

To : Scott Hicks  
Director, Teaching & Learning Center

From : Astrid Oviedo  
Assistant Professor, Department of Nursing

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Re : Teaching Legal Aspects of Nursing Practice Using Jurisprudence  
Grant for Excellence in Teaching and Learning Awarded March 2020

Date : 20 January 2021

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This is our report on the grant we received from the Teaching & Learning Center to conduct our project, Teaching the Legal Aspects of Nursing Practice Using Jurisprudence. We wrote a total of six (6) legal case studies (Appendix A to F). These legal case studies were implemented in the following courses:

Undergraduate Level

NUR 2020 Critical Thinking in the Nursing Discipline  
NUR 3150 Adult Health I  
NUR 4000 Nursing Research  
NUR 4150 Psychiatric-Mental Health Nursing

Graduate Level

NUR 5320 Classroom Teaching and Integration of Technology  
NUR 5110 Policy, Organization and Financing of Healthcare

NUR 2020. The legal case study was on a patient who died of pulmonary embolism and the students were asked the question, was the nurse liable for negligence. This case study illustrates the concept of proximate cause and the 4 elements of professional negligence. See Appendix A.

NUR 3150. The legal case study was on a patient with diabetic ketoacidosis and the students were to discuss if there was a reckless disregard of the patient's rights by the nurse and what would they have done if they were the nurse. This case study illustrates several concepts: recognizing the signs and symptoms of diabetic ketoacidosis, advocating for a patient and communicating with the provider and delegation to non-medical personnel. See Appendix B.

NUR 5320. The legal case study related to a student in a school of nursing who was expelled. The reason for her expulsion was related to her clinical performance and possibly her above-average body mass index which might have prevented the student from adequately performing in the clinical setting. This illustrates the concept of the academic rights of students.

NUR 4000. The legal case study involves a clinical trial where the question arises if adequate informed consent was given. This case study illustrates the concept of informed consent and especially what information must be disclosed in order to have valid informed consent.

NUR 5110. The legal case study involves an employee at a meat processing plant in which the employee was injured. The legal question arises if the employee received adequate health care from the provider and clinic staff. This case illustrates the need for clear policy regarding injury and understanding of negligence when developing policy that regulate employee health.

NUR 4150. The legal case study related to the psychiatric needs of a client post hospitalization. This study illustrated several aspects: need for timely care, legal and ethical principles associated with clients with psychiatric histories, clinical judgment and medications.

Evaluation by the students of including the legal aspects of nursing practice in the curriculum and using jurisprudence was good. A total of 163 students responded to the post-case study survey (see Table 1). Students comments regarding the legal aspects of nursing practice included the following:

- This practice involving the topics on the legal aspect of nursing practice was truly a thought-provoking and learning experience from me and I cannot wait to see what is in store next in the future.
- I really liked the legal case because when you think of nursing never does it come to first mind about laws and legal cases it opened my eyes to a different part of health care and I enjoyed learning about the material.
- I want to either teach, be a patient and or legal advocate, work in nursing compliance or the public school system with my BSN. So, the legal aspect of nursing is extremely important to my future career.
- Case was informative and helped bring forward learned material from lecture.

Table 1. Results of Survey on the Evaluation of the Topic (legal aspects of nursing practice) and Teaching Method (case study using jurisprudence)

Survey question	Mean
Topic. Rate the importance of the topic, legal aspects of nursing practice (or education, as the case may be), to your current or future practice as a nurse. - Not at all important, 0 to 100%	89.3
Problem-based learning. How would you rate this method - problem-based learning, in engaging your critical thinking skills from narration of the facts of the case, to forming your own decision, and rationalizing your own verdict or decision. - Not engaging my critical thinking skills, 0 to 100%	85.9
Legal case study. Please rate the teaching material - that is, the use of actual court decisions - in learning a legal aspect of nursing practice as compared to or in addition to lecture, reading textbook, and other media). - Not useful in my learning, 0 to 100%	80.2
Intellectual curiosity. How has the combined use of problem-based learning and a legal case study help engage your intellectual curiosity? - No intellectual curiosity, 0 to 100%	84.8
In learning the legal aspects of nursing practice, how important do you think is it to use an actual legal case as an illustrative example or as a teaching material? - NOT at all important, 0 to 100%	87.2
Would you like to see more topics on the legal aspect of nursing practice in your nursing courses?	77% Yes 23% No

Based on the findings from this survey, most students are interested in having exposure to more legal aspects of nursing practice in the future. The importance of these topics is well appreciated by the students and thus leads us to believe that developing a course designed with legal aspects of nursing practice and health care ethics would be beneficial to students seeking professional careers in nursing as well as other degrees within the College of Health Science. This course can be offered by the Department of Nursing (DON) under Special Topics with the potential for expansion later. This would be offered as a 3-credit hour course. Currently the DON already has a designated NURxxx for a special topics course. This could facilitate the DON moving forward with another special topics course entitled Legal Aspects of Nursing Practice and other Health Professions.

## Appendix A

Course: NUR 2020, Critical Thinking Course

You must post before you are enabled to see your classmates' posts.

You must reply to at least one other post. Your reply must be substantive content. An "I agree" or "great post" is not a substantive reply.

### **The Case**

On November 13, Wanda underwent bilateral breast reduction surgery at XYZ Medical Center. Dr. Angel performed the surgery, which lasted about two hours and forty-five minutes and ended at 3:00 p.m. At about 7:30 p.m. that evening, Wanda experienced cramps in her legs. A nurse examined her legs and concluded that all signs were negative for the presence of blood clots. The next morning, Wanda was examined by Dr. Fisher and released from the hospital.

On November 15, approximately fifty-one hours after the surgery, Wanda collapsed in her home. She was rushed to XYZ Medical Center by ambulance. Wanda was pronounced dead minutes after arriving at XYZ Medical Center.

An autopsy revealed that the cause of her death was a massive pulmonary embolus. A pulmonary embolus is a blood clot that develops in the body, travels through the arterial system, and lodges in the pulmonary artery, blocking the blood supply to the lungs and, potentially, triggering a fatal cardiac incident.

Wanda's daughter, Winnie, filed a case against XYZ Medical Center alleging that the hospital's negligence proximately caused Wanda's death because UMC had not placed anti-embolic stockings on Wanda before the surgery.

At trial, a doctor testified that anti-embolic stockings help to prevent blood clots and should be used if a patient is to be under general anesthesia for longer than thirty to forty-five minutes. This is because the patient's immobility during general anesthesia can cause blood clots in the legs. In Wanda's medical records, there was no documentation showing that the stockings had been used during her surgery. However, a nurse recalled that they had been used and said that she had forgotten to document it on the intraoperative records.

The surgeon, Dr. Angel, testified that when he arrived in the operating room he was unable to see if Wanda was wearing the stockings because her body had already been draped. He testified that anti-embolic stockings have been shown to reduce the incidence of blood clots in the deep veins of the legs during surgery. However, he said that no study showed that anti-embolic stockings could reduce the risk of a fatal pulmonary embolus. Dr. Angel opined that, though he orders anti-embolic stockings for his patients, the use of the stockings is not required by the standard of care and, therefore, UMC did not breach the standard of care.

A doctor testified on behalf of plaintiff, Winnie, that in his opinion, Wanda had been at an increased risk for developing a pulmonary embolus because she was morbidly obese, was taking birth control pills, and had undergone a surgery lasting over thirty minutes. He testified that the standard of care required the use of anti-embolic stockings during any surgery lasting over thirty minutes and, especially, for a patient with Wanda's other risk factors. He stated that it was

documented in medical literature that anti-embolic stockings aid blood circulation and prevent blood clots from forming in the deep veins of the legs. He said that blood clots in the deep veins of the legs are a type of clot that can break off and travel to the lungs.

### **What you need to know**

#### *A. The 4 Elements of professional negligence*

To prove a negligence claim, a plaintiff must show ALL of the following:

- (1) The existence of a duty on the part of the nurse/physician to conform to a specific standard of conduct;
- (2) Breach of that standard or duty;
- (3) Injury/damage resulted
- (4) The breach of the duty was the proximate cause of the plaintiff's injury.

Lacking one of the 4 elements automatically means there is NO professional negligence.

*B. Review Chapter 7, especially the sections on a) assuming a causal link (p. 90), checking the relationship (p. 91), and necessary conditions (p. 93).*

### **Question and Instructions**

Is the hospital / nurse liable? For now, assume that the hospital and nurse are one. That is if the nurse is liable, then the hospital is. If the nurse is not liable, then the hospital is not liable.

If your answer is: Yes, the hospital is liable. Provide rationales / reasons / arguments to support your answer for each of the 4 elements (duty, breach, proximate cause, and damages/injury).

If your answer is: No, the hospital is not liable. Cite which among the 4 elements is missing or lacking.

## Appendix B

Course: NUR 3150, Adult Health I

### Facts of the Case

**Day 1:** Mr. H1C was booked in a XYZ Detention Center. After having been informed that H1C was diabetic, an officer sent detainee H1C to see Nurse RN. Nurse RN went ahead and interviewed detainee H1C regarding his medical history. Per A1C, he had liver problems and hypertension. A1C's reported that his last medical appointment was a month prior to his arrest/detention and it was on this visit that he had a follow-up care for his diabetes for which he was given by his primary provider a sliding scale. Detainee A1C told nurse RN that he had not taken insulin for a month and that he was confused about when to take insulin. Detainee A1C also explicitly told nurse RN that there was nobody who could bring him insulin while he was in jail. Nurse RN then took detainee's A1C random blood sugar and it was 270 which was down from 280 upon his arrival and booking. Nurse RN wrote these readings on her progress notes plus her notation that "it was a little high" and that "it may be due to alcohol and drugs" and that the detainee was "alert and oriented x 4". She then faxed her progress notes (including the medical history) to doctor MD. Nurse RN recommended to MD that A1C's blood sugar be taken ACHS (ante cebum and hora somni, before meals and before bedtime). Nurse RN then implemented standing orders to give A1C carbohydrate-restricted diet (a standing order) and ACHS Accu-checks. Nurse RN also called A1C's providers who both said that the last time that they had seen A1C was 4 months prior. Right before she clocked out, nurse RN left clear instructions to the officers to monitor detainee A1C's blood sugar.

**Day 2.** At 6 AM, A1C's blood sugar was 250 which was reported to the MD. At 2:30 PM, A1C's blood sugar was 330 but Nurse RN did not report this to the MD. At 5:40 PM, detainee A1C was not feeling well and so an officer took him to see nurse RN. Detainee A1C reported feeling nauseous and had a vomiting episode. A1C reported that he felt agitated but denied that his blood sugar "was acting up." A1C denied increased thirst or increased urination or hunger, urination – none of the "classic" symptoms. He denied having any headache. Nurse RN concluded that detainee A1C was detoxing and placed him in a medical observation cell where he would be monitored by video and regularly observed in person by the officers. Nurse RN did not observe anything unusual other than the vomiting and so before she left, she told the officers to monitor detainee A1C and his blood sugar level.

**Day 3.** At 4:00 AM., detainee A1C reported to the officers that he was having chest pains. Ten minutes later, an officer observed A1C trying to make himself throw up (putting a finger against his throat) . Then, at 6:20 AM, an officer escorted A1C to the medical wing so that staff could test his blood sugar. A1C refused to have his blood sugar taken but reported chest pain and that his blood pressure was "out of control". Detainee A1C declined repeated offers throughout the day for nurse RN to take his blood sugar. Before nurse RN left her shift, she again instructed officers to "observe and keep an eye" at detainee A1C. Officers observing detainee A1C noted

that everything was "ok" until 10:15 p.m., when an officer observed detainee A1C attempting to make himself throw up (by putting his finger up against his throat). Then, at 10:45 p.m., an officer found detainee awake and breathing but unresponsive. An ambulance was called. The ambulance arrived several minutes later, but A1C stopped breathing "just seconds before" EMS (emergency personnel) entered his cell. The EMS took detainee A1C to the local hospital, where he died of diabetic ketoacidosis, with a blood sugar level of 1600 mg/dl.

One of the rules in the detention stated that inmates were responsible for providing their own insulin and that a nurse would secure it for detainees only if a doctor wrote a prescription.

Detainee A1C's brother filed this case against nurse RN and the officers of the XYZ detention center for inadequate treatment and reckless disregard of A1C's medical needs.

### **Instructions and Questions**

Briefly answer this: Do you think there was reckless disregard by nurse RN of A1C's medical condition? Why or why not? Please elaborate what you would have done if you were the nurse. Many cases like this boils down to what is called the "standard of care." In other words, what would a prudent nurse in a similar situation do?

Please don't ask me about other facts of the case. If you need to make assumptions in order to answer the question, then please state your suppositions or qualify your answer by all means. Answer in no more than 8 sentences. 10 sentences would be my absolute maximum; that is, no credit will be given for any point made beyond the 10<sup>th</sup> sentence. ☺ 15 points.

**Disclaimer:** This case study is for purely educational purposes only.

## Appendix C

Course: NUR 5120, Teaching in the Classroom and Integration of Technology

In this discussion board, you need to do an initial post first before you are able to see other students' posts.

As you may well realize, admission to nursing school is competitive. After being admitted, staying in nursing school is not easy either. Exams are high-stakes and clinical performance is at stake. Most students incur huge debts to complete nursing school. In such a high-pressure environment, friction and disagreements between students and faculty are likely. Grade appeals and student grievances come with the territory. A nurse educator's conduct should be above suspicion and beyond reproach in all areas - during lecture or clinical rotations, in giving evaluation and assessment, in the content and coverage of her examinations and so forth. Please read the case below and answer the questions that follow. It illustrates what we, as nurse educators, should be mindful of: student's rights.

### *The Case of a BSN Student with an above-average Body Mass Index*

**Disclaimer.** This case is for academic purposes only. This should not in any way be a guidance or the basis for any act or omission on your part as a nurse or nurse educator.

**Narration of Facts.** Early on Student Rose had already set her eyes in nursing school. She applied only to colleges with a nursing program. Upon her admission to XYZ college in 2001, student Rose indicated on her application her intended major, nursing. Likewise, in her admission interview she reiterated her intention of pursuing her bachelor's degree in nursing. Eventually she was accepted to XYZ College's Department of Nursing during her sophomore year. As with all admitted students, Student Rose was given the nursing student handbook with the understanding that requirements stated therein must be met for successful completion of the nursing program.

It is not denied student Rose was an overweight woman. On her application to XYZ College, Rose stated that she was 280 pounds and 5 feet 1 inch. Her student health records in College XYZ showed that she weighed between 290 and 310 pounds. It is on record that during her time as a student in XYZ College her weight did not considerably go below 300 pounds.

According to Student Rose, upon admission to the nursing program that was when infliction of emotional harm on her started. The first incident was when an administrator stated in public that they would have a difficult time finding a set of uniforms that would fit her. In class, she was used as a patient to illustrate how to do bed-making while an obese patient was in bed. And there were other similar incidents e.g. getting vital signs on obese patients.

In her junior year, the Department of Nursing had student Rose sign a "contract" that she would attend Weight Watchers and show proof of her attendance record in the Weight Watchers meetings. Student Rose promised to attend the weekly Weight Watcher sessions but refused to sign the contract. Also that junior year, student Rose failed a clinical component of a course for



reasons that were related to her weight and not her clinical performance. That was the only course student Rose failed.

According to the handbook, failure in a clinical course entailed expulsion from the program; however, the school officials offered student Rose a deal. She was asked to and student Rose did sign a contract below:

#### *Contract*

*I, student Rose, agree to the following conditions for continuing in the nursing program.*

- *Maintain a minimum weight loss of 2 pounds per week effective immediately*
- *Report to Professor ABC every Friday morning with evidence of progress in weight loss.*
- *Maintain academic standing as required.*

*I understand that failure to meet any and all of these conditions will result in my voluntary and immediate withdrawal from the nursing program.*

After failing to lose weight per the terms in the contract, student Rose was expelled from College XYZ right before her senior year and she transferred to another school. She eventually graduated from the second nursing school but Student Rose had to repeat a year because of the second school's 2-year residence requirement.

Student Rose, now a nurse, sues XYZ College for damages on breach of contract, loss of wages for the extra school year and infliction of emotional harm. Student Rose alleges that XYZ College had the duty to educate her while she paid her tuition and school fees, maintained her part of the contract which was the responsibilities contained in the student handbook. XYZ alleges that Student Rose voluntarily signed the contract and voluntarily transferred to another school.

#### **Questions and instructions.**

1) How would you decide the case on the breach of contract, loss of wages and infliction of emotional harm. Would you render judgment in favor of the college or the student? Justify your answers.

2) Respond to at least one other post.

3) You also need to do the Qualtrics survey which is an evaluation of this case study. The link to the survey is under this week's module.

## Appendix D

Course: NUR 4000, Nursing Research

Instructions:

- 1) you will not be able to see the discussion board until after your first post.
- 2) Please click on your own group. Which is your group? Your group is named after the first author of the article assigned to you. This discussion board has nothing to do with your article. You just have to click on your author to make the discussion group smaller and more meaningful and manageable.
- 3) This is a graded discussion. 5 points for your initial post. 5 points for a substantive reply.
- 4) You may use outside references/resources.

### Summary of Facts

In 2006, there was an outbreak of bacterial meningitis in the Philippines. XYZ Pharmaceuticals a drug company based in the United States was, at the time of the outbreak, seeking FDA approval of Noproboxacin, a new antibiotic, for its use in children. Learning about the outbreak, 3 American doctors flew to the Philippines to meet with Philippine doctors at the ABC Hospital where dozens of Filipino children with bacterial meningitis were hospitalized. After seeking Institutional Review Board (IRB) approval from ABC Hospital, the Filipino and American doctors recruited 200 Filipino children with bacterial meningitis (admitted to ABC hospital). The 200 children were randomly put into 2 groups: 125 children were in the experimental group who received the Noproboxacin, and 25 children were in the control group who received Ceftriaxone, an FDA-approved antibiotic whose safety and efficacy for the treatment of bacterial meningitis in children was established. After 2 weeks when the experiment concluded, XYZ pharmaceuticals and its doctors left. No follow-up care was given to the children. Upon the conclusion of the experiment, 10 children had died. Four of the children had been taking Noproboxacin and 6 had been taking Ceftriaxone. Many other children were left deaf, blind, paralyzed or with brain-damage.

Plaintiffs (the party suing) are the parents of the 10 children who died as a result of the clinical trial and the parents of the other children who were left deaf, blind, paralyzed and with brain-damage. The plaintiff parents contend that: 1) the children on Ceftriaxone were deliberately given less than the effective dose to make it appear that Noproboxacin was more effective 2) XYZ Pharmaceuticals knew that Noproboxacin had never been used on children and its use on animals had life-threatening side effects which included liver damage among others 3) XYZ Pharmaceuticals failed to disclose the experimental nature of the study 4) XYZ Pharmaceuticals failed to disclose to the parents the side effects or risks of Noproboxacin 5) XYZ Pharmaceuticals failed to inform them that Doctors without Borders was providing treatment free of charge at the same hospital and 6) the informed document was not read to them and if it was read to them it was not in Filipino, their native language.

### Question

Provide a checklist of processes/procedures/documentation you would have taken to ensure that informed consent was properly obtained and that would have prevented this litigation/case to be brought forward.

## Appendix E

### **Course: NUR 5110 Policy, Organization, and Financing Health**

In this discussion board, you need to do an initial post first before you are able to see other students' posts.

As you consider the role of the nurse and your role in the Advanced Practice Role, you must have a firm grasp on Policy, Organization and Finance. The reality is that individuals need to work and that they expect when they seek advice from those in the medical profession that they are receiving accurate data and guidance. Individuals rely on professionals in healthcare to abide by the rules governing them and to follow through with the information provided. Please read the following case below and answer the questions that follow. It illustrates what we as nurses should be mindful of: accountability and understanding of our practice.

The case of an injured plant worker and the care received.

Disclaimer. This case is for academic purposes only. This should not in any way be a guidance or the basis for any action or omission on your part as a nurse.

Narration of Facts: Janice is an employee at a meat processing plant ABC. According to Janice on June 26, 2013 Janice was hit by a pallet jack on the back of her left ankle. She received a deep laceration on the back of her left ankle, near her Achilles tendon. As soon as the injury happened she presented to the medical clinic. She was treated by J. Gooden (nurse) who "packed the torn tissues and Achilles tendon back in the area of the wound and placed steri-strips to hold the laceration together." Janice then returned to her job and finished her shift. On June 27th, Janice returned to the medical clinic and was seen by the nurse. Janice alleges that she had swelling, bleeding, and pain at the site of the wound. Janice returned to work and completed her shift. On or about June 28th, Janice once again returned to the medical clinic and was treated this time by T. Todd (a nurse), Janice continued to have swelling, bleeding, and severe bruising and edema around the wound. A telephone order for an X-ray of her left foot was ordered. Janice went to Hospital XYZ, where the x-ray was taken and Janice subsequently returned to work at ABC processing plant. Janice continued to have bleeding, severe, edema, and swelling at the wound site. Janice reports that she never saw a doctor at the medical clinic and was not referred to once during any of her visits to the medical clinic. On July 5, 2013 Janice presented to Hospital XYZ due to continued bleeding, severe edema, swelling, and pain at the site of injury to her left ankle injury. Janice was transferred to Hospital CDE with a diagnosis of complete Achilles tendon tear and specific ankle. After treatment at Hospital CDE Janice needed continued treatment from various providers to fight infection and to heal her left ankle.

Janice filed a lawsuit on September 15, 2014 claiming negligence in providing her care and treatment and as a result of the negligence of those caring for her at the medical clinic caused her damages in excess of 10,000.00.

Questions and instructions.

- 1.) How would you decide the case of negligence. Would you render judgement in favor of Janice (the plaintiff) or the defendants Nurse T. Todd and J. Gooden? Justify your answer.
- 2.) Respond to at least two post.

3.) You also need to do the Qualtrics survey which is an evaluation of this case study. The link to the survey is under this week's module. Please complete this once you have completed the discussion board.

**Appendix F**  
**Course: NUR 4150 Psych/Mental Health Fall 2020**

Please read and respond based on the information provided in the information below to receive credit for the assignment. This counts as a quiz grade.

Legal Case for Response:

Take everything that you have learned this semester into consideration while reading the following legal case. At the end you will determine what a ruling in the case. You will justify your answer, using your knowledge and a scholarly article to help you determine your ruling. This case and your responses count as 1 of your quiz grades. Please take the time to respond appropriately and have a critical discussion with your peers regarding the legal and ethical issues you find in this case.

Disclaimer. This case is for academic purposes only. This should not in any way be a guidance or the basis for any action or omission on your part as a nurse.

**Narration of Facts:**

A 49-year old woman was attacked while at work at a psychiatric clinic. Her attacker was a patient, a schizophrenic woman who had become paranoid, psychotic, and convinced that someone was following her and possibly trying to kill her. The patient entered the clinic, filled out some paperwork, and then pulled a butcher knife out of her handbag and repeatedly stabbed the staff person. The employee suffered wounds to her hands, arms, face, eyes, torso, heart, lungs, liver, bowels, buttocks, and vagina, and she lost her eyesight as a result of the attack. The patient had a well-documented history of chronic schizophrenia and noncompliance with medication. She had a history of violent behavior. Her last psychotic attack resulted in involuntary commitment. During her hospitalization she did not recognize the need to take medications. She was assessed as a moderately high risk of danger to others. She was released to the care of a community psychiatric clinic and saw an NP there. The NP had not reviewed the patient's history completely and lowered the dosage of antipsychotic medications because the woman said she did not like taking medications. A coworker witnessed the event and observed that her colleague suffered from disembowelment and eye gouged out.

The injured worker sued the clinic.

You are the nurse hearing this case in court. Consider all the information provided to determine if the worker is justified in her suit and why. Answer the questions below to help you make a final ruling on the case.

Questions and instructions. This assignment counts as one of your quiz grades:

- What legal and ethical issues are evident in this case and why?
- How would you decide the case of mishandling of medication? (what information is needed to decide the case?)
- Would you render judgement in favor of worker (the plaintiff) or the defendant the Nurse Practitioner (NP)? Justify your answer (use a scholarly journal article to justify your response).

- What are key items the provider (NP) have taken into consideration or have been concerned about during her interaction with the client?
- What actions by the provider (NP) may have contributed to the injuries the worker sustained?

To receive full credit for this quiz you must:


- Respond to at least two post with scholarly evidence to support your response.
- Provide 4 areas the NP should have addressed related to client medication

You also need to do the Qualtrics survey (link will be provided) which is an evaluation of this case study. The link to the survey will be added to the week module. Please complete this (survey) once you have completed the discussion board.

## Books Purchased

	Book	Price
1	Nurse Practitioners Business Practice and Legal Guide	98.43
2	Legal Nurse Consulting Practices, 3 <sup>rd</sup> Edition	107.62
3	Essentials of Nursing Law and Ethics	132.65
4	Legal and Ethical Issues for Health Professions	63.18
5	Legal Issues Confronting Today's Nursing Faculty: A Case Study Approach	10.69
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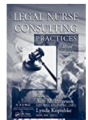
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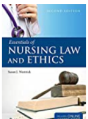
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