explained that psychologists have "an ethical responsibility to anticipate the possible purposes" behind a request to prepare an affidavit to be used in a custody dispute in order to prevent misuse of the evaluation and agreed that practices such as making evaluative statements about persons or relationships not observed directly are blatantly unethical. The petitioner's affidavit made such statements, and it was not until the show cause hearing that petitioner admitted to her bias toward her patient.<sup>62</sup>

### SEXUAL HARASSMENT

The *Ethical Principles of Psychologists and Code of Conduct*, in standard 3.02 on sexual harassment states that:

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist and that either (1) is unwelcome, is offensive or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts.<sup>63</sup>

The Board of Psychologist Examiners in *Gilmore v. Board of Psychologist Examiners*<sup>64</sup> revoked a psychologist's license because of sexual improprieties. The psychologist petitioned for judicial review. She argued that therapy had terminated before the sexual relationships began. The court of appeals held that evidence supported the board conclusion that the psychologist had violated an ethical standard in caring for her patients. When a psychologist's personal interests intrude into the practitioner–client relationship, the practitioner is obliged to seek objectivity through a third party. The board's findings and conclusions indicated that the petitioner failed to maintain that objectivity.

### REPORTING CHILD ABUSE

Two children were placed in the temporary custody of a foster family. One child was referred to a licensed psychologist for evaluation. After two interviews, the psychologist formed the

professional opinion that the child had been sexually molested. Based in part on statements made by the child, the psychologist further believed that the perpetrator of the suspected molestation was the father. At a hearing before the juvenile court, the court determined that the evidence did not support a finding the child had been abused by his father. Custody was returned to the parents. The child's parents subsequently initiated an action for medical malpractice against the psychologist. The psychologist claimed immunity from liability, as provided by a state child abuse reporting statute. The trial court and the parents appealed, arguing that the immunity provisions of the statute do not apply to the psychologist because she was not a "mandatory reporter" under that statute.<sup>65</sup>

The Georgia Court of Appeals held that the statute's grant of immunity from liability extended to the psychologist. The evidence did not establish bad faith on the part of the psychologist so as to deprive her of such immunity. The statute provides that any person participating in the making of a report or participating in any judicial proceeding or any other proceeding resulting in a report of suspected child abuse is immune from any civil or criminal liability that might otherwise be incurred or imposed, provided such participation pursuant to the statute is made in good faith. The grant of qualified immunity covers every person who, in good faith, participates over time in the making of a report to a child welfare agency. Proof of negligent reporting or bad judgment is not proof that the psychologist refused to fulfill her professional duties out of some harmful motive or that she consciously acted for some dishonest purpose. There was no competent evidence that the psychologist acted in bad faith.

## RADIOLOGY

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*Radiology technologists* are expected to conduct themselves in a professional manner, respond to patient needs, and support colleagues and associates in providing quality patient care. The American Society of Radiologic Technologists Code of Ethics provides in part that "The radiologic technologist assesses situations; exercises care, discretion and judgment; assumes responsibility for professional decisions; and acts in the best interest of the patient."<sup>66</sup> The technologist failed to exercise discretion in the following case by not making sure the patient was secured to the table prior to the examination to prevent the patient from falling.

### FAILURE TO RESTRAIN CAUSES PATIENT FALL

The plaintiff in *Cockerton v. Mercy Hospital Medical Center*<sup>67</sup> was admitted to the hospital for the purpose of surgery. Her physician ordered postsurgical X-rays for her head and face to be taken the next day. A hospital employee took the plaintiff from her room to the X-ray department by wheelchair. A nurse had assessed her condition as slightly "woozy" and drowsy. An X-ray technician took charge of the plaintiff in the X-ray room. After the plaintiff was taken inside the X-ray room, she was transferred from a wheelchair to a portable chair for the procedure. After being moved, the plaintiff complained of nausea. The technician did not use the restraint straps to secure the plaintiff to the chair. At some point during the procedure, the plaintiff had a fainting seizure. The technician called for help. When another hospital employee entered the room, the technician was holding the plaintiff in an upright position. She appeared nonresponsive. The plaintiff only remembered being stood up and having a lead jacket placed across her back and shoulders. The technician maintains that the plaintiff did

not fall. At the time the plaintiff left the X-ray room, her level of consciousness was poor. The plaintiff’s physician noticed a deflection of the plaintiff’s nose but had difficulty assessing it because of the surgical procedure from the day before.

The following day, the deflection of the plaintiff’s nose was much more evident. A specialist was contacted, and an attempt was made to correct the deformity. The specialist made an observation that it would require a substantial injury to the nose to deflect it to that severity.

The plaintiff instituted proceedings against the hospital, alleging that the negligence of the nurses or technicians allowed her to fall during the procedure and subsequently caused injury. The jury concluded that the hospital was negligent in leaving the plaintiff unattended or failing to restrain her, which proximately caused her fall and injury.

The X-ray technician testified that during the X-ray the plaintiff appeared to have a “seizure episode.” She also testified that she left the plaintiff unattended for a brief period of time and that she did not use the restraint straps that were attached to the portable X-ray chair. Using the restraint straps would have secured the plaintiff to the portable chair during the X-ray examination.

## RESPIRATORY CARE

Respiratory care involves the treatment, management, diagnostic testing, and control of patients with cardiopulmonary deficits. A *respiratory therapist* (RT) is a person employed in the practice of respiratory care who has the knowledge and skill necessary to administer respiratory care. As with other health care professions, respiratory RTs are expected to comply with their professional code of ethics. The American Association for Respiratory Care in its Statement of Ethics and Professional Conduct requires that RTs “Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.”<sup>68</sup> That code was violated in *State University v. Young*.<sup>69</sup> In this case the RT was suspended for using the same syringe for drawing blood from a number of critically ill patients. The therapist had been warned several times of the dangers of that practice and that it violated the state’s policy of providing quality patient care.

Although an RT is responsible for the negligent acts, the employer is can be held responsible for the negligent acts of the therapist under the legal doctrine of *respondeat superior*.



### CASE: RESTOCKING THE CODE CART

In *Dixon v. Taylor*,<sup>111 N.C. App. 97, 431 S.E.2d 778 (1993)</sup>, Dixon had been admitted to the hospital and was diagnosed with pneumonia in her right lung. Dixon’s condition began to deteriorate, and she was moved to the intensive care unit (ICU). A code blue was eventually called, signifying that her cardiac and respiratory functions were believed to have ceased. During the code, a decision was made to intubate by inserting an endotracheal tube into Dixon so that she could be given respiratory support by a mechanical ventilator.

As Dixon’s condition stabilized, Dr. Taylor, Dixon’s physician at that time, ordered that she be gradually weaned from the respirator. Blackham, a respiratory therapist employed by the hospital, extubated Dixon at 10:15 p.m. Taylor left Dixon’s room to advise her family that she had been extubated.

Blackham decided an oxygen mask would provide better oxygen to Dixon but could not locate a mask in the ICU; thus, he left ICU and went across the hall to the critical care unit. When Blackham returned to Dixon's room with the oxygen mask and placed it on Dixon, he realized that she was not breathing properly. Blackham realized that she would have to be reintubated as quickly as possible.

A second code was called and Shackleford, a nurse in the cardiac critical care unit, responded to the code. Shackleford recorded on the code sheet that she arrived in Dixon's room at 10:30 p.m. She testified that Blackham said he had too short of a blade and he needed a medium, a Number 4 MacIntosh laryngoscope blade which was not on the code cart. The code cart is a cart equipped with all the medicines, supplies, and instruments needed for a code emergency. The code cart in the ICU had not been restocked after the first code that morning; thus, Shackleford was sent to obtain the needed blade from the critical care unit across the hall.

When Shackleford returned to the ICU, the blade was passed to Taylor, who had responded to the code and was attempting to reintubate Dixon. After receiving the blade, Taylor was able to quickly intubate Dixon. Dixon was placed on a ventilator, but she never regained consciousness. After the family was informed there was no hope that Dixon would recover the use of her brain, the family requested that no extraordinary measures be taken to prolong her life.

A medical negligence claim was filed against Taylor and the hospital. The jury found that Taylor was not negligent. Evidence presented at trial established that the hospital's breach of duty in not having the code cart properly restocked resulted in a 3-minute delay in the intubation of Dixon. Reasonable minds could accept from the testimony at trial that the hospital's breach of duty was a cause of Dixon's brain death, without which the injury would not have occurred. Foreseeability on the part of the hospital can be established from the evidence introduced by the plaintiff that the written standards for the hospital require every code cart be stocked with a Number 4 MacIntosh blade. This evidence permits a reasonable inference that the hospital should have foreseen that the failure to have the code cart stocked with the blade could lead to critical delays in intubating a patient. Accordingly, there was substantial evidence that the failure to have the code cart stocked with the proper blade was a proximate cause of Dixon's fatal injuries.

### **Ethical and Legal Issues**

1. Describe the ethical issues involved in this case.
2. Explain how the elements of negligence are met in this case.
3. What steps could be implemented to prevent similar occurrences in the future?

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## **SOCIAL WORK**

*Social workers* in the hospital setting assist patients and families with: psychosocial issues; obtaining insurance coverage; making difficult care decisions; and, assisting the patient and family in planning for postdischarge care. As with many professions, social workers are often overlooked and underused when it comes to the team approach to health care. It has, over the years, been a low priority with hospitals to hire an effective team, adequately staffed to address the myriad of issues that need to be addressed in the delivery of patient care.

The National Association of Social Workers Code of Ethics specifies the following six purposes:<sup>70</sup>

1. The Code identifies core values on which social work’s mission is based.
2. The Code summarizes broad ethical principles that reflect the profession’s core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The Code is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The Code provides ethical standards to which the general public can hold the social work profession accountable.
5. The Code socializes practitioners new to the field to social work’s mission, values, ethical principles, and ethical standards.
6. The Code articulates standards that the social work professional itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members. [For information on NASW adjudication procedures, see NASW Procedures for the Adjudication of Grievances.] In subscribing to this Code, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings for sanctions based on it.

As with any profession, legal and moral concern social workers as well, as noted in the following news clipping.



### Caseworker Fired after Baby Dies

A District of Columbia social worker was fired Tuesday following the death of a baby who was reported as neglected, city officials said.

The city’s Child and Family Service Agency received a call about the 6-month-old boy in March, but the social worker assigned to the case never visited the child, interim Attorney General Peter Nickles said.

*Nikita Stewart, The Washington Post, July 8, 2008*

## CERTIFICATION OF HEALTH CARE PROFESSIONALS

The *certification* of health care professionals is the recognition by a governmental or professional association that an individual’s expertise meets the standards of that group. Some professional groups establish their own minimum standards for certification in those professions that are not licensed by a particular state. Certification by an association or group is a self-regulation credentialing process.

## LICENSING OF HEALTH CARE PROFESSIONAL

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*Licensure* can be defined as the process by which some competent authority grants permission to a qualified individual or entity to perform certain specified activities that would be illegal without a license. As it applies to health care personnel, licensure refers to the process by which licensing boards, agencies, or departments of the several states grant to individuals who meet certain predetermined standards the legal right to practice in a health care profession and to use a specified health care practitioner's title. The commonly stated objectives of licensing laws are to limit and control admission to the different health care occupations and to protect the public from unqualified practitioners by promulgating and enforcing standards of practice within the professions. Health professions commonly requiring licensure include dentists, nurses, pharmacists, PAs, osteopaths, physicians, and podiatrists.

The authority of states to license health care practitioners is explicit in their regulatory powers. Implicit in the power to license is the right to collect licensing fees, establish standards of practice, require certain minimum qualifications and competency levels of applicants, and impose on applicants other requirements necessary to protect the general public welfare. This authority, which is vested in the legislature, may be delegated to political subdivisions or to state boards, agencies, and departments. In some instances, the scope of the delegated power is made specific in the legislation; in others, the licensing authority may have wide discretion in performing its functions. In either case, however, the authority granted by the legislature may not be exceeded.

### SUSPENSION AND REVOCATION OF LICENSE

Licensing boards have the authority to suspend or revoke the license of a health care professional found to have violated specified norms of conduct. Such violations may include procurement of a license by fraud; unprofessional, dishonorable, immoral, or illegal conduct; performance of specific actions prohibited by statute; and malpractice. Suspension and revocation procedures are most commonly contained in a state's licensing act; in some jurisdictions, however, the procedure for suspension and revocation of a license is left to the discretion of the licensing board.

## HELPFUL ADVICE FOR CAREGIVERS

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- Break down the barriers between departments and work as a team.
- Abide by the ethical code of one's profession.
- Do not criticize the professional skills of others.
- Maintain complete medical records.
- Provide each patient with medical care comparable with national standards.
- Seek the aid of professional medical consultants when indicated.
- Obtain informed consent for diagnostic and therapeutic procedures.
- Inform the patient of the risks, benefits, and alternatives to proposed procedures.
- Practice the specialty in which you have been trained.
- Participate in continuing education programs.
- Keep patient information confidential.

- Check patient equipment regularly, and monitor it for safe use.
- When terminating a professional relationship, give adequate written notice to the patient.
- Authenticate all telephone orders.
- Obtain a qualified substitute when you will be absent from your practice.
- Be a good listener, and allow each patient sufficient time to express fears and anxieties.
- Develop and implement an interdisciplinary plan of care for each patient.
- Safely administer patient medications.
- Closely monitor each patient's response to treatment.
- Provide education and teaching to patients.
- Foster a sense of trust and feeling of significance.
- Communicate with the patient and other caregivers.
- Provide cost-effective care without sacrificing quality.

## CHAPTER REVIEW

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1. The contents of codes of ethics vary depending on the risks associated with a particular profession.
  - Ethical codes for psychologists, for example, define relationships with clients in greater depth because of the personal one-to-one relationship they have with their clients.
  - Practicing outside one's scope of practice has both ethical and legal concerns.
2. Legislation in many states imposes a duty on hospitals to provide emergency care. If the public is aware that a hospital furnishes emergency services and relies on that knowledge, the hospital has a duty to provide those services to the public.
3. Hospitals are expected to notify specialty on-call physicians when their particular skills are required in the emergency department. A physician who is on call and fails to respond to a request to attend a patient can be liable for injuries suffered by the patient because of his or her failure to respond.
4. There can be both ethical and legal repercussions if a professional incorrectly interprets a physician's orders.
5. A defense that sexual improprieties with clients did not take place during treatment sessions is unacceptable conduct.
6. Scope of practice refers to the permissible boundaries of practice for health care professionals, as is often defined in state statutes, which define the actions, duties, and limits of professionals in their particular roles.
7. A professional who exceeds his or her scope of practice as defined by state practice acts can be found to have violated licensure provisions or to have performed tasks that are reserved by statute for another health care professional.
8. The power and authority to regulate drugs and their products, packaging, and distribution rest primarily with federal and state governments.
9. Certification of health care professionals is the recognition by a governmental or professional association that an individual's expertise meets the standards of that group.
10. Licensure can be defined as the process by which some competent authority grants permission to a qualified individual or entity to perform certain specified activities that would be illegal without a license.



## TEST YOUR UNDERSTANDING

### TERMINOLOGY

advanced practice nurse certification	licensure	pharmacist
chiropractor	medical assistant	physical therapy
clinical nurse specialist	nonmaleficence	physician assistant
dentist	nurse anesthetist	psychologist
dietitian	nurse midwife	radiology technologists
float nurse	nurse practitioner	registered nurse
laboratory medical	nursing assistant	respiratory therapist
technologists	paramedic	social workers
	patient care teams	special duty nurse

### REVIEW QUESTIONS

1. Describe how ethics and the law have an impact on the various health care professions discussed in this chapter.
2. Discuss the ethical and legal implications of practicing outside one's scope of practice.
3. Discuss the circumstances under which a hospital has a duty to provide emergency services to the public?
4. Are sexual improprieties acceptable with clients as long as they do not take place during treatment? Explain your answer.
5. Consider under what circumstances a professional's legal responsibilities may overlap with his or her ethical duties.
6. Describe how and why the scope of practice for various professionals (e.g., nurses and pharmacists) is changing.
7. Discuss what action a caregiver should take, if any, if a physician's written orders appear questionable.
8. Describe a professional's responsibilities when a patient's condition takes a turn for the worse.
9. Describe the difference between the certification and licensing of a health care professional.

### NOTES

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