

## Legal Issues in Maternal/Newborn and Women's Health

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GENERAL LEGAL  
NURSE/PHYSICIAN COMMUNICATION  
DOCUMENTATION/FAILURE TO RESCUE  
RISK MANAGEMENT  
POLICIES AND PROCEDURES  
INFORMED CONSENT  
CHILD PROTECTION

## Important To Remember

You spend more time and more important time with every patient – they rely on you. You are their assistant, caregiver, and the kind voice they hear through out the day.

Give them your full attention. Listen to their concerns and follow-up. They will remember you and your kindness. If you are talking amongst yourselves it should be only related to patient care.

Are You Important? You bet.

These factors are the key to the patient's success.

Key to the patient's life. So are you!

Listen and build a relationship.

## Biggest Reasons for Lawsuits Against Nurses

- ▶ Didn't communicate with MD.
- ▶ Didn't monitor or interpret fetal monitor strip.
- ▶ Didn't follow policies or guidelines.
- ▶ Documentation does not support care.
- ▶ Chain of command.
- ▶ Failure to follow physician orders
- ▶ Communication failure with patient, physician other nurses.
- ▶ Assessment and clinical judgment.
- ▶ Issues with discharge.

## Medical Malpractice Lawsuit

In a medical malpractice action, a plaintiff (patient or family member) must prove that the defendant (hospital or institution) breached a duty of care to the patient or plaintiff and that this breach was the reason for the injury.

Must show the generally accepted standards of procedure or practice that would be followed by the average competent practitioner under the same or similar circumstances (expert, policies and procedures)

## Proving Medical Malpractice

1. Complaint is filed by plaintiff alleging that a generally accepted standards of procedure or practice that would be followed by the average competent practitioner under the same or similar circumstances (expert, policies and procedures) exists.
2. That the defendant practitioner departed from these standards (evidence: medical records or witnesses).
3. The departure was the proximate cause of the alleged injuries or damage (medical expert).

## Negligence

NEGLIGENCE- IT IS OMITTING AN ACT OR DEVIATION FROM THE STANDARD OF CARE THAT A REASONABLY PRUDENT PERSON WOULD NOT OMIT OR COMMIT UNDER SIMILAR CIRCUMSTANCES. MERE FAILURE TO EXERCISE REASONABLE CARE.

GROSS NEGLIGENCE-IS THE LACK OF EVEN SLIGHT CARE OR A CONSCIOUS, RECKLESS, VOLUNTARY DISREGARD OF THE NEED TO USE REASONABLE CARE WHICH IS LIKELY TO CAUSE FORESEEABLE GRAVE INJURY OR HARM.

## ELEMENTS OF NEGLIGENCE CLAIM

Duty- The defendant owes a legal duty to the plaintiff under the circumstances.

Breach-The defendant breached that legal duty by acting or failing to act in a certain way.

Causation-It was the defendant's actions or inaction that actually caused the plaintiff's injury.

Damages-The plaintiff was harmed or injured as a result of the defendant's action.

## SCOPE OF PRACTICE

BOARD OF NURSING ACT PROVIDES FOR THE SCOPE OF PRACTICE

PROVIDE SAFE CARE WITHIN THE LIMITS OF NURSING PRACTICE AND TO AVOID THE RISK OF BEING ACCUSED OF PRACTICING MEDICINE WITHOUT A LICENSE

READ AND KNOW THE NURSE PRACTICE ACT

- ▶ Nurses roles have expanded as physicians spend less time at the bedside and rely more on Nursing Staffs to be their eyes and ears.
- ▶ OB is one of the most frequent areas for lawsuits.

## LAWSUITS AND NURSES

Lawsuits that involve nurses are usually civil cases that try to prove negligence and medical malpractice as we discussed. When you inadvertently fail to document that you provided the care as specifically outlined by an order or standards of care, you could be held negligent.

When you fail to document that you notified a physician of change in patient status you could be held negligent.

In order to receive punitive damages the Plaintiff must show that hospital or nurse was: reckless, willful or grossly negligent.

## NURSE'S RESPONSIBILITY

COMMUNICATE WITH HEALTH CARE TEAM-THIS IS CRUCIAL

DEVELOP A RELATIONSHIP WITH PATIENT- IMPORTANT MEMBER OF THE HEALTH TEAM.

MAINTAIN CLEAR, CONCISE, ACCURATE, COMPLETE, AND LEGIBLE DOCUMENTATION.

QUESTION APPROPRIATENESS OF CARE WHEN HARM CAN BE DONE TO PATIENT.

CHECK MEDICAL ORDERS FREQUENTLY. RESULTS OF TESTS. COMMUNICATE.

USE CHAIN OF COMMAND.

## From a Patients Viewpoint

How would you want to be treated by your nurse?

Was the nurse focused on patient?

Cell phones?

Non-work conversations?

How does this make you feel when you are the patient?

Is the patient the sole focus?

## COMMUNICATION WITH THE PHYSICIAN

Failure to call the doctor about a change in condition of the patient can be considered negligence.

You have a legal responsibility to intervene on behalf of your patient.

There are malpractice cases that have investigated the persistence to contact the physician.

Document if you called. Document if you got through. What you said what physician said.

Communication is a key factor in every case.

Communication Guidelines:

Provide the following:

Relevant history and demographic information

Chief complaint and associated problems

Physiologic status (vital signs, contractions, physical examinations)

Patient's responses to interventions and procedures

Presentation of the ongoing plan of care

Provide all findings requiring referrals, other tests, to team members

## NURSE AND PHYSICIAN INTERACTION

Almost one million dollars was paid in settlement as a result of a breakdown in communication by a doctor and a nurse. In this situation, the patient was instructed by her physician to report to the hospital after she complained of vaginal bleeding. As per hospital protocol she was placed on a fetal monitor which showed some variable decelerations. The woman underwent a cesarean delivery but the baby died within six hours after birth. An autopsy revealed asphyxia secondary to intrauterine bleeding from a tear in the umbilical cord. The physician claimed that the nurse did not inform him of the variable decelerations. The nurse on the other hand, was not aware that the patient had told the physician that she had experienced vaginal bleeding prior to her hospital admission as the bleeding had stopped once she was admitted. The inadequate communication between the physician and the nurse who each failed to adequately assess and communicate their concerns and findings resulted in the poor defensibility of this cases and an \$800,000 settlement.

Liability Issues in Perinatal Nursing, Donna Miller Rostant, Rebecca Cady, Lippincott, Chapter 20 Nurse Physician Communication, Christine A. Sullivan and Mary A. Bowden

## Case Examples

Nurse was found negligent in detecting signs of fetal distress and in failing to communicate an abnormal fetal heart rate pattern to the physician. The obstetrician was not notified of the abnormal fetal heart rate decelerations during a critical period when irreparable damage to the fetal brain had already occurred.

The obstetrician testified that the nurse's failure to inform him of the decelerations once they presented prevented him from intervening in a timely manner. Verdict over 3.5 million

Failure of the nurse to communicate all pertinent information to the physician resulted in a delayed diagnosis and cesarean section resulting in a neonatal death. Nurse told the physician about decelerations but not other symptoms. Patient had told the nurse that she felt a sharp pain followed by vaginal bleeding. Physician did not have all the information and ordered a cesarean section during which the ruptured uterus was found. Baby died and the nurse was found negligent.

## Failure To Notify Physician Of Abnormal Monitor Strip Readings

For more than an hour a number of different nurses caring for mother saw problems with fetal monitor tracings but, the physician was never notified.

Start of cesarean was delayed several hours and the infant was delivered with brain damage and cerebral palsy.

Court of Appeals of Louisiana approved a jury verdict in favor of the infant and family.

Eighty percent against the hospitals and nurses for negligence and twenty percent against the obstetrician for medical malpractice. *Johnson v. Morehouse Gen Hosp.*, \_\_\_ So. 3d. \_\_\_, 2009, WL, 4912390 (La. App., December 22, 2009) Referenced in *Legal Eagle Eye Newsletter For the Nursing Profession*, March 2010, Page 7

## USE CHAIN OF COMMAND

Nurses may encounter physicians who fail to respond to their nursing assessment of a patient's condition. The nurse may feel that the physician's response is not appropriate. It is the nurse's responsibility to the patient to take a positive action to intervene.

Most organizations use a chain of command where the nurse consents with the registered nurse then charge nurse, or director. And this chain usually goes to the chief medical officer or similar official.

Institutions have chain of command policies.

USE THEM-IT IS EXPECTED OF YOU.

You have a legal obligation to the patient.

This is the most requested policy.

## Importance of Communication

This is the single most important aspect of patient care. It is involved in almost every situation that results in poor patient care and even lawsuits.

Reasons for failure for communication:

1. Fear of communication with physician. (report concerns)
2. Waiting so as not to bother physician. Courtesy. NOT ALWAYS APPROPRIATE
3. Failure to persist.

4. Lack of documentation of communication. Failure to document pertinent communications.

5. Failure to initiate chain of command.

6. Failure to communicate among peers. Not just physicians. Oncoming nurses should thoroughly assess the patient record, history, progress when assuming care. Leaving nurse should ensure that the nurse's notes reflect up to date patient information. All pertinent information.

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## Lewis Blackman Requirements

Institutes a mechanism whereby a patient can request that a nurse call his or her attending physician regarding the patient's medical care. If so requested, the nurse must place the call and notify the physician and his or her designee of the patient's concerns. Patient has a right to access attending or physician on call. **Not just nurse practitioner or resident. Physician must respond promptly.**

## Documenting Is Everything



## Why is documentation important?

1. Continuation of Care/Quality Improvement
2. Defense Lawsuits
3. Physician Review
4. Legally required (JCAHO/SC LAW) and
5. Quality assurance/Hospital protocol and protocol
6. Insurance billing
7. Chronological Record

## Documentation

A study of 300 obstetrical medical malpractice cases showed that documentation was a critical factor in the situation itself and in the defense of the case.

In a courtroom even the finest care is hard to defend if not documented.

Why?

Poorly kept nursing notes suggest poor communication. And then poor care. Courts have held that poor documentation creates a presumption of poor care. Imagine yourself on the jury.

Ability to remember long after events take place. Statute of limitations.

## Issues With Documentation

Late entries

Inaccuracy

Corrections Versus Alterations

Incomplete Or Missing Records

Missing Fetal Monitor Records

Frequency Of Completeness

Fetal Monitoring Documentation

## ADMISSION ASSESSMENT

Reason for admission as stated by patient and events leading up to hospitalization

Date of last normal menstrual period, frequency of period, and results of early pelvic examination findings

Obstetric history, starting with the first pregnancy and including all pregnancies up to the current pregnancy

Past medical illnesses or surgeries

Family history, genetic, mental retardation, metabolic problems, multiple births

Talk to the patient. What is the complaint, concern, history. Listen to the patient. The patient or family member can tell you what you need to know about the patient?

Allergies, Drug Sensitivities

Exposure to viruses, bleeding, nausea and vomiting, infections and diseases

Substance abuse history

Weight changes

Exercise, sleep, elimination, hazardous agents

Vital signs.

## Admission Assessment Physical Examination

Review of prenatal history and allergies. Vital signs.

Abdominal palpation for estimated fetal size, position and presentation and determination of fundal height.

Review of diagnostic testing, blood work, procedures, and biophysical monitoring.

Measurements of height and weight.

Evaluation of the condition for which the patient is hospitalized

The medical and nursing admission assessments provide a overview of the patients status at the time of admission.

Documenting as much information as possible on admission will allow more informed decisions to be made about the plan of care.

Talk to the patient. What is the complaint, concern, history. Listen to the patient. The patient or family member can tell you what you need to know about the patient. Remember to COMMUNICATE.

Pelvic exam as indicated.

Comprehensive physical assessment of body systems.

## Ongoing Assessment

The nurse is responsible for ongoing assessment of the mother and fetus throughout the stages of labor.

Maternal physiologic status, labor progress and fetal well-being should be continuously monitored.

Warning! The patient who is admitted in labor and classified as "low risk" may not maintain that status throughout the labor and delivery process.

The nurse must assess regularly according to established standards and change the plan of care in order to meet the needs of the patient.

Nursing assessment includes vital signs, palpitation of the uterine fundus and observation of bleeding. Typically this assessment is done every 15 minutes during the first hour following delivery.

Patient responses and action taken.

## Case Of Documenting At End Of Shift

Day of possible discharge. Patient anxious to go home.

8:00 Nurse gets the vital signs and notes changes on her own documentation but does not chart until the end of shift at 5:00 pm

9:00 Physician meets with patient and nurse decides to discharge patient at noon. (Question here: what did nurse tell physician)

12:00 Patient discharged home.

5:00 Nurse enters vital signs and information into the record at end of shift.

9:00 Patient returns back to hospital and eventually passes away due to internal bleeding.

Case settles. Why?

## Discharge Documentation

1. Make sure patient knows discharge instructions.
2. Teach back.
3. **Still ready for discharge?**
4. Call physician if changes.
5. Has the correct equipment?

## Documentation Do And Don'ts

1. Check that you have the correct chart before you begin writing. Document date, time of the care and who is providing care.
2. Check to make sure you have the right patient.
3. Record observations. Detailed.
4. Write legibly and neatly and if typing reread for accuracy.
5. Document as soon as possible after providing care.
6. Document chain of command used.
7. Document conversations with physicians in detail and time.
8. Use accepted clocking mechanism.
9. Use quotes.
10. Occurrence Reporting. Do not document in the record that you did an occurrence report.
11. Do not chart ahead
12. Do not change inappropriately

## Hand Off

- ▶ **Situation:** patient name, room number, admission date, physician
- ▶ **Background:**
- ▶ **Assessment:** Biophysical and or psychosocial assessment, abnormal vital signs, pain score,
- ▶ **Recommendations:** Concerned about? Watching? Need to do? Warning signs?

## The Most Common Hospital Mistake/ MSNBC NEWS

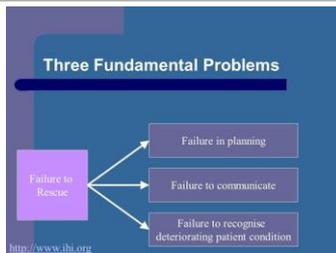
**Before Code Blue: Who's minding the patient?**

Little-known 'failure to rescue' is most common hospital safety mistake.

Failure to rescue (FTR) refers to a death after a treatable complication. The rate of FTRs in surgical patients derived from routine administrative data is recognised as an important indicator of patient safety by the United States' Agency for Healthcare Research and Quality.



## Failure to Rescue



## Life in a High Consequence Industry



## High Reliability— Five Key Principles

### Sensitivity to Operations

- Focus on systems and processes and how they affect patient care.

### Reluctance to Simplify

- Systems are made simple, but the explanation for failure is rigorously pursued and understood.

### Preoccupation with Failure

- Relentless pursuit of perfection and a constant search for what might go wrong.

### Deference to Expertise

- Information is freely shared and staff are engaged.
- In a crisis, the person with the most expertise leads.

### Resilience

- The organization quickly contains and mitigates errors.

## Error Reporting Helps Providers Learn About:

Risks: hazardous conditions hidden in process.

Actual errors: errors that occur during patient care.

Causes of errors: underlying weaknesses in systems and processes that explain why an error happened

Error prevention: ways to prevent recurrent events

Studies in several industries indicate that there are 50 and 100 near misses for every accident.

## Subpoena

If you receive a subpoena contact your legal or risk management office immediately.

Different types of subpoenas: There are two different types of subpoenas. One requires records and one requires testimony.

Cannot ignore. There is a deadline set forth on the subpoena.

Specific laws regulate what information may be released with a subpoena and what will require a court order. But a response is required. Work with your legal or risk management office to determine what information you may release or if you have to appear in court or in a deposition.

## Deposition

The opposing attorney has a right to take your deposition. This means that you will be put under oath just as you would be in court, and an attorney will ask you questions relating to this case. The attorney's question and your answers will be taken down by a court reporter. Your attorney will also be present. No judge will be present. You cannot ask your lawyer questions during the deposition.

Your testimony may be used in court. Listen carefully to each question. Answer only the questions asked. You have to answer verbally. You may request that the question be repeated and you may request a break. Do not argue with the attorney. If you do not recall or do not know the answer the best answer is to state that you do not remember or that you do not know.

## INSTITUTIONAL POLICIES, PROTOCOLS AND PROCEDURES

Institutional policies and procedures are considered part of the standard of care that a nurse will be held to follow.

Follow policy, procedure, and protocol established by the institution. If the physician requests deviation from the institution's policy, procedure, or protocol, ensure that the physician writes the order.

What are the hospital or clinic policies? Make sure you know the hospital or clinic policies and have reviewed the ones that apply to your area of practice.

## Policies, Protocols and Procedures Case

**Delivery and labor nurses allegedly failed to follow hospital protocols during childbirth, which is believed to have caused irreversible brain damage to the baby.**

Medical malpractice and negligence team secured a large settlement for a family whose baby was born with irreversible brain damage due to alleged delivery nurse negligence. The settlement secured is sufficient enough to enable the family takes care of the child for the rest of his life.

**During the delivery, nurses allegedly failed following the hospital protocol on giving the patient Pitocin – a drug used to augment labor.**

The hospital's Pitocin policy simplifies the delivery and makes fetal injury impossible. Nurses are provided with a checklist that is to be completed before the administration of Pitocin and after. The aim of the policy is to ensure the correct administration of the drug that may otherwise cause excessive uterine contractions.

In the specific situation, the nurses did not follow the hospital protocol. The law firm posited that this resulted in excessive uterine contractions that contributed to fetal distress, which is why the baby was born with brain damage.

Pitocin is a synthetic branded version of oxytocin – a hormone that induces labor in the female body. Its use is recommended in the case of pregnancies that last for more than 41 weeks and high blood pressure at full term. At the same time, the synthetic version of the hormone is highly potent. It makes the delivery process faster and much more forceful.

## Informed Consents

Informed Consent is the responsibility of the physician. Not the form but the consent. If the patient has not discussed with his or her physician. **STOP**- get the physician and get the consent.

- 1. Patient's diagnosis
- 2. General nature and purpose of the Contemplated Treatment
- 3. The potential benefits and probable outcome of the treatment. What the treatment would involve including complications, discomforts or complications
- 4. The material risks involved and potential problems related to recuperation
- 5. Likelihood of success associated with treatment
- 6. Possible result if treatment is not given
- 7. Existence of any significant alternative methods.

**DOCUMENT INFORMATION GIVEN TO PATIENT**

## Patient is Unable to Consent

This means the patient is unable:

- to appreciate the nature and implications of the patient's condition and proposed health care,
- to make a reasoned decision concerning the proposed health care or to communicate that decision in an unambiguous manner.
- This definition **does not** include minors unless they are married or judicially emancipated.

## Certification by Two Physicians. Persons who may Consent.

A patient's inability to consent must be certified by two licensed physicians who examined the patient.

Physician must give an opinion regarding the cause and nature or inability to consent and whether or not it is permanent.

If a patient is not able to consent the order of persons able to consent is in Adult Health Consent Act.

1. A guardian
2. An attorney-in-fact appointed by the patient in a durable power of attorney and health care power of attorney.
3. Statutory power.
4. A spouse of the patient unless separated and divorced.
5. An adult child./majority
6. A parent
7. Sibling/majority
8. Grandparent, grandchild.
9. Any other relative by blood or marriage

## Emergency Situation

***In an emergency*** the patient's inability to consent may be certified by a health care professional responsible for the care of the patient if the health care professional states in writing in the patient's record that the delay occasioned by obtaining certification from two licensed physicians would be detrimental to the patient's health.

## When Health Care can be Provided Without Consent

Healthcare may be provided without consent to a patient who is unable to consent if no person authorized to make health care decisions for the patient is available immediately, and in the reasonable medical judgment of the attending physician

there is a substantial risk of death, serious permanent disfigurement, or loss or impairment of organ, or bodily member or other serious threat to the health of patient.

## Minor's Consent to Health Services

**SECTION 63-5-340.** Minor's consent to health services.

Any minor who has reached the age of **sixteen years may consent to any health services from a person authorized by law to render the particular health service for himself and the consent of no other person shall be necessary unless such involves an operation** which shall be performed only if such is essential to the health or life of such child in the opinion of the performing physician and a consultant physician if one is available.

## Married Minors Consent

**SECTION 63-5-330.** Married minors consent to health procedures.

The consent of a married minor or, if a married minor be unable to give consent by reason of physical disability, then the consent of the spouse of the married minor to the performance by any licensed medical, surgical or dental practitioners, or any hospital, or their agents or employees, of any lawful diagnostic, therapeutic surgical or postmortem procedure upon or in respect to such minor or any minor child of such minor, shall, notwithstanding the minority of such minor, be valid and legally effective for all purposes and shall be binding upon such minor, his parents, spouse, heirs, executors and administrators as effectively as if such minor or the spouse of such minor were eighteen years of age.

## Legal Capacity of Minors

Minors who have had a child do not become emancipated. Minors with children may consent to the health care of their children but, may not be able to consent for their own healthcare.

**SECTION 63-5-360.** Minor parent consent to health services for child.

Any minor who has been married or has borne a child may consent to health services for the child.

## Health Services to Minors Without Consent

**SECTION 63-5-350.** Health services to minors without parental consent.

Health services of any kind may be rendered to minors of any age without the consent of a parent or legal guardian when, in the judgment of a person authorized by law to render a particular health service, such services are deemed necessary unless such involves an operation which shall be performed only if such is essential to the health or life of such child in the opinion of the performing physician and a consultant physician if one is available.

## Mother Refuses Treatment

If fetus is viable then must contact DSS and work towards a delivery.

“Viability” means that stage of human development when the fetus is potentially able to live outside of the mother’s come with or without the aid of artificial life support systems. For the purposes of this chapter, a legal presumption is hereby created that viability occurs no sooner than the twenty-fourth week of pregnancy.

## C-Section Issues

Many lawsuits occur when the patient and the physician are determining whether or not to have a c-section and when to go ahead and have the c-section.

A woman was in labor and under the care of an obstetrical resident. The patient later brought charges of malpractice as a result of an alleged delay in performing a cesarean section. The plaintiff and her experts felt that due to repeated decelerations, prolonged drops in the fetal heart rate, and meconium staining, a cesarean should have been performed sooner. The physician stated that he advised the mother that the cesarean was needed at 3 and she withheld the consents. It came down to minutes and the nurses’ notes indicated that he asked at 3:45. She consented right after 4. Award for mother. Child suffered from profound mental retardation.

## Mandatory Reporting

▶ **SECTION 63-7-310** South Care Code Of Laws:

- ▶ Persons required to report.
- ▶ (A) A **physician, nurse, dentist, optometrist, medical examiner, or coroner, or an employee of a county medical examiner’s or coroner’s office, or any other medical, emergency medical services, mental health, or allied health professional, member of the clergy including a Christian Science Practitioner or religious healer, school teacher, counselor, principal, assistant principal, school attendance officer, social or public assistance worker, substance abuse treatment staff, or childcare worker in a childcare center or foster care facility, foster parent, police or law enforcement officer, juvenile justice worker, undertaker, funeral home director or employee of a funeral home, persons responsible for processing films, computer technician, judge, or a volunteer non-attorney guardian ad litem serving on behalf of the South Carolina Guardian Ad Litem Program or on behalf of Richland County CASA must report in accordance with this section when in the person’s professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused or neglected as defined in Section 63-7-20.**

## REPORTING

**SECTION 63-7-390.** Reporter immunity from liability.

A person required or permitted to report pursuant to Section 63-7-310 or who participates in an investigation or judicial proceedings resulting from the report, acting in good faith, is immune from civil and criminal liability which might otherwise result by reason of these actions. In all such civil or criminal proceedings, good faith is rebuttably presumed. Immunity under this section extends to full disclosure by the person of facts which gave the person reason to believe that the child’s physical or mental health or welfare had been or might be adversely affected by abuse or neglect.

**SECTION 63-7-410.** Failure to report; penalties.

A person required to report a case of child abuse or neglect or a person required to perform any other function under this article who knowingly fails to do so, or a person who threatens or attempts to intimidate a witness is guilty of a misdemeanor and, upon conviction, must be fined not more than five hundred dollars or imprisoned not more than six months, or both.

## PHOTOS AND X-RAYS

**SECTION 63-7-380.** Photos and x-rays without parental consent; release of medical records.

A person required to report under Section 63-7-310 may take, or cause to be taken, color photographs of the areas of trauma visible on a child who is the subject of a report and, if medically indicated, a physician may cause to be performed a radiological examination or other medical examinations or tests of the child without the consent of the child’s parents or guardians. Copies of all photographs, negatives, radiological, and other medical reports must be sent to the department at the time a report pursuant to Section 63-7-310 is made, or as soon as reasonably possible after the report is made. Upon written request of the consulting care physician or the hospital facility and without consent of the child’s parent or legal guardian, the primary care physician shall release the medical records, radiologic imaging, photos, and all other health information only to the consulting care physician and the hospital facility. The consulting care physician and the hospital facility only may release the records to law enforcement in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.512(b).

## DSS REPORTING

A report to DSS should be made when a health care provider has reason to believe that a pregnant woman, with a viable fetus, is abusing an illegal substance and the underlying conduct is not only illegal but also may be placing the fetus at a substantial risk of harm. However, testing of the mother requires consent.

In *Whitner v. State of South Carolina*, 328 S.C. 1, 492 S.E. 2d 777(1997) cert denied 523 U.S. 1145, 118 S.Ct. 1857, 140 L.Ed2d 1104 (1998) the South Carolina Supreme Court held that pregnant women who risk harm to their viable fetuses may be prosecuted under the state child abuse laws. This case specifically targeted women who use illegal drugs during pregnancy. Held that a viable fetus is a child for the purposes of the South Carolina child abuse and child endangerment statute.

## Ferguson v. City of Charleston

### 532 US 67, 2001

- ▶ The US Supreme Court in *Ferguson* held that a maternal drug test without consent of the mother and reporting positive test results to the police is unconstitutional.
- ▶ It was found by the Court that the drug screen is a "search" covered by the Fourth Amendment and required a consent by the patient.
- ▶ It is important to get the mother's permission prior to getting a drug screen so this may be reported if positive. After, delivery may use baby's drug screen however, better to get this information earlier in pregnancy.

## Testing and Consent

- ▶ Therefore, maternal drug testing and reporting the results to the police or DSS cannot be done without the mother's consent to the drug screen. However, if the mother consents to testing or the baby tests positive after birth then the health care worker would report suspected cases of illegal drug use by a pregnant woman (24 weeks or greater) The absence of drug testing does not eliminate responsibility for mandatory reporting. Check with your hospital attorney and hospital policy.

## Withholding Health Care Minor

**SECTION 63-7-950.** Withholding health care.

(A) Upon receipt of a report that a parent or other person responsible for the welfare of a child will not consent to health care needed by the child, the department shall investigate pursuant to Section 63-7-920. Upon a determination by a preponderance of evidence that adequate health care was withheld for religious reasons or other reasons reflecting an exercise of judgment by the parent or guardian as to the best interest of the child, the department may enter a finding that the child is in need of medical care and that the parent or other person responsible does not consent to medical care for religious reasons or other reasons reflecting an exercise of judgment as to the best interests of the child. The department may not enter a finding by a preponderance of evidence that the parent or other person responsible for the child has abused or neglected the child because of the withholding of medical treatment for religious reasons or for other reasons reflecting an exercise of judgment as to the best interests of the child. However, the department may petition the family court for an order finding that medical care is necessary to prevent death or permanent harm to the child. Upon a determination that a preponderance of evidence shows that the child might die or suffer permanent harm, the court may issue its order authorizing medical treatment without the consent of the parent or other person responsible for the welfare of the child. The department may move for emergency relief pursuant to family court rules when necessary for the health of the child.

(B) Proceedings brought under this section must be considered child abuse and neglect proceedings only for purposes of appointment of representation pursuant to Section 63-7-1620.

(C) This section does not authorize intervention if the child is under the care of a physician licensed under Chapter 47, Title 48, who supports the decision of the parent or guardian as a matter of reasonable medical judgment.

## Daniel's Law

Safe Haven for newborns. Named for a baby that survived being buried in an Allendale County Landfill soon after birth.

Daniel's Law allows infants under the age of 60 days to be left in the physical custody of a hospital employee without the disclosure or identity of person leaving infant.

Law also establishes procedures and protections for the hospital and DSS. Hospital must take physical custody of the infant.

Must inform the person leaving the infant of legal consequences and attempt to get as much information as possible to help treat infant. Must inform DSS within 24 hours.

DSS will publish notice in paper within 48 hours of taking custody regarding baby and must file a petition for a permanency planning hearing to be held within 30 to 60 days.

Intent is to save babies and not harm or punish anyone.

## Sources

South Carolina Code of Laws/Case Law

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