Journal of Healthcare Management and Leadership
Year:2023, Sayı: 1, 72-79

Sağlık Yönetimi ve Liderlik Dergisi
Yıl:2023, Sayı: 1, 72-79

JOURNAL OF HEALTHCARE MANAGEMENT AND LEADERSHIP (JOHMAL)
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SAĞLIK YÖNETİMİ VE LİDERLİK DERGİSİ

E-ISSN: 2667-5838 | https://dergipark.org.tr/tr/pub/johmal | **Paper Type:** Research Paper, **Makale Türü:** Araştırma Makalesi

Sayı:3, Nisan 2023 | **Issue:**3, April 2023 | **Received Date / Geliş Tarihi:** 24/01/2023 **Accepted Date / Kabul Tarihi**: 11/04/2023

THE RESPONSIBILITY OF NURSES IN TEAMWORK
From The Establishment of The Professional Figure to The Position of Guarantee and The Principle of Entrustment

Atıf/ to Cite (APA): Palladino, F.P. and Pusadaini Thapa, P. (2023). The Responsibility of Nurses in Teamwork from The Establishment of The Professional Figure to The Position of Guarantee and The Principle of Entrustment, Journal of Healthcare Management and Leadership (JOHMAL), (1), 72-79.

DOI: https://doi.org/10.35345/johmal.

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ABSTRACT

Since the very beginnings of the role of the nurse, this profession has undergone notable changes thanks to a structured framework of normative as well as formative development which has meant that nursing has become an intellectual and autonomous role requiring in-depth subject knowledge and competencies.
Within the Italian healthcare system and elsewhere, the nurse is a crucial figure, an integral and integrated part of the professional healthcare teams whose responsibilities require a deeper awareness and knowledge of their role. To gain a better understanding, it is essential to look at the historical evolution and see how nursing has gone from being considered 'manual' work, to what it is today - a highly-skilled, socio-professional role, with all the qualifications, competencies, autonomous decision-making powers and responsibilities that such a role demands - whether dealing with patients, or within the healthcare teams. It follows, therefore, that such 'intellectual professionals' must be fully aware of their professional responsibilities and that these must be appropriately assimilated, as well as juridical concepts of responsibility.
Although this report is brief, I sincerely trust that such a personal and hermeneutical approach may encourage all within the profession to put into practice and continually improve upon the fundamental principles that are in place to ensure the health and well-being of the patient.
Keywords: Teamwork, Responsibility, Nurses

INTRODUCTION

Aspects such as ethics, professional autonomy, skills, and responsibility, are aspects that the nurse has always faced in his daily life. So much so that, in recent years, thanks to and above all to the changes that have taken place with important regulatory institutes that have regulated its educational and especially professional development, we have moved from what was called for the nurse "auxiliary

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activity" The Court of First Instance held that the Court of First Instance had jurisdiction to rule on the question of whether a medical profession had exercised a dominant position for many years, to the full legal and formal recognition of that profession and its legal and social validity.
In fact, as is well known to all and thanks to the (T.U.L.S Gazzetta Ufficiale, 1934) no. 1265 of 27 July 1934 (Gazzetta Ufficiale, 1940)S Official Journal (Gazzetta Ufficiale, 1974)), the nurse was considered as a subordinate and auxiliary of the doctor and seen for the most part as a mere executor of services taking shelter, facing the possible assumption of responsibility, behind the high and imposing protective wall established by Royal Decree No. 1310 of 2 May 1940 (2) (Official Journal, 1940), which in addition to limiting the scope of the nurse's work only and exclusively in the hospital, outlined in detail and unequivocally the tasks mostly addressed to the request for services by the doctor. Subsequently, thanks to the D.P.R. 225 of 14.03.1974(3) (Official Journal, 1974), which updated the aforementioned R.D. No 1310, it extended the space of action of the nurse in the territorial area and the concept of "implementation of rules and provisions" mentioned in art. 1-lett. A of the job description outlined in R.D. No. 1310, updated and replaced with the concept of "scheduling" of the 1974 job description, favoring the nurse an approach to work and its subsequent implementation to a more autonomous form.

LITERATURE - STUDY and RESEARCH

Alongside the primordial form of professional autonomy that arose in the 1974 job description, in addition to the function of "mere executive", the characters or "distinctive attributes emerge" of the profession together with the function of a timely and comprehensive approach to the needs of the patient with the organization of its work plan and professional integration with other health professionals highlighting the collaborative traits and responsibilities and, to comfort, to art. 1 of the above-mentioned D.P.R. No 225, are subsequently integrated 3 further paragraphs concerning more specifically the team activity, promote initiatives of competence and perform any other task related to their functions(4) (Cantarelli & Frati (Cantarelli & Frati, 2009, p. 21) "that *person or individual who interacts constantly in a group or with society and constitutes its matrix that performs its socio-professional functions through a network of formal and informal relationships".*
Subsequently, the substantial abolition of any form of subordination to the medical profession occurred with the D.M. No 739 of 14.09.1994. Still, the definitive turning point that has allowed the repeal of the job description and has outlined to date the distinctive features of one of the most important professions in the health sector was Law n. 42 of 26.02.1999. Unprecedented, L.42/99 has given the nurse the much-desired professional autonomy without any kind of job and, in addition to further widening the operational boundaries, It also identified the skills that should be sought in the training of the professional profile and the code of ethics, avoiding to overrule the skills provided for other health professionals. From the aforementioned regulatory institution of 1999, the scope of operation as well as the concept of professional autonomy was further implemented by Law No. 251 of 10.08.2000 and, to date, the nursing profession is in all respects part of the intellectual health professions with its own autonomy and specific skills. Inevitably and with autonomy and skills, from this historical moment, a greater knowledge of the concept of professional responsibility and awareness of the role was born in every Nurse.
From the *constitutional roots of Article 32 and* ius novum (Giurisprudenza rilevabile presso la banca dati della corte Suprema di Cassazione) detectable in the database of the Supreme Court of Cassation). As mentioned in a previous article, we wish to reiterate that attributing the guarantee position has led to a greater burden (Pavich, 2013, p. 213) 213). To better *understand this concept, every professional has*

to control their working environment by eliminating any source that could generate potential risks with the intent to protect the "good health" - constitutionally protected - from any form of danger that could undermine its integrity, since the position of guarantee that permeates the professional fabric of every health care, is also based on art. 40 c.p. co. 2 according to which "not to prevent an event that you have the legal obligation to prevent, is equivalent to cause it".

Therefore, the conduct violated by the health professional to a prohibition imposed by law, takes on particular criminal importance substantiating itself in an action, that form of conduct that constitutes active conduct generating the C.D. crimes commissioner; or the omission, that is that conduct that is configured in passive or inactive behaviors that emerge from the lack of action or reaction substantiating in the c.d. crimes. The homicidal conduct, in turn, finds a very close correlation to the event through the "causal link". This correlation has been the subject of several doctrinal elaborations where the most known is the c.d. theory of "conditio sine qua non ***or equivalence of causes", according to which*** every single condition without *which the event would not have occurred is* the cause of the event, subdivided then, in two important categories: proper *and improper* crimes.To be clearer, in the kind of homicidal offenses of its own, it includes all those crimes such as the failure to help or the omission of a report; on the other hand for misconduct improper crimes which, include all those crimes that are based in the ratio of the norm referred to in art. 40 c.p. in which the committee, which has the role of guarantor of the protection of the protected good, also responds to the results related, derived or caused by its failure to take action, for example a health care that voluntarily, for negligence, inexperience or recklessness generates an injury or causes the death of a patient he should have treated.

The continuous evolution of legislation and progress in the health field, combined with the multiple specializations of health professionals, has generated as a natural consequence in the contemporary healthcare reality an approach to diagnostic performance-multidisciplinary therapy also legitimized by the latest scientific advances. Well, what is important to point out as the main focus, in addition to the constitutional principles consecrating the guaranteed position and the personality of criminal responsibility, is first of all, to frame and define a medical team as a professional and multidisciplinary cooperation between several health professionals, arising from synchronous or diachronic activities where each component involved, following the regulatory institutes in force, to be able to pursue the success of the health service (Mattarolo & Cester, 2007)). Under what has just been defined, it does not appear at all to integrate the concept mentioned above distinguishing three different forms of team: 1) the department team, in which doctors cooperate - synchronously or diachronically - according to an organizational model of a hierarchical nature; 2) the team in the strict sense, relating to the form of multidisciplinary synchronic cooperation; 3) the team in the broad sense, involving the simultaneous cooperation of professionals putting in place heterogeneous interventions at different stages of health treatment. *A* further *and optimal delineation of this structural distinction, to avoid exasperated and unnecessary "fragmentations"* of responsibility, within each type of team described above, is placed as an organizational principle (Marasco, Zenobi, & Cipolloni, 2012) (Canestrari, Giunta, Guerrini, & Padovani, 2009) (Palma, 2009) (Fiori & Marchetti, 2009) (Veneziani, I delitti colposi, 2003) the " (Sentenza Corte Cassazione n° 11208/2017, 2018) safety-risk that (Sentenza Corte Cassazione n° 30998, 2018) principle carries genetically, It is important to point out that in the health service provided in teams and not only - as stated by doctrine - are ascribed all those prodromiche activities detrimental to legal assets protected, identified as "risky activities legally authorized".And it is precisely in the bed of these activities considered "risky", authorized, and convergent that the principle of entrustment finds its natural operation. Moreover, it is appropriate to emphasize that the healthcare professional is always required to identify and choose - according to the surriferita diligence - the best possible solution for the patient in compliance with the C.D. "obligation of behavior"(8) (Marasco, Zenobi, & Cipolloni, 2012)

(Canestrari, Giunta, Guerrini, & Padovani, 2009) (Palma, 2009) (Fiori & Marchetti, 2009) (Veneziani, 2003) expecting the scrupulous application of the general or sector guidelines that do not always represent a discharge of liability from professional fault(9) (Judgment of the Supreme Court n. 11208/2017, 2018) sometimes requiring a higher standard of diligence(10) (Judgment of the Supreme Court No. 30998, 2018).

The conceptualization of the principle (Fineschi, 1989), refers to *the division of responsibility in health* care (Chiapusso, et al., 2014), multi-subjective cooperation with different competencies where, by the rule of law and professional diligence required. Every professional is not only obliged by specific legal obligations towards the patient to perform his performance/ task but is also required - while trusting in the cooperation of cohorts and according to the principle of guarantee - to supervise controlling the the performance of the functions of other operators competing in care and to facilitate any reporting if it perceives the occurrence of an error or an event resulting from fault(12) (Chiapusso, Sordo, Genovese, Magon, Steffano, & Vercesi, 2014). Concerning the division of responsibilities described in this way by the doctrine, the majority case-law is opposed in that the Court of Cassation is more inclined to a broader concept of the team by referring to that term to all the various types of integrated multidisciplinary health cooperation, applying the same evaluative character related to the assessment of personal criminal liability outlining the main aspects of team responsibility in three fundamental criteria:

1. All the services carried out in teams are to be understood as multi-personal activities competitors, therefore, any criminal liability of the operators is part of the culpable cooperation, without prejudice to the operator's awareness of a particular unlawful or culpable supply (13) (COST. (Cost.) (2009) (2009) (2009) III, 2009);
2. Because of the profile, role, and competencies acquired, the criteria for attributing liability for fault are subject to specialization but above all to the competence and experience gained by the operator (14) (IV, (2004) (2009)
3. These are health activities and services provided to users, in accordance with the principles of guarantee and in view of the experience and skills acquired, is to be (Todeschini, 2016) (2004) (2015));

in order to better understand the contents of the above summary, according to the case-law and the specific *guarantee obligation regulated by the objective imposition of specific precautionary obligations anchored in the proper performance of the duties of professional expertise and diligence to which every healthcare professional is a recipient, the latter appears to be relieved of the burden of compulsory supervision of the professional behaviour of others, thus being able "to devote himself to the specific* tasks of the curative treatment designated with due exclusivity and concentration" (Mantovani, 1997) (Forti G. , 1981) (Giovine, 2003) (Bisacci, 2009) (Palma A. , 2016) (Marinucci & Marrubini, Profili penalistici del lavoro medico-chirurgico in equipe, in temi, 1968)) (Marinucci & (2006), 2006) because, in the (Belfiore, 1986) of the personal guarantee obligation, The subjective extension of liability remains when the person who relies is already at fault for having violated precautionary rules or having omitted prudential conduct trusting that other professionals, in different capacities and roles, eliminate the infringement or remedy the omission.

For this purpose, also, the current jurisprudential guidelines, while sharing the effectiveness of the principle of trust, recognize in the latter the operational limits that emerge from concrete circumstances attributable to an incorrect, inadequate and unreliable behavior of the professional and connected to the specific obligation and role arising from the hierarchical position of the team leader in preventing and correcting the work of others (18) (Belfiore, 1986) . Therefore, the principle in question fulfills a mere function of delimitation of the obligations of diligence incumbent on each participant in the risky

interactive activity, relieving each subject from harmful events deriving from the non-compliance of others but responding only for violation of its own rules “cautelari”. Difatti, se ogni singolo professionista – con autodeterminazione responsabile - fosse obbligato ad un così rigoroso obbligo di controllo verso gli altri operatori, vanificherebbe la finalità terapeutica della prestazione dovuta.(19) (Iadecola) (Marinucci & Marrubini) (IV, 1989) (IV, 1996)(Martinelli, 1197) (Strong, 1996).

CONCLUSIONS and RECOMMENDATIONS

Remaining on the subject of culpable imputation, the principle of assignment is an excellent regulatory criterion concerning the subdivision of work in the health sector but, if the need is found to go into detail carefully in identifying the more specific criteria, it is necessary to return to the so-called Roxinian criterion, i.e. the distinction introduced by Claus Roxin between “common duties and divided duties”. The dichotomy of these two forms of duties is essentially characterized by the fact that among the " common duties," there are all the duties that create in favor of the user a double guarantee to protect good health and non-compliance can result only and exclusively by all the professionals involved in the care process; otherwise, the " divided duties" base their guarantee on the obligation imposed on the partner or individual professional involved in the healthcare service, on the simultaneous observance of the duty of diligence related to the acquired competence and experience(20) (Belfiore, 1986). According to what has just been reported, the duties incumbent on each of the subjects participating in the performance of the surgical intervention as a team can be considered " divided" , even if - it is appropriate to point out - the intensity of this division could in practice be different: a second indeed, of the circumstances in which the aforesaid activity is carried out . For example, suppose a team surgery involves the activity of several primary operating surgeons exclusively. In that case, the division of duties, moreover on the same burden, will be total, and none of those mentioned above participants in the surgery will have to worry about controlling the activity performed by others.
Instead, as very frequently happens, it is a surgical operation carried out by a surgical team structured in a "hierarchical" way - it being understood that in this case, the division of roles means that each of the participants in the team as mentioned above must concentrate fundamentally on the correct performance of one's role, disinterested in controlling the work of others – the phenomenon of the division of " duties ", will always remain attributable to the person who coordinates and directs the activity of the entire team(21) (IV, 2014) (IV, 2015) (IV, 2016). In fact, in this regard, it is important to reiterate that the aforementioned principle, used as a limit to the duty of diligence attributable to each of the team members, favors the definition of the spheres of responsibility of the individual participants in the work process limited within the specific sector covered and secured by the performance of each(22) (Vero) (Fiadanca & Musco). In this way, each doctor in the team will only be responsible for the correct fulfillment connected to the duty of diligence and expertise entrusted to him without being burdened with the obligation to supervise the behavior of the other team members but to verify their correctness. According to the majority jurisprudence, all this does not represent an alienation of one's responsibilities in the multi-subjective integration in the therapeutic scenario without prejudice to the rules imposed by the law artist. The basic rule is that each operator in carrying out multidisciplinary team cooperation is liable only and exclusively for non-compliance with the "rule" closely connected to the law artis of one's specific sector and competences, an "exception" made only and exclusively in the hypothesis relating to the perception - due to the functional connection - of all those factual circumstances that can be invoked for non-compliance with the precautionary "rules" imposed(23) (IV C. C., 2008). What has just been stated, to protect the health and life of the patient correlated to the

observance of the principle of the personality of criminal liability, if the aforementioned non-compliances are found, an alternative "diligent" behavior is required linked to the "duty of control" of the healthcare provider, without any sectorial nature of the tasks and compatibly with one's wealth of knowledge and technical skills; this regime is described by the doctrine as the principle of the so-called " tempered or relative " entrustment(24) (Marinucci & Marrubini, Profili penalistici del lavoro medico-chirurgico in equipe, in temi, 1968).

Moving towards the conclusions, the aforementioned " duty of control" - included in the so-called "secondary relational duties" (25) (Mantovani, 1997)- which arises as a result of the termination of the operation of the principle of assignment, is to be implemented only and exclusively in concrete incomplete circumstances of the expectation of reliability of others, and would really represent a precautionary rule, aimed however not directly at avoiding the harmful event, but at neutralizing a dangerous conduct of others which could in turn generate a harmful event. As a comfort, as reported in the doctrine, it appears necessary to observe that when, exceptionally, the principle of entrustment does not operate, the aforementioned relational duties take over, which can be distinguished in 1) synergistic or complementary obligations: aimed at coordinating the conduct of a subject with that of others; 2) ancillary obligations: aimed at neutralizing that other interveners exploit their conduct in a harmful way; 3) heterotropic obligations: which instead constitute obligations of control or information addressed to third parties and come into relief when there are relationships of superordination or subordination between cooperators(26) (Cornacchia, 2011). Also, as a comfort, the jurisprudence, with particular regard to ascertaining the causality of the fault, in all those cases in which it has found the impossibility of configuring a team responsibility, has repeatedly crystallized the procedural need to reconstruct the lawful conduct o suitable alternative to prevent a harmful event by proceeding with the assessment of the causal link for the event that occurred, also assessing the conduct of the person who was required to comply with the duties as mentioned earlier in relation to the duties mentioned above (27) (IV C. C., 2014). (IV C. C., 2015) (Veneziani, Casualità della colpa e comportamento alternativo lecito in Cassazione Penale, 2013).

With reference to the observations presented, a key concept emerges for the healthcare professional which must necessarily lead us to reconsider our role and to foster greater awareness as, in all cases in which there is an integrated multidisciplinary cooperation carried out between several professionals, there is unlawful as well as inappropriate conduct, the professional who plays the role of guarantor is called to wait not only for due professional diligence but also for those relational precautions that are dutiful and necessary to neutralize any form of risk and danger for the patient's safety.

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