BOOK REVIEW

Nursing Negligence: Analyzing Malpractice in the Hospital Setting. By JANET PITTS BECKMANN. Thousand Oaks, London, and New Delhi: Sage Publications, 1996. 272 pages; \$55.00 hardcover; \$25.95 paperback.

The risk management literature has been consistently clear: clinical issues aside, physicians can decrease the probability they will be involved in malpractice litigation if they maintain caring relationships with patients and their families. Janet Pitts Beckmann, in *Nursing Negligence*, adds another nugget of data to this by now conventional advice: interprofessional issues aside, physicians might further diminish their malpractice exposure by maintaining solid communication pathways with the nurses with whom they work. Irrespective of clinical site, Beckmann argues, malpractice suits that involve circumstances resulting either in a patient's death or in a life filled with profound disability almost inevitably include instances in which nurses failed to inform physicians of significant clinical changes, or physicians failed to heed their colleagues' warnings.

Beckmann's primary intent, however, is to call nurses and administrators' attention to the largely unexplored dimensions of hospital-based nursing malpractice. Recent data show that 75% of all malpractice incidents occur in hospitals and a "sizeable" portion of these claims are acknowledged to stem from the negligence of that amorphous group of practitioners known as "supervised health care personnel" (p. 3). Little else is known, and databases one might analyze are largely unavailable. Thus, Beckmann had to construct her own database of 747 federal and state civil court decisions and jury verdict reports (representing cases in 45 states) from the LEXIS-NEXIS network before she could even begin her qualitative and quantitative analysis of both the etiology of nursing malpractice and the mortality and morbidity associated with it.

Unfortunately, the first thing that strikes the reader is Beckmann's failure to address two critical issues in her unique database. Although she herself is (as is this reviewer) a registered nurse (RN), she never overtly clarifies whether the "nurses" in her database and subsequent analysis are also RNs. One might assume they are from her descriptions of their clinical practice and their professional responsibility. But, then again, in a changing health care system in which licensed practical nurses (LPNs) can administer some medications and treatments and nursing assistants, or, as they are now called, unlicensed assistive personnel, have increasing assessment responsibilities, one might as easily not. This is more than a quibble over a definition, as such clarification may be important to the legal accountability of RNs as clinicians with responsibility for their own and others' practices.

The lack of clarity about professional status also confuses the roles for which those in her database were held to task. We

simply do not know if nurses were sued as individual practitioners, if they were held accountable for the actions or inactions of those they supervised, if hospitals were judged liable for the actions of their nurse employees, or, as is increasingly likely, all scenarios were involved. Such a differentiation has important legal implications ignored in the book's final chapter. Nurses, whoever they may be, must do more than adopt efficient risk management strategies. They, as well as their medical and administrative colleagues, must also be aware that under the wrenching conditions of a lawsuit, their interests, those of other health care personnel, and those of their employing hospital may not always coincide.

Still, this particular critique does not diminish Beckmann's overall accomplishment. She presents impressive "hard" data to counter anecdotal reports, and her thoughtful analysis saves the reader from becoming overwhelmed by all numbers crunched. She begins with the aggregate data about nursing negligence in the hospital setting, which are quite sobering: in fully litigated malpractice cases, 29% of all instances of nursing negligence had caused or contributed to a patient's death, and 71% had resulted in significant patient disability (pp. 20-21). Further, two broad nursing care problem areas emerged from her data as responsible for the greatest number of adverse outcomes: inadequate communication with physicians about nursing assessment data (27%), and errors in medication administration (19%). The remaining problem areas (which do not sum to 100 because of rounding) were failure to properly perform nursing treatments and procedures (14%), inadequate patient-centered nursing assessments (14%), failure to provide a safe environment (13%), failure to use equipment properly (4%), and failure to control or prevent nosocomial infections (2%) (pp. 30-32).

As Beckmann points out in subsequent chapters, these numbers vary when one moves from the hospital writ large to its particular clinical units. She examines nursing malpractice separately in the emergency department, the psychiatric unit, the medical unit, the operating room, the recovery room, the surgical unit, the pediatric unit, the labor room, the delivery room, and the newborn nursery. Problematic areas shift somewhat in numerical priority. Malpractice involving equipment, usually surgical sponges, ranks higher in the operating room than on the psychiatric unit. There, priority of place shifts to malpractice involving inadequate nursing assessments—inevitably, assessments of changes in a patient's mental status. None of these data present any surprises. Rather, the surprises come from what remains the same. Irrespective of clinical site, inadequate communication with physicians—that is, nurses not telling physicians about pertinent clinical information—remains the single, most responsible antecedent for cases of nursing malpractice.

Now, the obvious question is why this communication problem should concern physicians and administrators as well as nurses (apart from the self-evident rationale that when one clinician is sued, everyone is sued). Beckmann does not address this issue. Her stated desire is that her work stimulate the nursing profession to face the reality of the need to maintain accepted standards (p. 282). As far as she is concerned, both the communication problem and its solution lie solely within nursing's domain. If we only reported significant changes in a patient's clinical condition to the physician, if we only refused to be hesitant

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about calling the physician in the middle of the night, if we only developed effective listening skills, and on and on, then we might save our patients and ourselves from the tragedy of adverse outcomes (pp. 268–269). There is, to be sure, something almost comforting in such functional advice. For however chilling her data may seem to nurses, they can also be seen as professionally empowering. Malpractice cases are, in the end, a statement about what it is that society holds the nursing profession accountable for in its practice. And given that society, through its tortuous legal mechanisms, has declared that certain areas—those such as communicating clinical findings, medication administration, and environmental control—are within our sole domain, we have a firm foundation on which to continue to hone our clinical responsibilities and to assert our disciplinary prerogatives.

But communication, in particular, is not and can never be the strictly functional process to which Beckmann reduces it. (Admittedly courts also reduce its complexity, interested as they are in determining only who knew what when.) Communication is an essentially social process, influenced as much by a nurse's assertiveness as by the organizational culture, the power relationships, and the interpersonal milieu within which he or she practices. It is, to borrow a popular phrase from other fields of risk management, a systems process—a comment on the ways institutions, or, in Beckmann's case, hospitals, support or impede the free flow of data.

An example might clarify this point. Nursing researchers have long discovered that expert clinicians depend heavily on what we term "intuitive" ways of knowing patients and their probable clinical courses. Such knowledge is, of course, built on a solid data-

base of both past and present patient encounters. But it is knowledge that often comes into play before "hard" clinical data do. That is, expert nurses sometimes just "know" their patient is souring before they have laboratory results or vital sign measures to support their assessment. Thus, they depend on a system that supports this way of knowing for their effectiveness. They need, in particular, organizational structures that allow the development of close, respectful, and trusting working relationships between them and their medical colleagues. Clinical intuition, of course, is not unique to nursing. Physicians need such structures as well. They also need to know that their hospital's organizational structure enables them to depend on nurses who, because they have practiced together over time, will acknowledge their concerns and act before their sense of an impending crisis becomes a clinical reality.

This, in the end, is why the communication issues raised in Beckmann's analysis of nursing negligence should be of such concern to those outside the discipline. It is not only our problem to solve. It is a social problem, representative of the ways in which nurses, who are the focus of this review, and physicians, for whom communication issues also loom large in their malpractice cases, feel empowered or defeated within a system. We will bear our responsibility in owning and correcting our participation in events—communication events and all others—that result in adverse patient outcomes. But we also call on others to bear their responsibility, and to own and correct their ways of participating in a system that all too often makes the simple acts of talking and listening so impossibly difficult.—**PATRICIA D'ANTONIO, RN, PhD,** *University of Pennsylvania, Philadelphia.*