ABSTRACT: If you work in the medical field, you probably fear that someday you may be sued. Lawsuits are scary, and the process is intimidating. Lawsuits can take years to resolve. You may spend a significant amount of time reviewing records and imaging studies, meeting with insurance claims investigators, risk managers, and your own lawyer. As the lawsuit progresses, you may have to give a deposition under oath. If there is no resolution of the matter, it will proceed to trial. The trial will typically last between 1 and 2 weeks, depending on the complexity of the issues involved. If you are named in the lawsuit, you are expected to attend the trial every day. You will gain a new respect for the jury system and will look at a jury summons in a whole new light. The purpose of this article is to help radiology nurses understand litigation, especially malpractice. Having this information will allow the radiology nurse to examine his or her own practice and assess if one can make small changes to everyday activities to improve the chances of successfully preventing or defending any malpractice suit and, more importantly, to improve patient outcomes. The rules governing litigation vary by jurisdiction. These are some general rules but, of course, your attorney will tell you what you need to know in your area. (J Radiol Nurs 2015;34:13-24.)

KEYWORDS: Nursing; Malpractice; Litigation; Malpractice insurance; Medical records and documentation.

WHAT IS LITIGATION?

Litigation is a lawsuit. It is a dispute or contest brought before a court. One or more parties sue one or more parties for something. There are various types of lawsuits (matrimonial, contract, libel, etc.).

One very common type of lawsuit is for negligence. Someone claims (alleges) they suffered property damage, physical damage, or even death because someone was negligent. For example, suppose you make a bad turn and hit a parked car. The owner of the parked car may sue you for the damage to the car. Let us also suppose there is a passenger in the car who claims he now has whiplash because you struck this car. He may sue you for his personal injury.

Elements

The elements of a lawsuit or of a cause of action are those basic things a plaintiff (the party that initiates a lawsuit) must prove to establish a prima facie case. A prima facie case means that the plaintiff has legally sufficient evidence to require a jury or trier of fact to decide each element of the case. Every case of negligence has the same four elements. This is true whether the claim involves negligently maintaining your sidewalk or

Karen A. Butler, Esq, RN, managing partner, and Michael D. Lostritto, Esq, associate attorney, are from the Albany law firm of Thuillez, Ford, Gold, Butler & Monroe, LLP, Albany, NY.

Corresponding author: Karen A. Butler, Thuillez, Ford, Gold, Butler & Monroe, LLP, 20 Corporate Woods Boulevard, Albany, NY 12211. E-mail: kbutler@thuillezford.com; cfollos@thuillezford.com

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“Malpractice 101: Strategies for Defending Your Practice”, GNA ID # 317126 has been approved for 2.5 contact hours. This continuing nursing education activity was approved by the Georgia Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission On Accreditation. Go to www.arinursing.org and click on Education, Directed Journal Reading (DJR) or go to www.arinursing.org/education/directedreading.cfm for more information.
whether it involves malpractice in performing brain surgery. These four elements are always present:

- Duty
- Breach
- Proximate cause
- Injury

Negligence is the failure to use reasonable care. For example, if a driver follows too closely behind another vehicle or a home owner fails to shovel his walkway, the plaintiff may allege that the defendant (the party against whom a lawsuit is brought) is liable because he failed to use reasonable care. Negligence is the failure to do something a reasonable person would do or failing to do something a reasonable person would do under the same or similar circumstances. It is a reasonable person standard.

MALPRACTICE

Malpractice is a special kind of negligence (New York Pattern Jury Instructions Civil, 2014). Malpractice is negligence by a professional (New York Pattern Jury Instructions Civil, 2014). For example, there can be architectural malpractice or accounting malpractice (New York Pattern Jury Instructions Civil, 2014). There is, of course, medical malpractice, which we will be discussing.

Negligence Versus Malpractice

Malpractice is negligence by a professional (New York Pattern Jury Instructions Civil, 2014). Sometimes, there is a dispute about whether an action is for ordinary versus medical negligence. The determining factor is whether the acts or omissions complained of involve a matter of medical science or art requiring special skills not ordinarily possessed by laypersons or whether the conduct complained of can be assessed on the basis of everyday experience (New York Pattern Jury Instructions Civil, 2014). Another basis of medical malpractice can be that the duty allegedly breached arose from or is substantially related to the physician-patient relationship (New York Pattern Jury Instructions Civil, 2014). It is sometimes very important to determine if an action is for ordinary negligence or malpractice. The statute of limitations may be different, the damages available may be capped for one cause of action but not the other, and most importantly, in most jurisdictions, the plaintiff must produce expert proof of the applicable standard of care in a medical malpractice case and that the medical provider breached or deviated from that standard of care (New York Pattern Jury Instructions Civil, 2014).

Burden of Proof

The plaintiff has the burden of proof. That means that the plaintiff must establish by a fair preponderance of the credible evidence that the claim the plaintiff makes is true (New York Pattern Jury Instructions Civil, 2014). If the evidence is balanced on both sides, then a finding in favor of defendant is required. Whether the plaintiff has made out a prima facie case is a question for the court to decide. The plaintiff must establish a prima facie case for each element of the cause of action before the case even goes to a jury.

Duty

To establish a prima facie case, the plaintiff must plead and prove that the defendant owed some duty to the plaintiff (New York Pattern Jury Instructions Civil, 2014). For example, suppose you are sitting by the pool, reading your book as a person drowns. You do nothing to help, and do not even try to bring the situation to anyone’s attention. Can you be sued? No, because there was no duty. In a medical malpractice case, the court looks to whether there was a duty owed to the person injured (New York Pattern Jury Instructions Civil, 2014). For example, a nurse sued a doctor who ordered a patient out of bed. The patient was obese, and the nurse hurt his or her back trying to move the patient. The nurse could not sue her employer (the hospital) because she was barred from doing so by Worker’s compensation. So, being creative, she tried to sue the doctor who gave the order. The judge dismissed the case. The judge held that the doctor owed a duty to the patient but did not owe a duty to the nurse.

NURSING MALPRACTICE

A nurse may be sued for malpractice. The definition of nursing malpractice is as follows:

Doing something that a reasonably prudent nurse would not do or failing to do something that a reasonably prudent nurse would do under the circumstances (New York Pattern Jury Instructions Civil, 2014). It is a deviation from accepted nursing practice.

There are two parts to this issue. First, the plaintiff must present proof of the standard of care; then, there must be proof that the defendant breached the standard (New York Pattern Jury Instructions Civil, 2014).

Establishing a Deviation

How does the plaintiff prove to a jury, not one of which has any medical experience, that there was a deviation from accepted standards of nursing care? The plaintiff must present legally sufficient proof from which a rational jury may conclude that there was a deviation from accepted standards of nursing practice (New York Pattern Jury Instructions Civil, 2014). This can be done in one of several ways:

- Through the testimony of one or more experts;
• Through the use of the hospital’s own existing policies and procedures (as they existed at the time—therefore they must be saved);
• Through the introduction of the hospitals’ own care plans/pathways (as existed at the time);
• Through the use of practice guidelines as embedded in the facilities’ own electronic medical record (EMR) (Curran & Berman, 2013); and
• Through existing standards recognized as authoritative (e.g., Center for Disease Control and Prevention or Advanced Cardiac Life Support).

However, by far, the most prevalent evidence of a deviation from accepted standards is testimony by an expert.

Who May Testify as to Standards of Nursing Practice
Surprisingly, it is not entirely clear that a nurse must testify as to standards of nursing care. In some jurisdictions, physicians are allowed to offer expert opinion evidence of the standard of care for nurses. However, for any expert, foundation must be established that shows the expert is familiar with the procedure or care at issue in the case. For example, if the case involves nerve damage from insertion of an intravenous (IV), the expert must have experience starting IVs and should be familiar with the standards accepted for performing this procedure.

CAUSATION
If the plaintiff has proved that there was a deviation of accepted standards by first proving what the standard is and then proving that there was a deviation, the plaintiff must then come forth with sufficient proof that the deviation was a substantial cause of the injury (New York Pattern Jury Instructions Civil, 2014). Generally, a doctor is needed to testify that a specific action (or inaction) was a substantial factor in causing the injury.

INJURY
The last element in any medical malpractice case is injury (New York Pattern Jury Instructions Civil, 2014). There must be an injury present. It must be an injury for which the court allows recovery. Suppose someone presents to the emergency room with a leg injury. An X-ray is done and is read as negative. The reading is wrong as the patient actually has a fracture. The leg is placed in a splint, and the patient is given pain medication and a referral to an orthopedic surgeon. The next day, the orthopedist looks at the X-ray, makes the appropriate diagnosis, and initiates treatment. Did the emergency room physician deviate from accepted standards? Perhaps. However, there is no injury. This is exactly what would have been done even if the fracture was seen on the X-ray. Another example is a case where there was a retained lap pad. It was found later when the patient had exploratory surgery. The patient was full of cancer, and the surgeon closed without removing the lap pad or the cancer. The patient died of cancer a few weeks later. Was there a deviation from accepted standards when the lap pad was left in the patient? Absolutely. However, there was no injury attributable to the retained lap pad.

Every injury is not one for which there is compensation. For example, a spouse may recover damages for loss of consortium. A claim for loss of consortium seeks to recover for the deprivation of the benefits of a family or marital relationship because of the injuries caused by another. However, in many jurisdictions, a common law spouse may not collect. In some jurisdictions, the damages in a wrongful death claim are limited to pecuniary loss or loss for economic damages only. In many jurisdictions (not New York), there are caps on damages for pain and suffering.

ORIGINS OF A MALPRACTICE LAWSUIT
We have all seen and know about accidents or errors in our daily practice that could result in a lawsuit. But these incidents never end up in litigation. For example, hundreds of people fall in nursing homes and hospitals every year often suffering severe fractures. Only a small percentage of these people end up in court. Why?

There are many theories about how and why some people are willing to bring a lawsuit and others would not sue no matter what happened. Certainly if people are angry or believe they have been treated unfairly or dishonestly, they are more likely to sue (Wojcieszak, Saxton, & Finkelstein, 2010). Some studies suggest that if a practitioner apologizes for an error, there is less likelihood of a lawsuit (Wojcieszak et al., 2010).

In some jurisdictions, there are malpractice panels. However, many people are surprised to learn that in most jurisdictions, including New York, the primary gatekeeper for lawsuits is the attorney for the plaintiff. What factors will an experienced attorney consider before bringing a malpractice case?

1. The first thing the attorney for the plaintiff will do is check to be sure there are no conflicts between his office and the potential defendants in the case. This can be challenging when the law firm is large with multiple offices and different departments handling different types of cases.
2. Next, the attorney for the plaintiff will ascertain enough facts to be sure that the statute of limitations has not run. In some situations, the statute of limitations can be very short. Normally, in New York, the statute of limitations is 2.5 years for medical malpractice. (Abrams, Greenberg, & Moy, 2011). However, if the claim is against a municipality, the statute requires a notice of
claim within 90 days and commencement of the lawsuit within 1 year and 90 days.
3. The attorney will look for other bars to recovery such as workers’ compensation or immunity.
4. Next, the attorney will obtain medical records for the plaintiff (Abrams et al., 2011). The attorney will look for evidence of each of the following:
   a. A breach in the standard of medical care;
   b. Injury to his client;
   c. A causal connection between the injury and the deviation from accepted standards; and
   d. The records should also be reviewed by an expert in the relevant field to determine if there was a deviation from accepted standards.
5. The attorney will then look at subsequent records and financial records to see if the injury and value of the injury justifies his investment in bringing the case.
6. The attorney will calculate the value of any legitimate liens on recovery, for example, Medicare, Medicaid, and workers’ compensation.
7. The attorney will then calculate whether it is financially attractive to bring a lawsuit. If liability is weak but the potential recovery is huge, the attorney may decide to take the risk of losing the suit because of the potential for a large verdict (and fee). If there is a relatively minor injury but liability is a slam dunk, the attorney may decide to take the case because it may settle without a lot of time and effort resulting in a modest fee with small risk. The case may be one where liability is arguably present and the injury is fairly severe, but the lien is so large the attorney would be working for the lien holder and not his client.

All the aforementioned points show that our society cannot rely on the tort system to improve or monitor quality. The system does not work that way.

If after considering these factors, the attorney decides it is worth his time and investment to bring a lawsuit, the plaintiff’s attorney and the plaintiff enter into a contract. The plaintiff will be responsible for all fees and expenses, including experts, travel, mileage, transcripts, printing, and so on. The attorney’s fee will be contingent on the plaintiff winning or settling the case, and the attorney will receive a percentage of the award or settlement. The plaintiff’s attorney then pours over all the plaintiff’s records to determine what health care providers he/she will sue (Abrams et al., 2011). The plaintiff then drafts a complaint, which is served on all the defendants in the case (Abrams et al., 2011).

**THE MOST COMMON CLAIMS**

Here are examples of allegations raised against nurses working in radiology:

- Allergic reactions;
- Failing to respond to an emergency situation;
- Falls;
- Failing to monitor the patient in the radiology department;
- Compartment syndrome after an infusion of contrast;
- Failing to be sure the ordering physician was notified of critical or unexpected findings; and
- Failing to take the appropriate images or views;

These are the most common claims in nursing malpractice, generally:

- Failing to monitor (i.e., compartment syndrome, fetal distress);
- Failing to notify physician of changes;
- Failing to document;
- Falls;
- Injuries (i.e., burns, nerve damage, malpositioning);
- Retained instruments/sponges/lap pads/needles;
- Wrong site/procedure;
- Elopement;
- Failure to intervene with impaired professional;
- Medication errors;
- Transfusions;
- Failure to question orders;
- Failure to follow chain of command;
- Failure to communicate/continuity of care;
- Obstetrics nursing/Operating room nursing related issues;
- Failure to follow procedures (i.e., air embolism when central line removed, failure to change IV site) (Monroe, 2013).

**FACILITY NEGLIGENCE**

A facility is vicariously liable for its employees when they are acting in the course of their employment (New York Pattern Jury Instructions Civil, 2014). Even if an employee is negligent or provides care in a manner that violates your policies and procedures, that employee will most likely be found to be working within the course of his or her employment (New York Pattern Jury Instructions Civil, 2014). A few examples of actions that would not generally be considered as working within the course of employment are stealing, sexual contact with a patient, and leaving the facility during the workday to perform a personal errand (New York Pattern Jury Instructions Civil, 2014).

**SHOULD YOU GET YOUR OWN INSURANCE?**

There are definitely pros and cons to getting your own insurance. At this time, it is still relatively uncommon for a nurse to be individually named in a lawsuit although it does happen (Monroe, 2013). Many nurses are told that they are more likely to be sued if they have their own policy (Monroe, 2013). However, this is not
likely. The attorney for the plaintiff would not know whether you have your own coverage until discovery. However, the plaintiff’s attorney may not be willing to discontinue against you, individually, after he learns that you have insurance. Having your own coverage may complicate the hospital’s ability to settle a claim if your policy is primary and must be offered before the hospital’s policy. You are most likely covered under the hospital’s policy for any action, which arises out of the course of your employment (Brous, 2014). But you could be sued for something done when not working for the hospital (Brous, 2014). Having your own policy would ensure coverage (Brous, 2014).

If you work for a doctor’s office or in a setting other than a hospital or nursing home, there may not be insurance to cover employees other than policies for the individual doctors. You should ask. You should follow-up yearly as sometimes groups choose not to renew the group’s policy.

One of the provisions in many individual policies is coverage for claims of professional misconduct (Brous, 2014). This is a great advantage if you are investigated by your nursing board. Individual policies may also pay for miscellaneous expenses when you are called to give testimony after you have left the employ of the hospital or other entity where you were working at the time of the incident. Typically, policies will pay your lost wages and travel expenses when appearing as a witness in a case for a previous employer.

Whether to have your own policy is an individual decision, which you should make after careful consideration and based on your own practice.

**SERVICE OF A SUMMONS AND COMPLAINT**

The complaint is the pleading that starts the lawsuit (Abrams et al., 2011). The document that is filed and served on the defendants explains where the action is brought (venue), the basis for venue and jurisdiction, who is being sued, the type of action being brought (i.e., negligence, malpractice, wrongful death), the time frame, general descriptions of the allegations sufficient to address each element of the cause of action, the relief sought, and the attorney for the plaintiff (Abrams et al., 2011). There must be enough information in the complaint to demonstrate why the pleader is entitled to relief (Abrams et al., 2011). In some jurisdictions, the complaint must specify the amount of damages sought, but in other jurisdictions, the plaintiff is not allowed to specify an amount (Abrams et al., 2011).

An action is commenced by filing the summons and complaint in the venue and court chosen by the plaintiff (Abrams et al., 2011). After filing, the complaint is served on each defendant (Abrams et al., 2011). The rules regarding proper service are very technical and must be followed to gain jurisdiction over the defendant. If you are served, you should note the date, day of the week, and how service was made (were you handed the complaint, was it attached to your door, handed to your child?) (Abrams et al., 2011). Your attorney will need to know the details about service.

**NEVER IGNORE**

If you are served with papers indicating you are being sued, the papers cannot be ignored. If you ignore the complaint and the time to answer lapses, you are then in default (Abrams et al., 2011). In other words, you have lost the lawsuit and the only issue left to be decided will be the amount of damages. In some circumstances, your attorney may be able to make a motion to set aside the default judgment, but it can be difficult (Abrams et al., 2011). It is much better and easier to deal with the complaint promptly. These principles apply whether you are sued for medical malpractice or because your dog bit the mailman.

**ARE YOU BEING SUED?**

To determine if you are the subject of the lawsuit, read the caption. The caption is the top part of the document. It will tell you the county in which the action is being brought, the names of the plaintiffs, then the words “versus” followed by the names of the defendants.

If it appears from the document that the lawsuit is related to your job, bring the entire document to your supervisor or your risk manager. Make a copy yourself. If you have insurance, you must notify your insurance company immediately (Abrams et al., 2011). Fax or e-mail a copy to the insurance company within 24 hr (if the complaint is about a dog bite, notify your home owner’s insurance) (Abrams et al., 2011). Stay in close contact with your supervisor and/or your insurance company to be sure an answer is prepared and served on your behalf in the time limit prescribed (Abrams et al., 2011).

The document responding to the complaint is called the Answer (Abrams et al., 2011). This is the pleading that the defendant must serve in response to the complaint (Abrams et al., 2011). If the defendant was properly served and the defendant fails to appear by serving an Answer, then the plaintiff can make a motion for a default judgment against the defendant (Abrams et al., 2011). The defendant has lost the lawsuit, and the only issue to be decided is damages. The Answer admits/denies/denies knowledge or information sufficient to respond to each individual paragraph in the complaint (Abrams et al., 2011). The Answer is a legal document prepared by your attorney. It also contains affirmative defenses that often are deemed waived if not pled in the Answer. The Answer takes time to
prepare. The attorney usually must consult with you and/or your employer to prepare the Answer properly. The attorney must know your relationship to the other parties and the dates of treatment. The answer must be served within 20 days (or 30 days—depending on how you were served.) The 20 days includes weekends and holidays. Therefore, it is very important that you get the complaint into the proper hands as soon as possible. There must be time for your employer or for your insurance company to secure legal counsel and for that lawyer to acquaint himself enough with the facts to serve the Answer (Abrams et al., 2011).

You should not panic about a lawsuit but you must be appropriately concerned. You should be notified of the identity of your attorney by your insurance company or risk manager. You are under an obligation to cooperate in your defense of the lawsuit (Abrams et al., 2011). That means, you must make yourself available to meet with your attorney (Abrams et al., 2011). You must be honest—you cannot change the facts. Failing to cooperate with your defense by failing to cooperate with counsel or failing to be truthful could result in your insurance company disclaiming coverage (Abrams et al., 2011).

It is extremely important that you do not discuss the facts of the lawsuit with anyone other than your own attorney or your insurance company. Do not discuss with coworkers even if they are also sued or you think one or more of your coworkers is a potential witness. It is very important not to e-mail or text any information about the lawsuit. Any such communication (conversation, e-mail, text, etc.) is discoverable.

The only document you should review is the plaintiff’s medical record. Do not even hold a pen or pencil in your hand when reviewing any original record. Never attempt to alter or add to the medical record.

YOU—A WITNESS

Sometimes a nurse is sued directly for malpractice along with the facility for which he or she works (Monroe, 2013). However, the most common scenario is that the facility is sued for malpractice and you are not named, but your care may be an issue in the case. Sometimes, the entire lawsuit is based on your interaction with a patient, yet only the facility is sued (Monroe, 2013). The facility is vicariously liable for the acts of its employees acting in the course of their employment (Monroe, 2013). Your employer can act only through you and the other employees. Therefore, if you were negligent, the facility was negligent (Monroe, 2013).

When you are an employee who is a witness in a lawsuit, you may not even know that the lawsuit has been commenced. Your first notice of the action may be a call from your risk manager/office manager to arrange a meeting with you and a representative of their insurance company or with the attorney for the facility (Monroe, 2013). You are still required to cooperate and make yourself available (Monroe, 2013). You cannot discuss the case with coworkers or anyone else.

It is still very stressful to be involved in a lawsuit even if you are not sued directly. All the following sections regarding discovery and depositions apply to you—the witness and to when you are named individually in a lawsuit.

DISCOVERY

After all the parties have appeared, that is, the complaint was served and the defendants have appeared and served an answer, there is a period of discovery (Abrams et al., 2011). These are pretrial devices that are available to each party to obtain facts and information about the other party’s case (Abrams et al., 2011). There are numerous devices for discovery. There are demands for documents, e-discovery, interrogatories, demands for Health Insurance Portability and Accountability Act authorizations to obtain medical and mental health records, subpoenas for testimony of nonparties, notices to admit, demands for experts, depositions, demands for photographs, surveillance, witnesses, insurance information, tax returns, previous medical records, worker’s compensation records, personnel records, demands to physically or mentally examine the plaintiff, policies, procedures, inspections of premises, to name a few (Abrams et al., 2011).

Discovery may last 8 months or 8 years. It is very important that you continue to stay in touch with your attorney and advise him if your contact information changes. You may be asked to meet your attorney. The attorney and/or her paralegal may ask you for documents. It is very important that you remember that you cannot speak about any aspect of the lawsuit with anyone except your attorney or your insurance company. You may not speak to any other party, codefendant, plaintiff, or witness about the lawsuit or the facts underlying the lawsuit. You may not share or exchange memos, notes, letters, e-mails, texts, or any other communication about the case.

WHAT IS DISCOVERABLE?

The entire medical record for the plaintiff is discoverable. It is not likely that you are the custodian of the record. It will be produced by the hospital’s Management Information System. In addition, any notes, memoranda, studies, imaging records, photographs, or other records that mention the plaintiff are discoverable (Abrams et al., 2011). This includes photographs taken during a procedure, imaging studies, logbooks, appointment records, billing records, physical therapy or dietary records, other
unrelated hospital records, and so on (Abrams et al., 2011). Anything you have relating to the person who is the subject of the action is discoverable. This also includes any notebooks you may have with writings about the patient (Abrams et al., 2011). It includes any diary or journal entries (Abrams et al., 2011). Your Facebook entries are discoverable even if blocked from view if they discuss work. Never discuss work on Facebook or any other social media. E-mails and/or text messages are not privileged and are discoverable. Your personnel file, evaluations, education records, resume, purchasing orders, facility policies, and procedures are all discoverable. Maintenance records, building plans, biomedical records, and surveillance footage may need to be produced. The attorneys may request a site inspection where they inspect the premises and take pictures. They may come in to inspect a piece of equipment or an examination table.

PRIVILEGED MATERIAL

Some information is privileged and protected from discovery. Conversations with your attorney are privileged. Quality assurance (QA), peer review, and credentialing materials are privileged as long as they were created and maintained as part of the facility’s quality improvement and medical malpractice prevention program. Minutes of root cause analysis meetings are privileged except statements made by defendants in the case. To be discoverable, the statements must be about the actual patient and incident at issue. Privilege varies widely among jurisdictions, and if you have any questions you should ask the attorney for your facility. Your own medical records are privileged unless your health or physical condition becomes an issue in the case.

DEPOSITIONS

A deposition means taking the testimony of a party under oath (Abrams et al., 2011). The deposition is always transcribed by a stenographer, and a transcript is produced (Abrams et al., 2011). The deposition may be videotaped. The deposition may be used to impeach the testimony of a witness at trial. The testimony may also be used in a motion to dismiss or for summary judgment (Summary judgment is a decision entered by a court for one party against another where there are no disputes as to the material facts of the case requiring trial of the matter, and one party is entitled to judgment as a matter of law.)

Depositions are part of discovery (Abrams et al., 2011). It is a time when the attorneys may ask questions of a party or witness while the person is under oath (Abrams et al., 2011). Lying under oath is a crime. The purpose of the deposition is to discover what the person will say if called to testify at the trial (Abrams et al., 2011). If the attorney does not ask a particularly important question, then the attorney does not get to know the answer. Generally, you cannot win your lawsuit at the deposition. However, you could lose your lawsuit because of a bad deposition. A deposition locks in your testimony. If your testimony changes at the time of trial, the previous deposition testimony will be used to impeach your credibility as a witness. It is therefore very important to be thoroughly prepared for your deposition. Here are some general rules:

1. Meet your attorney more than once, if possible;
2. Take as much time as you need to become very familiar with the complete record;
3. Review nothing but the record and relevant policies—for example, review no personal notes about the incident or nursing articles or texts to prepare for your deposition. The writings would then be discoverable.
4. Arrive early;
5. Plan to spend the entire day;
6. Dress like the professional you are;
7. Maintain a pleasant but professional demeanor;
8. All answers must be out loud and in words—no nodding or UmmHumm;
9. Do not volunteer anything;
10. Only answer the question asked;
11. Never suggest a better question;
12. Do not lie;
13. Do not guess or speculate (unless you measured it, you do not know the distance from the patient’s stretcher to the nurse’s station!);
14. It is OK to request a break;
15. “I don’t know” or “I don’t remember” are perfectly acceptable answers if true;
16. Do not answer a question you do not understand—ask the attorney to rephrase or say “I don’t understand the question;”
17. Wait very patiently until the end of the question, take a breath, think, then give a concise, truthful answer;
18. The plaintiff may videotape your testimony, and he has the right to do so (Monroe, 2013).

About 2 weeks after the deposition, you will receive a transcript of your testimony. You must review it very carefully for accuracy. If you are satisfied, sign it before a notary and return it to your attorney. Any changes must be made on a separate piece of paper, which is also signed and notarized. All these rules may be subject to some jurisdictional differences. Your attorney will prepare you.

TRIAL

Cases are resolved before trial in a variety of ways. Sometimes, the case is dismissed by the judge. Often a case will settle. The plaintiff’s attorney may voluntarily
discontinue the action against one or more of the defendants. However, sometimes the case goes to trial.

A deposition is stressful enough. A trial is stress on steroids. At the deposition, you sat with your attorney at a table with other attorneys asking questions. At the trial, you are up on the witness stand, sandwiched between a scary looking judge and a scarier jury. Your attorney is far, far away looking at a pad, or occasionally jumping out of his/her chair to object. How are you going to survive this experience?

Several months before, you will be notified of the trial date (Abrams et al., 2011). If you will not be available, it is imperative that you notify your attorney IMMEDIATELY.

If you have been sued individually, you must attend the trial every single day. Dress like a professional. Slacks and a sweater, a suit, or dress are fine. If you run out of clothes, wear a neat and pressed uniform. You will assist with your defense every day. You will be helping to carry boxes in and out of the courthouse, conferring on jury selection, handing notes to your attorney about evidence, and calling the hospital risk manager for documents or witnesses. Attending a trial as a defendant is not a passive process. Here are some guidelines:

1. From the time you park your car on the first day to the time the verdict is delivered, you are being observed by the jurors. Always be polite and pleasant looking, but do not speak with anyone who is or may be a juror;
2. You will be surrounded by jurors at the metal detector—leave your knife at home. Your cell phone may be taken. Do not argue;
3. Jurors will watch what you are reading, bring something noncontroversial;
4. It is a lot of hurry up and wait, be patient;
5. Never swear;
6. Hold doors for people;
7. You cannot speak to a juror, you cannot give gifts to jurors, you cannot flirt with a juror (seriously all these things have happened);
8. Assume the jury will GOOGLE you—clean up your Internet profile;
9. Listen to everything in the openings and arguments on motions before a judge—try to understand the plaintiff’s theory of the case;
10. Be sure you and your attorney are on the same page as to the defense theory;
11. Explain medical and factual issues to your attorney if he/she seems confused.

ORDER OF THE TRIAL

There are rules for everything. For example, the plaintiff always goes first because he has the burden of proof (Abrams et al., 2011). The exception to this is when the attorneys make closing arguments, in which case the plaintiff goes last (Abrams et al., 2011). The plaintiff’s table is always the table closest to the jury.

The attorney for the plaintiff starts jury selection by telling the jurors a little about the case and introducing the parties, attorneys, and witnesses (Abrams et al., 2011). He will then ask the jurors questions about their own lives. Then, the defendant’s attorney asks questions. If there is more than one defendant, the defendants do everything in the order of the caption. The parties take turns exercising challenges to get rid of jurors (Abrams et al., 2011). The number of jurors needed varies by jurisdiction. When the jury is selected, the plaintiff’s attorney gives an opening statement (Abrams et al., 2011). Then, the defendant attorneys give openings.

Exhibits such as the medical record are marked with little stickers. The parties may stipulate the records into evidence, or someone may be called to authenticate the records.

You may be called during the plaintiff’s case. You may be the very first witness. This is an extremely unpleasant introduction to the jury. Be very prepared. You will meet with your attorney several times before this happens. You will probably meet a last time the night before. If you get a chance, your attorney will show you the courtroom and have you sit in the witness chair before you actually testify. The testimony is under oath. You will walk to the front of the courtroom and face the clerk. The clerk will ask you to raise your right hand and place your left hand on a Bible. If this is a problem for you based on your religion or for any other reason, you must tell your attorney ahead of time so the clerk can seamlessly administer a different oath or affirmation. Proceed to the witness chair. You will feel alone up there. Take a breath, pour your water, fix your microphone, give a nervous smile to the jurors, and wait for the first question. Answer questions honestly. If you feel comfortable, make eye contact with the jury. If there is an objection, stop talking and wait for a ruling from the judge. If the objection is sustained, do not answer. If the objection is overruled, then you must answer the question. If you are not sure, ask the judge. Do not look to your attorney for answers.

The plaintiff’s attorney will ask you almost exclusively leading questions. These are questions that are usually answered yes or no. For example “You did not call the doctor DID YOU?” Sometimes you cannot answer the question with a yes or no, because it is too complicated. The attorney may demand “Answer YES or NO!!” If you cannot, turn to the judge and say “I can’t answer yes or no.” The judge will either direct you to try to give a yes or no answer, or he may ask the attorney to rephrase.
Conversely when your attorney asks questions, the questions must be nonleading and open-ended questions that do not suggest an answer such as “What did you do then?” or “Can you describe your assessment for the jury?”

In a medical malpractice trial, the plaintiff must usually have an expert to testify as to the standard of care and must offer proof that the defendant deviated from the standards (Abrams et al., 2011). There must also be expert proof that the deviation caused the injury (Abrams et al., 2011). In complex cases, it is not unusual for the plaintiff to call five or six experts. If the injuries are serious, there may be an economist and life care planner.

At the end of the plaintiff’s proof, the plaintiff rests. Your attorney will then make a motion to dismiss the case arguing the proof was not sufficient. The motion is usually denied, or the judge will reserve meaning he will decide later.

You may be called as a witness a second time by your own attorney during your “case in chief,” which starts after the plaintiff indicates he is done by resting. Now your attorney goes first with the cross-examination following. The decision to call you a second time is a tactical one depending on whether there were further issues raised by the experts or another witness who needs to be addressed.

When everyone has finished their proof, the parties give closing arguments (Abrams et al., 2011). The plaintiff goes last (Abrams et al., 2011). Do not gesture wildly during the attorney’s closing. Neither the jurors do like that nor the judge does.

After closing arguments, the judge reads jury instructions (Abrams et al., 2011). Look attentive. Then, the jury goes to deliberate. This is the very toughest part of the trial. Sometimes, the jury sends out questions and asks to have testimony read back. It eventually ends, and they return with a verdict. Be gracious no matter what the verdict. After the verdict is read, confer with your attorney to see what will happen next or if it is over.

**YOU—THE WITNESS**

If you are not sued individually but are a witness, you may only attend the trial for your own testimony. You must still spend a considerable time preparing. If you are not sued, but the entire case involves allegations that you were negligent, your facility and/or your attorney may decide that you should be the person who attends the trial every day.

**IMPLICATIONS FOR PRACTICE**

How should you present yourself to decrease your chances of being sued? How do you help to persuade the plaintiff and/or his/her attorney from bringing a suit? How should you document so you can defend your actions?

Medical record content is the single best way to dissuade a potential plaintiff and/or his/her attorney from bringing a suit (Abrams et al., 2011). If the plaintiff’s attorney finds a medical record that is clear, concise, complete, and accurate, the attorney may decide not to bring an action (Abrams et al., 2011). This does not mean quantity or volume of the records will prevent liability instead it is the quality of the documentation that will most assist in risk prevention.

However, if a case is put into suit, the medical record is the most reliable evidence of what really happened (Abrams et al., 2011).

**DOCUMENTATION**

The medical record is the single-most important piece of evidence in any malpractice trial (Abrams et al., 2011).

*It is Exhibit A*

Pages are blown up and shown to the jury.

The jury has the record in the jury room.

The jury will give more weight to the record than to any other piece of evidence in the record (Abrams et al., 2011).

Why is that? Cases drag on for years, and no one reliably remembers what happened. The chart is the best and probably only proof. The notes written or entered in the medical record at the time of the event, before there was any litigation and often before there was any untoward event, are the best source in determining what really happened. If the witnesses contradict each other, the jurors will believe what is in the record (Abrams et al., 2011). Moreover, the quality of the record including the choice of words and the information included or excluded influences any attorney reviewing a case for malpractice. There are no absolute guidelines as to what must be documented. The nurse must tailor his/her documentation to the particular patient and situation. However, here are some general guidelines based on my own experience.

**EMR/Electronic Health Record—Legal Impact**

An EMR is a medical record in electronic format for one provider (Curran & Berman, 2013). An electronic health record is an electronic record that goes across health provider systems (Curran & Berman, 2013). EMRs capture a lot of information. In litigation, the record is printed to create a hard copy. The hard copy may look very different than the screens you are used to. E-discovery allows for discovery of underlying electronically stored information (Curran & Berman, 2013). Metadata is the information that lies within a computer or software system (Curran & Berman, 2013).
& Berman, 2013). It captures time of creation, changes, user, who accessed what information, and time of electronic signature (Curran & Berman, 2013). Metadata may be needed to authenticate the record and/or author (Curran & Berman, 2013). The EMR captures the identity of any person accessing the record and exactly what pages were accessed, when, and for how long (Curran & Berman, 2013). Suppose you testify that before starting a procedure, it is your practice to review laboratories. By looking at the computerized record, the attorneys can tell exactly for how long and at what time you reviewed any laboratory work (Curran & Berman, 2013). The attorneys can tell if you looked at the consent or drug allergies.

The EMR captures any changes made to the record (Curran & Berman, 2013). You should take care to document on the correct record so that you are not forced to delete documentation. You will be asked at your deposition why you chose to alter the record. In addition, always log out after you finish documentation on an EMR. You do not want another person using your identity to document in the record. Always use the appropriate abbreviations that are approved by your facility. Texting abbreviations are not abbreviations.

Be aware of templates. You may be entering information you do not intend to enter or documenting activities or assessments that did not happen. For example, what will the paper copy of your note look like if you check normal cardiovascular examination? Many practitioners are surprised to find exactly how much has now been documented. For example, you may have just documented “skin warm, dry, pink, pulses 2+/=- throughout, heart sounds-normal PMI, regular rate, rhythm, normal S1, S2 with no murmurs, rubs or gallops, normal carotid uptake and amplitude without bruits, no jugular vein distention, without peripheral edema, no clubbing, brisk capillary refill etc.”

When every single operative note for a laparoscopic cholecystectomy is exactly the same, the jury will not believe it represents what really happened during the plaintiff's surgery. This is true of any template. There was a case involving an informed consent issue. The informed consent note was beautiful, thorough, well written, and all inclusive. The doctor noted that he/she discussed multiple risks, including nerve damage, hemorrhage, infection, pulmonary embolism, scar, pain, lack of improvement, stroke, death, and so on. He/she allowed the patient to ask questions and responded to all her questions to her satisfaction. They discussed the alternatives to surgery including other procedures or the option of no treatment. She accepted the risks as described and chose to have the surgery. The note was very persuasive until one read the patient’s entire record. She had had several surgical procedures by the same physician. For every single procedure, the note regarding informed consent was exactly the same. The note was then meaningless, and the jury no longer believed there had been any discussion regarding consent at all.

Document on the appropriate form. If there is a form for a particular activity, you must use that form. All boxes, blanks, or checklists must not only be completed but must accurately describe your findings and/or activities.

You should always remember that the time of documentation is captured in an electronic record—not time of activity (Curran & Berman, 2013). Therefore, the time of activity must be contained in the note.

Consider this note:

16:00—Patient complains of knee pain. Rate 6 of 10. Medicated with meperidine per telephone order Dr. Smith with relief.

What does this note mean? Was the pain at 1600? Was the call to the doctor at 1600? What did the doctor say? What was the doctor told? Was any assessment done of the knee/leg? Was the meperidine given at 1600? Or was the pain relieved at 1600? What does relieved mean? Was the pain now 0 of 10 or 4 of 10?

Too often, nurses and physicians, as a result of institutional policy, document by exception things/assessments that must be documented even if normal. For example, if someone had an open reduction internal fixation of an extremity and checking a patient’s circulation, motion, sensation, and temperature (CMST) need to be done every hour, the CMST must be documented every hour even if normal. Putting an initial next to a CarePath that says “CMST will be normal” or “CMST will be checked every hour” will not convince anyone that you actually checked the patient. It certainly will not convince any jury that, not only did you complete the assessment every hour, but it was completely normal. Of course, the fact that the case is in litigation probably indicates something bad happened. There is nothing worse than a chart that is completely silent about assessments of an extremity postoperation for 8 hours until there is an entry that the patient (now plaintiff) has a cold and pulseless leg. In fact, lack of documentation will lead a reasonable jury to conclude that the patient was never checked at all.

**DOS AND DON'TS OF CHARTING**

Try to document just the facts. What you see, hear, and feel. Do not editorialize in the record (Abrams et al., 2011). Do not characterize behavior, instead describe the behavior. For example, do not say “patient was agitated” but describe the behavior: “Patient attempting to pull out IV and Foley, attempting to climb off the stretcher.” Document what you did. Document your assessment, for example, is the patient oriented? What are his vital signs? Did you call the doctor? Give

There are things to consider when following orders. Normally, a nurse following the order of a physician is shielded from liability (New York Pattern Jury Instructions Civil, 2014). The exception is if the order given is erroneous or clearly inconsistent with normal practice. Nurses, therefore, always have a duty to inquire of the physician any questionable orders. The conversation with the physician and anyone else with whom you spoke (pharmacy and supervisor) concerning an order must be documented (Abrams et al., 2011). Orders should never be entered or followed unless given by a physician or other practitioner authorized to give the order. Telephone orders must be read back and confirmed including the name of the patient. Never document that you read back an order unless you did so. If you are calling a physician for an order, document the time of the call and why you called as well as the substance of the conversation. If you called multiple times with no response, document all attempts and other steps taken to report changes in your patient’s condition, for example, notifying your supervisor or nurse manager.

How would you answer this documentation question:

1. You find Ms. Jones lying on the floor next to the stretcher. Ms. Jones tells you she tried to get up to the bathroom without help and fell. How do you document:
   a. Patient fell while walking to bathroom.
   b. Patient failed to call for help as instructed. Patient fell attempting to walk to bathroom without assistance.
   c. Patient found on floor next to stretcher. Patient states she fell as attempted to walk to bathroom.
   d. Patient apparently fell walking to bathroom.

The answer is “c” because that is the most accurate description of what happened.

2. A patient is admitted with a diagnosis of ruptured appendix. She was treated for several days by her primary physician who advised her to take famotidine. She complains that her doctor did not really believe her complaints of being sick. How do you document:
   a. Patient has been treating with her primary care physician since abdominal pain started on Sunday but was treated with famotidine only.
   b. Patient states she has been on famotidine for 4 days per order primary care physician with no improvement of abdominal pain.
   c. Patient has had pain in abdomen for 4 days.
   d. Patient reports that her primary care physician is an idiot who thought she was a drug addict and refused to believe she was sick.

The answer here is “b” because that is the most accurate and complete answer without editorializing.

Be ever vigilant to give the correct medication to the correct patient, via the correct route and at the correct time. If a dose of medication is not given, the reason should be documented clearly. All medication errors must be reported. Do not take medication from PYXIS to give to a different patient.

DELEGATION
   o Right task
   o Right person
   o Right patient
   o Right training.

For example, suppose at your institution, a nurse’s aide or certified nursing assistant is tasked to do vital signs, a common practice. Typically, the aide then either writes the vital signs on her work sheet to chart later or enters the vital signs into the record on a flow sheet and/or graphic record. However, the aide cannot make a determination that the vital signs are normal. It does not matter that your aide is experienced, reliable, and you trust his/her. He/she is not the licensed professional. He/she cannot make a determination that is part of a nursing assessment. You should not rely on the aide to let you know about abnormal vital signs. This is beyond the scope of practice of a nurse’s aide. Likewise, if you are asked to perform a procedure that is beyond the scope of your practice, you must refuse. There is no such thing as “working under a doctor’s license.”

COMMUNICATION

The art and science of nursing depends on accurate and timely communication. You communicate through the record, through report, by telephone, and through your actions. You communicate with the patient, family, and a myriad of other health care professionals.

When communicating with the patient and family, never be dishonest. Be and sound responsive to complaints and concerns by the patient and family. You should respond with an explanation (why the X-ray is taking so long) or a corrective action (if you are chilly, I can get you a warm blanket). Always act like a professional. Do not over share with a patient or family. No one wants or needs to know about your divorce, your new car, that you are being floated, the hospital is short-staffed, you are very busy, and so on. Look, dress,
and act like the professional you are. Always display your name badge with your role clearly identified. You should always be and sound concerned. Respond to requests for help. Make eye contact. Do not patronize.

Do not make suggestions in front of the patient or family. For example:

- Nurse Bob Jones, in his continuing quest to be the undisputed smartest person in the room, is in his febrile patient’s room as the doctor makes rounds. He offers several suggestions to the doctor—Do you want blood cultures? Do you want infectious disease to see him? Do you want an X-ray? At the deposition, the plaintiff’s wife testifies: “Even Nurse Bob knew he should see a specialist and have an X-ray!” It is certainly acceptable as a member of the health care team to make suggestions, but unless it is an emergency, the suggestions should be made out of the presence of the patient and family.
  - Avoid speculation
    - Do not speculate about what may or may not happen. Suppose your patient has a cough. You tell the patient and his family that you are calling the physician. You also tell them that the doctor will probably order a chest X-ray. Well he does not order an X-ray. Later, the patient dies of lung cancer. Based on her memory of what you said about an X-ray, the patient’s wife firmly believes malpractice occurred and that failure of the doctor to order an X-ray caused her husband’s death. At her deposition, his wife testifies “the nurse said he needed an X-ray!”
  - Do not convey a negative opinion about another health care professional
    - Never criticize another facility (“your mother never should have been allowed to fall at the nursing home!” or “we’ve had other patients come back from that hospital with decubiti”). Do not criticize the other shift, specialty, floor, professional, or any other person caring for the patient. Do not blame the policy or the hospital, the other staff, the economy, or the government for problems. If you convey to the patient an opinion that care was not optimal for any reason when things go wrong, the patient is more likely to call a lawyer.

Incidents

The incident report is, in most jurisdictions, privileged and protected from discovery. However, it may be discoverable in some situations (Abrams et al., 2011). The initial incident report should contain the information in the record—just the facts. What you found, saw, and heard. The report should not be speculative or offer an opinion. The names of witnesses to any incident should be contained in the report. Document injuries and treatment. Document the patient complaints if any and the findings on physical assessment. Document what was done to address any injuries. You should document the name of the doctor and supervisor called regarding any incident and the time. Never e-mail or text anyone about any incident. All e-mails and text messages are discoverable. As your institution develops an EMR system, methods for documenting and tracking QA activities including incidents should be carefully developed with the involvement of information technology, risk management, outside counsel, and/or your insurance company to be sure this information is created, stored, maintained, and accessed in a manner that protects privilege.

Root cause analysis/QA/minutes—There is a skill in conducting and documenting root cause analysis while preserving privilege. Your risk manager/QA staff should work closely with counsel and your insurance carrier to be sure this is done properly.

CONCLUSION

Being sued or even being called as a witness in a lawsuit is a stressful experience. Remember you cannot change the facts. Always be honest, direct, and concise. Lawsuits are only about money. Keep things in perspective and you will do fine.

References


