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Ethical and Legal Analysis of a Patient Case

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ABSTRACT
As health care professionals encounter increasingly complex issues surrounding patient care, it is important to develop an effective approach in investigating the legal and ethical consequences of such scenarios. This paper presents a systematic process to analyze and solve the legal and ethical implications of a specific patient case. This procedure may be used by other practitioners as a template for analyzing practice issues involving their respective professions.

INTRODUCTION
Health care professionals are constantly faced with an ever-changing practice environment brought about by influences from within and outside of their professions. The increasing complexity of the health care environment forces these professionals to make more complex ethical and legal decisions regarding patient care and other issues.

An important question to consider is whether health care practitioners have the necessary background, knowledge and skills to make the most appropriate legal and ethical decisions. Although basic legal and ethical issues are covered in most entry-level professional programs in allied health, it is questionable whether new practicing clinicians have the depth of knowledge and understanding of these issues in their present practice environments. Some experienced clinical professionals would allude to the fact that their exposure to the legal and ethical issues surrounding the profession has been more of an “on-the-job training”, rather that a concept they have previously learned before becoming licensed practitioners.

With this in mind, it is reasonable to assume that some legal and ethical dilemmas confronting health care clinicians could have been handled in a more efficient and effective manner if practitioners followed a systematic approach to analyzing these issues. This case study attempts to illustrate the process involved in methodically analyzing the legal and ethical implications surrounding a specific practice issue in physical therapy. Although this case study particularly looks as the ethical and legal ramifications of a particular patient-practitioner interaction in the physical therapy practice environment, the methods of analysis could be applied to any health care practice setting

CASE BACKGROUND
Jill is a physical therapist and Director of Rehabilitation Services in a Skilled Nursing Facility (SNF). Mary is a 75 year-old female who was admitted to the facility for continuation of rehabilitation secondary to a total hip replacement. After treating Mary one Sunday afternoon, Jill wheeled her back to her room. She documented the treatment performed, and then went to another facility to treat a few more patients.

The following day, Jill received a call from Edith, the Director of Nursing Services in the facility. Edith stated that a few minutes after Jill left, Mary evidently tried to get up from her wheelchair to turn down the volume of her television and fell, hitting her head on the floor. When asked why she tried to get up on her own despite previous instructions not to do so, Mary stated that Jill did

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not put her call light within reach and that there was no one around to call. Edith relayed that Mary's condition deteriorated over a 12-hour period and was subsequently sent out to the acute hospital (immediately after the incident, Mary's physician was called and he ordered them to keep Mary in the facility for observation). Mary suffered an intracranial hemorrhage and died early the following day.

That same day, Jill, Edith and Betty (the facility administrator) met to review Mary's chart. When asked if she made sure Mary had her call light, Jill stated that she was not sure if she did. Jill admitted to being preoccupied that day because of her heavy caseload and other personal problems. However, Jill stated that she had always placed the call light within reach of her patients in the past. Edith and Betty then asked Jill to revise the PT note that she did the day before to reflect that she had given Mary the call light. Edith, who was also the charge nurse on the day of the incident, already "reconstructed" her chart entries accordingly. Betty was afraid of a big lawsuit coming from Mary's family, so she ordered everyone involved in Mary's care to "strengthen" their documentation to reflect that the facility was not responsible for her injury and consequent death.

Jill was pressured by Betty to change her documentation, implying that she may be terminated if she did not agree to make the revisions. Betty wanted Jill to completely revise the whole note. Consequently, Mary's family sued the facility for negligence.

PART 1: ETHICAL ANALYSIS

The decision-making process that will be utilized to ethically analyze this case will be patterned after the process suggested by Swisher and Krueger-Brophy[1] in the book "Legal and Ethical Issues in Physical Therapy". This is a multi-step process that aims at examining the problem to come up with the most appropriate solution.

Step 1 in this process is to define the problem. A problem, which requires further ethical analysis, is one that concerns right or wrong human conduct. In this case, the ethical problem confronting Jill is whether she should agree to change her documentation of Mary's intervention the previous day. It may appear at the outset that this problem falls within Zaner's zone of relative certainty, as alteration of medical records is both legally and ethically inappropriate. However, on deeper analysis, one may make the contention that it is not as simple as having a definite right or wrong answer. Assuming that Jill made the determination that she did leave the call light within Mary's reach, the matter of changing the documentation to more clearly reflect the treatment received by the patient that day is more important than the potential legal ramifications arising from the alteration of medical records.

Step 2 in this process involves the generation of feasible options, or possible courses of action in response to the particular ethical problem. Looking again at the case, Jill may consider three possible options. She may decide not to change her documentation, completely revise the previous documentation or write an addendum to her previous documentation that would more closely reflect the treatment that she performed to the patient.

Step 3 involves the identification of ethical principles while recognizing legal, contextual, and environmental influences. Swisher and Krueger-Brophy designed an ethical clinical decision-matrix that outlines the ethical principles surrounding the problem. This outline is used in this case and is presented in Table 1.

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Table 1: Ethical Decision-Making Outline (adapted from Krueger and Swisher-Brophy2)

1. Duties, rights and obligations of the PT. An examination of the duties, rights and obligations of the practitioner. Jill's duty was to provide appropriate care to the patient within her scope of practice, disclose accurate information regarding patient's condition, and protect the institution from harm. Mary had the right to receive appropriate medical care while in the facility, to be protected from harm and environmental hazards and to receive accurate information in her medical chart.
2. Anticipated consequences. The anticipated repercussions of the proposed action include harm to patient, disclosure of erroneous information through alteration of medical chart and potential loss of employment if PT refuses to follow the administrator.
3. Virtues. The virtues that are important to the case include honesty and truthfulness in disclosure of information, responsibility to the patient, loyalty to the institution and duty to family (loss of occupation will impact the family).
4. Legal, Contextual and Societal Implications. What would be the consequent legal, contextual and societal ramifications of the proposed action? This must be analyzed according to the participants of the case. The legal ramifications include the PT for providing substandard care, the Director of Nursing and Facility Administrator for alteration of medical records, and the facility for the inappropriate actions of its employees, its inability to provide the patient with safe environment which led to the patient's injuries and consequent death, and the society due to the high cost of health care litigation.

Step 4 involves prioritizing values where conflicts exist. The decision arising from the prioritization of values is influenced by the philosophical orientation of the person making the decision. In this particular case, if Jill follows the deontological perspective which places the duties and rights of persons as most important, she will choose not to alter her documentation as this action will put the patient's needs and rights first. If Jill follows the utilitarian perspective which would require her to commit to an action that is satisfying to a majority, she will choose to make changes in her documentation to protect the facility from a potentially expensive litigation and loss of reputation.

Step 5 involves the development of a plan that reflects the ethical decision-making process noted in Step 4. In this particular case, it appears that Jill would make a decision not to alter the medical record as the most appropriate course of action. However, it is possible for Jill to engage in "creative" problem solving that might be acceptable to both sides ("moral creativity"). It may be possible for Jill to write a late entry on the medical chart to more appropriately reflect the treatment received by Mary the previous day. This would avoid the legal and ethical consequences of altering the medical chart, and at the same time allow Jill and the facility to strengthen their documentation skills to strengthen their contention that the injury was not a result of negligence on their part.

Step 6 involves the implementation of the course of action determined in Step 5. In this step, Jill will put a late entry in the chart. It is also in this step that she reassesses the consequences of her actions in and the social and environmental impact. She may have to look at her relationship with the Director of Nursing and Administrator, and possibly look for another job if her decision has negatively impacted her working relationship with the individuals.

PART 2: LEGAL ANALYSIS

There are two issues that require analysis from a legal perspective. The first is Mary's injury that consequently led to her death, and second, the falsification of medical records by Jill and Edith. The legal analysis will follow the four elements of negligence discussed by Swisher and Krueger-Brophy.[2]

Issue No. 1: Mary's injuries: Analysis on the Elements of Negligence

Element 1: Duty. Legal duty is established in the therapy context when there is a patient-therapist relationship. There may be arguments on both sides to indicate that Jill is negligent in her duty as a physical therapist. Clearly, Jill and Mary have a patient-therapist relationship because Jill had been providing physical therapy interventions for the patient. However, one factor to consider is whether the alleged act of omission (not putting the call light within the patient's reach) happened during the time that Jill was performing her professional duty to Mary. In this light, a technical question to consider is to determine when the actual PT intervention ended. Did Jill's intervention end in the PT area before Mary was transported back to her room, or did Jill perform other patient-related tasks when she transported the patient back (transfer training, bed mobility, etc.) to her room? If the

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intervention did not end until Jill left Mary's room, then not giving the call light to the patient was clearly during the intervention session, and thus, Jill may be held liable for this incident.

What happens then if there was "negligence" performed by a PT while doing non-PT related tasks in the facility? What if Mary was NOT on the physical therapy caseload, and Jill just happened to help the patient go back to her room then failed to give her the call light? She may not be liable as a PT because there is NO patient-therapist duty. Would this line of reasoning be acceptable if we assume that the physical therapy intervention ended prior to Mary being transported back to the room?

Is the Skilled Nursing Facility institution responsible for this incident? When the facility accepted Mary as a patient, it entered into a contract with her to provide care. The facility had a duty to provide Mary with medical care, while Mary had a duty to pay the establishment for the services rendered. This incident is clearly a breach of that contract, and as such, the facility failed to provide an acceptable level of care for the patient. Jill may not be liable as a physical therapy professional, but the facility is liable in Jill's capacity as an employee of the institution.

Element 2: Breach of Duty: Standard of Care. The second element in determining negligence is whether Jill met the standard of care. Did she act in a reasonable manner given the circumstances as compared to what another prudent therapist would do? Mary's fall and consequent injury leading to her death may be viewed as NOT directly a result of the physical therapy intervention given to Mary. Giving the call light to a patient does not require the skills and expertise of a physical therapist, and as such, Jill may not be responsible for the incident in her capacity as a PT. On the other hand, assuming that Jill really failed to put the call light within Mary's reach, does that act of "negligence" fall within her scope of practice? Does Jill's act of omission violate the acceptable standard of care both of the facility and the APTA code of ethics? APTA Code of Ethics, Principle 3 reads: "PTs accept responsibility for the exercise of sound judgment". Not putting the call light close to the patient is obviously NOT sound judgment.

What would another prudent therapist do? Most likely, this therapist would make sure that the patient is safe and precautions have been put in place (i.e. making sure that the call light is within the patient's reach) before leaving the patient. If such is the case, then Jill clearly failed to provide the standard of care to Mary. Moreover, assuring that the call light is within the patient's reach is a standard of care in skilled nursing facilities. This facility has a policy on call lights, which is clearly outlined in the Policy and Procedures manual. Jill clearly violated the standard of care of her profession and her facility.

Is the facility negligent in providing care within the acceptable standards? Whether the fall happened partially as a result of patient's lapse in judgment, the fact of the matter was that the injuries to the patient while under the facility's care indicates a failure to provide care within acceptable standards. This argument may be strengthened by documentation which indicated that the facility was short-staffed that day (below the acceptable industry standards), and the evaluation of the patient's mental status (she appeared to be alert, oriented, not confused, able to follow directions), and fall risk profile (they had established that the patient is a high fall-risk and therefore extra measures should have been enforced to ensure the patient's safety).

Elements 3 and 4: Causation and Harm. The third element of negligence indicates that the action of the therapist caused the injury. The fourth element indicates that the injury caused harm to the patient. In this case, the patient stated that the reason why she got up from her wheelchair despite previous instructions not to was that the call light was not placed within her reach and that there was no one around to call. It was reasonable to conclude that she would have not gotten up if the call light was within her reach. Therefore the cause of her fall may be attributed to the improperly placed call light by Jill. The facility is liable because it failed to provide the patient with a safe environment. Even if a direct causation cannot be established, the fact that the injury occurred must show that there was negligence on the part of the therapist and the facility (doctrine of res ipsa loquitur, "the thing speaks for itself", which refers to situations when it is assumed that a person's injury was caused by negligence of another party because the incident would not have occurred unless someone was negligent). The fact that the patient suffered injuries which caused her death indicates that the incident caused harm to the patient.

In the final analysis, it appears that the four elements of negligence are present in this case, indicating that both Jill and the facility are liable for Mary's injury and consequent death.

Other case laws related to alleged negligence by physical therapists also reflected on these four elements of negligence. In McAvenue v. Bryn Mawr Hospital,[3] a patient fell while undergoing physical therapy treatments. The expert witness for the appellant testified on cross examination that in his opinion, the fracture of the appellant's leg was a stress or spontaneous

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fracture caused by the appellant's loss of calcium, causing her bone to spontaneously fracture, causing the fall. The trial court stated that:

"The general test of liability is whether the injury could be foreseen by an ordinary intelligent man as the natural and probable outcome of the act complained of…Negligence is the want of due care under the circumstances. The sole test of negligence is whether the conduct of the person under scrutiny conforms to the standard of the reasonably prudent."

In Griffin v. The Methodist Hospital,[4] the patient brought medical malpractice against the hospital, claiming that negligent treatment caused achilles tendon contracture. Affidavits submitted by the nurse and physical therapist on hospital's motion for summary judgment on the patient's malpractice claim were conclusory, and thus were not competent to establish as a matter of law that the hospital complied with applicable standard of care; affidavits stated standard of care for the patient generally but did not address care or treatment necessary to prevent condition, and did not specify when or how the nurses assigned to the patient properly assessed her condition, did not specify neuromuscular status assessed by the physical therapist, areas of deficiency, or what the therapeutic intervention was, and failed to articulate what physician's orders were regarding physical therapy or how they were complied with.

WHO IS TO BLAME? CONTRIBUTORY AND COMPARATIVE NEGLIGENCE, RESPONDEAT SUPERIOR AND CORPORATE NEGLIGENCE

Another aspect to consider is to analyze who is to blame for this particular incident. Mary had been instructed several times prior to the incident that she is not to get up out of the chair and ambulate without assistance. Since her intact cognitive status had been established, there is not reason to believe that she is not able to understand the consequences of this action. On the other hand there is also no reason not to believe that the reason why she got up was that she could not reach the call light and that no one was there to assist her. If this incident happened in a state that recognizes contributory negligence, then Mary must be held partly responsible for her actions. The facility is responsible for Jill's action under the doctrine of respondeat superior. Jill was performing her duties within the scope of her employment, and therefore, the facility is responsible for Jill's actions.

Issue No. 2: Falsification of Documents

The medical record is a very important document in the facility in its documentation of appropriate patient care. It is also its strongest defense against potential negligent action. The lack of a complete medical record puts the facility in a very precarious situation when it tries to defend itself against accusations of improper and inappropriate care. Some courts will allow the jury to resolve ambiguities in the patient's medical record in favor of the patient.[5]

Incomplete records may prove to also be detrimental to a facility's defense against a lawsuit. There will be questions in the credibility of the medical record if the entry is written a few days or weeks after the actual treatment was performed. More suspect would be the addition of information regarding the patient's care after the patient had sustained an injury in the facility.

In this case, the addition to the record appears to be more to establish a defense rather than to reflect the actual treatment performed. In Foley v. Flushing Hospital and Medical Center,[6] the physician amended the patient's medical record to show that the medication was given orally after the father complained of injuries caused by the injection of medication. The change in the record was dated to show when it was made, and there was no attempt to conceal the change. Nonetheless, the change, along with the proof of the injury, was found to constitute sufficient evidence to go the jury on the question whether the medication was administered orally or by injection.[7]

The Facility Administrator and the Director of Nursing (Betty and Edith) may have been thinking of the reasons given above as the reason why a mere addition to Jill's documentation may not be sufficient defense for the facility. However, is the alternative- the complete alteration of a part of a patient's medical record- legal? If the plaintiff can show that the record was altered, the plaintiff may be able to destroy the credibility of the entire medical record. In the case of Pisel v. Stamford Hospital,[8] a nurse who falsified the patient's chart to show that she had checked the patient's heartbeat every half-hour made that entry in retrospect because she knew that procedure was good nursing practice. The court held in the subsequent negligence action that: In addition to all the other evidence in the case, the significance of the revised medical hospital record should not be overlooked. Although the defendant understandably attempted to minimize what was done by characterizing the action as merely one of ordering expanded notes and by attributing it to poor judgment, the trier (of fact) was not required to be charitable. An allowable inference from the bungled attempt to cover up the staff inadequacies was that the revision indicated a consciousness of negligence.

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Edith is guilty of illegal alteration of medical records, which is a federal offense. Whether the intent of the changes made in the record was to more clearly describe and document the sequence of events surrounding the incident, the fact remains that Edith destroyed the previous medical record entries and replaced it with new ones.

CONCLUSION

This case study attempted to present to the reader a systematic ethical and legal analysis of a specific practice issue in physical therapy. The use of a multi-step process as presented in this paper may be used by other practitioners as a template for analyzing practice issues involving their respective professions.

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