

# Has Malpractice Changed Nursing Practice?

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## INTRODUCTION

Medical malpractice constitutes a large range of legal issues that directly impact nursing practice. In addition to causing harm to patients, malpractice negatively affects nurses involved in malpractice claims, which can impact their standing within the organization for which they work, as well as their personal financial situation.

According to Pierce (2019), "Professional malpractice is the failure to provide the degree of care required under the scope of your license that results in an injury" (p. 14).

## SIGNIFICANCE

- Regardless of healthcare providers seeking to promote a safe environment and give quality care to their patients, medical errors occur often, making malpractice the third-leading cause of death in the United States (Paradiso & Sweeney, 2019).
- Between 2007 and 2016, 73% of medical professional liability cases reported nurses as the responsible party connected to inpatient care (Hoffman, 2019).
- Medical malpractice constitutes extreme spending for hospitals each year. Annually, malpractice related healthcare spending can exceed upwards of \$60 billion (Bono et al., 2021).
- From 2018 to 2021, 28 Medical Malpractice Payment Reports were filed against RNs working in the commonwealth of Pennsylvania. 2,141 Adverse Action Reports were reported against RNs of Pennsylvania during the same time period (NPBD, 2022).
- Nine Medical Malpractice Payment Reports that were filed against RNs in the commonwealth of Pennsylvania between 2018 and 2021 exhausted a payment range of greater than \$500,000. Four of those payments were greater than \$1,000,000. (NPBD, 2022).

## POSITION STATEMENT

Malpractice has changed and continues to change nursing practice. Through malpractice, new technology and nursing policy has developed to ensure patient's receive safe and effective medical care.

## SUPPORT FOR POSITION

Malpractice data analysis and investigation enables healthcare settings to address systemic approaches to patient safety more efficiently through creating a just culture environment.

- According to Jorie Zajicek (2020), "the reporting and investigation of medical errors is crucial to prevent the recurrence of error. As humans are not infallible and actions rarely occur in isolation, addressing system error focuses on the "blame" more fairly and is more effective in preventing future errors" (p. 28).
- When malpractice occurs, organizations must conduct a comprehensive investigation into the causal factors of the issue. This is known as a root cause analysis (RCA). The goal of an RCA is to create a corrective practice plan that addresses the current event while also enacting changes that prevent future occurrences through a system-wide approach. This method focuses on implementing change within a medical practice system as opposed to solely on a practicing individual (McGowan et al., 2022).
- According to Siegal, et al. (2019), "Intelligence gleaned from medical malpractice cases helps health care institutions analyze their litigation practices, trend financial outcomes, and even identify clinical services needing attention" (para. 1). Medical malpractice data can also be a powerful patient safety tool by revealing clinical patterns that contribute to medical errors (Siegal, 2019).

## IMPLICATIONS FOR PRACTICE

The utilization of medical malpractice data allows organizations to implement evidence-based change to prevent error recurrence and promote patient safety in the clinical setting. Data analysis is crucial in showcasing problem areas within practice and enabling organizations to develop corrective planning in response to malpractice. It is important for healthcare organizations to be cognizant of former malpractice issues in order to bring about positive reform, promote a therapeutic environment for patients, and maintain a positive workspace for providers.

- The three most common contributing factors in malpractice occur during the patient assessment, management of therapies, and communication periods among providers stages of care (Myers, 2021). With this knowledge, it is important for healthcare providers to be diligent in their tasks within each of these areas.
- Furthermore, "focus must shift from blaming individuals for human error and, instead, developing a multi-faceted system and culture of protection surrounding providers and patients. Successful examples of this approach include standardization of patient handoff, perioperative checklists, use of EMRs to verify accurate medications, and increased visibility and involvement of pharmacists" (McGowan et al., 2022, para. 4).



(Silva & Silva, 2021)

## CONCLUSION

Malpractice continues to be a cause of concern for registered nurses and the safety of their patients. The implementation of a supportive clinical culture along with the adaptation of policies that support nurses and promote safe practice can prevent future mistakes in caretaking. Systematic approaches to correcting medical malpractice errors using historical data can help to create a safer environment for patients as well as healthcare providers. The nursing profession can continue to benefit from all research that aims to create positive developments within practice for patient-centered care.

## REFERENCES

- Bono, Michael J., Wermuth, Harrison R., Hipskind, John E. (2021). Medical Malpractice. *National Library of Medicine*. <https://www.ncbi.nlm.nih.gov/books/NBK470573/>
- Hoffman, J. (2019). Nursing malpractice cases and lawsuit statistics. *CRICO*. <https://www.rmfi.harvard.edu/clinician-resources/newsletter-and-publication/2019/sps-april-nursing>
- McGowan, J., Wojahn, A., Nicolini, JR., (2022). Risk Management Event Evaluation and Responsibilities. *National Library of Medicine*. <https://www.ncbi.nlm.nih.gov/books/NBK559326/>
- Myers, L. C., Heard, L., & Mort, E. (2020). Lessons learned from medical malpractice claims involving critical care nurses. *American Association of Critical-Care Nurses*. <https://doi.org/10.4037/ajcc2020341>
- National Practitioner Data Bank. (2022). Map of NPDB Reports. *Data Analysis Tool*. chart. <https://www.npdb.hrsa.gov/analysisistool/>
- Paradiso, L., & Sweeney, N. (2019). Just culture: It's more than policy. *Nursing management*, 50(6), 38–45. <https://doi.org/10.1097/01.NUMA.0000558482.07815.ae>
- Pierce, L. (2019). Malpractice 101. *Colorado Nurse*, 119(4), 14–15. <https://misericordia.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=139774679&site=ehost-live>
- Siegal, D., Swift, J., Forget, J., & Slowick, T. (2020). Harnessing the power of medical malpractice data to improve patient care. *Journal of Healthcare Risk Management*, 39(3), 28–36. <https://doi-org.misericordia.idm.oclc.org/10.1002/jhrm.21393>
- Silva, Silva. (2019). Medical Malpractice. *Silva & Silva Attorneys and Counselors at Law*. [photograph]. <https://www.silvasilva.com/concerns-about-medical-malpractice-in-florida/>
- Zajicek, J. (2020). To Err Is Human, Unless You Are a Healthcare Provider. *Belmont Health Law Journal*, 4, 1-33. <https://heinonline.org/HOL/P?h=hein.journals/belhlj4&i=106>