Medical Malpractice Cases Involving Nurses (and Often Physicians)

by Jock Hoffman and Winnie Yu

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Since most patient care involves nursing, it would be accurate to say that the vast majority of medical malpractice cases "involve" nurses. In reality, nurses are named as defendants in significantly fewer cases than their physician colleagues, but they are far from immune. Of course, when measured against the overall volume of encounters, health care rarely involves anyone's malpractice, or errors, or adverse outcomes. Thanks to highly trained, competent nurses and physicians working together, the vast majority of health care encounters conclude successfully.

But unfortunately, errors do occasionally occur, systems fail, and patients suffer injuries as a result. And when a plaintiff (the patient, family member, or estate) believes an injury was preventable, they look to be compensated for their loss. Generally, the onus is placed on the clinician responsible for the patient when the alleged error occurred, or on the person responsible for the error. Most often, that named defendant is a physician. Less often (but not infrequently) the plaintiff names a nurse. In settings with multi-disciplinary care teams, plaintiffs frequently name both physicians and nurses in the same malpractice case.

From 2002 to 2006, the number of nurses insured by CRICO increased 27 percent (from 13,400 to 17,000). Across the CRICO-insured institutions, an average of three malpractice cases per month either name a nurse defendant, or identify the Nursing service as responsible for the patient at the time of the allegedly negligent event. Among the significant details:

- nursing-related cases represent 16 percent of all CRICO cases and 21 percent of all CRICO incurred losses;
- of the 364 nursing-related cases filed from 1998–2007, 41 percent involved high-severity injuries (including 89 deaths);

- close to half of the nursing cases (45 percent) also named one or more physicians as defendants;
- the total incurred dollars (reserves or payments, and expenses) for cases involving nursing for the 10-year period was $173 million;
- analysis of the cases that were closed during this same 10-year period shows that nursing-related events accounted for $71 million in indemnity payments (average=$441,000);
- safety and security (often slips/falls) topped the list of allegation types;
- the majority of the nursing cases alleged errors related to diagnosis or treatment;

Continued on page 3

Table 1

CRICO Professional Liability Cases

Cases Asserted 1998–2007	All CRICO	All cases involving nurses[a]	Cases in which a physician and a nurse were named
Total cases	2,342	364	163
Cases with high-severity injury[b]	986	149	117
Total incurred	$849M	$173M	$127M
Average indemnity incurred	$670,000	$685,000	$963,000
Cases Closed 1998–2007			
Total cases	2,338	339	150
Cases closed with indemnity payment	31%	47%	53%
Total indemnity payment	$375M	$71M	$56M
Average indemnity payment	$521,000	$441,000	$709,000
Cases closed with indemnity payment >$1M	125 (5%)	21 (6%)	17 (11%)

a Claims and suits in which a nurse was named as a defendant or Nursing determined to be the service responsible for the patient at the time of the alleged event.

b The patient died, or suffered a permanent significant, major, or grave injury.

Continued from page 1

3. The nursing staff's lack of awareness regarding critical aspects of this patient's medical condition (e.g., history of sleep apnea, use of CPAP, and recent acute bronchitis) ultimately impeded the care she received.

   Risk is reduced for a patient transferring from one location or service to another when a report noting key information about his or her medical history is provided to the receiving caregiver. Such information can guide decisions, e.g., the regulation of medications provided to the patient, rooming the patient closer to the nurses' station (allowing for more frequent observation), or flagging the need for special care.

4. The patient's casual admission for overnight post-op observation appears to have been subject to numerous (errant) assumptions. Her uncontrolled pain was not promptly reported to her physician and she received narcotics in excess of those originally ordered.

   Casual admissions to holding facilities can be dangerous in the absence of specific notes/orders regarding any pre-existing health conditions. Likewise, the nursing staff can minimize the risk of an adverse event by monitoring each patient through continual clinical assessment and reporting any deterioration in his or her condition. Failure to recognize the (sometimes subtle) significance of the physician's orders (e.g., when to contact him or her) places patients at unnecessary risk for an adverse event.

5. The orders written for this patient were too narrow to cover the realm of possible clinical needs of someone with a history of multiple health problems. Most critically, the postoperative orders did not adequately address monitoring the patient's respiratory status

   Care plans should go with the patient across care sites and feature prominent clinical risk issues, in order to keep providers aware of complicating factors that increase risk to the patient. Multiple providers and disciplines must maintain awareness and ensure monitoring of serious clinical risks before, during, and after treatment. Electronic order entry and medical record systems with decision support tools that flag concerns and highlight significant aspects of a patient's problem list (and also prompt recommended actions) offer promise—where available. ■

- 45 percent of incurred losses (i.e., dollars) associated with nursing cases, stems from obstetrics-related cases naming a nurse midwife, RN, or both;
- in the recent five-year period (2002–2007), nurse practitioners and nurse midwives saw a significant jump in the number of cases in which they were named as defendants;
- more than half (57 percent) of the NP cases were diagnosis-related; 89 percent alleged inadequate clinical judgment (e.g., failure to order tests, failure to obtain a consult);
- 21 CRICO cases naming 29 certified nurse midwives (and 24 physicians) account for $27.6 million in incurred losses.

Cases in which both a physician and a nurse are named compose 45 percent of the nursing cases. More than half of those cases closed with an indemnity payment, a significantly higher percentage than the average for all CRICO cases (31 percent). The average payment for nursing cases in which a physician was also named is 61 percent higher than those without a physician defendant.

As several contributors to this issue of Forum point out, the once-sharp delineation of roles and responsibilities for nurses and physicians continues to blur. When they clash, the only potential winner is the plaintiff's attorney. But when physicians and nurses work together to develop best practices to help them provide safe, high quality care, their patients benefit and the clinicians (nurses and physicians) greatly reduce their risk of being "involved" in a malpractice case. ■

Table 3

CRICO Cases Involving Nurses
1998–2007 (N=364 cases)

Total Defendants	**N=1,132**
Institution/Organization	321
Physician	387
Nurse	373
Registered Nurse	297
Nurse Practictioner	41
Certified Nurse Midwife	29
Licensed Practical Nurse	3
Nurse Assistant	2
CRNA	1
Top Allegations	**N=364**
Safety and security	81
Medical treatment	59
Obstetrics-related	46
Diagnosis-related	46
Surgical treatment	36
Medication-related	33
Patient monitoring	27
Top Risk Management Issues	**N=1,334***
Failure to ensure patient safety	23% of cases
Miscommunication among providers	21% of cases
Inadequate patient monitoring	17% of cases
Policy/protocol not followed	12% of cases
Mismanagement of labor and delivery	12% of cases
Inadequate staff training	9% of cases
Never Events	
Patient death associated with a fall	10
Retained foreign object after surgery/procedure	16†

*More than one risk management issue may be assigned to each case.
†Only three since 2003.