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The Nursing Profession in the 1990's: Negligence and Malpractice Liability

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THE NURSING PROFESSION IN THE 1990'S: NEGLIGENCE AND MALPRACTICE LIABILITY

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I. INTRODUCTION

Nursing is maturing into an increasingly advanced, sophisticated, specialized, and independent profession. Consequently, nurses are confronting new challenges and undertaking additional responsibilities. The nurse’s role in providing patient care clearly is expanding—especially as a response to the insistent demand for additional and more cost-effective health care.

Traditionally, a distinct division existed between a nurse and a physician. The nurse functioned within a very delimited framework. Rather than diagnose, treat, or prescribe medication (activities definitely performed by physicians), it was sufficient for the nurse to wait for and then undiscerningly obey the physician's order. Indeed, it was unprecedented for a nurse to question a physician's order. The nurse was expected to assist the physician and not question the practice or competency of a physician.

The role of the nurse has been recast remarkably. Conventional notions concerning the division of responsibility between physicians and nurses are disappearing. The locus of authority for patient care decision-making is diffusing. Today, many of a physician's traditional functions are undertaken by nurses who frequently operate independently of a physician. In many instances the nurse's responsibilities have been increased to encompass the actual examination, diagnosis, and treatment of a patient without any direct supervision by a physician.

The nurse's expanded role in patient care, the higher acuity level of hospitalized patients, the continual development of highly specialized and sophisticated medical technology, the heightened emphasis on independent nursing practice, and the evolution and maturation of nursing into a "profession" will thrust nurses into positions of increased accountability. A corresponding rise in legal liability will inevitably result.

Nurses currently are more noticeable and will appear in the courtroom as expert witnesses, defendants, and most commonly, as co-defendants with hospitals and other health care providers. Nurses naturally are concerned with their potential legal liability and consequently will procure more and greater malpractice insurance. As a direct result of increased coverage, however, patients' attorneys will more frequently name and sue nurses individually as defendants in a lawsuit.

Since expanded responsibility portends increased liability, a thorough understanding of the law must be achieved for nurses' rights to be adequately protected and for nurses to be held properly accountable for their legal obligations. This work examines the legal rights, responsibilities, and particularly the potential legal liability of the nurse, in the contexts of modern nursing practice and current statutes and caselaw. The work focuses on one major aspect of the nurse's legal liability - the tort, or civil wrong, of negligence.

The first major part of the work defines key legal concepts and terms, discusses the elements of the tort lawsuit of negligence, and explains important tort rules. The standard of care required of the nurse and the sources of that standard are analyzed. Many nursing functions and responsibilities have been the subject of court treatment, thereby providing authoritative guidelines as to the proper standard of care. Examples from the caselaw are provided to illustrate how nurses can contravene the applicable standard of care. The standard of care for nurses who practice in specialized roles is examined. A negligence lawsuit is differentiated from a malpractice action. The necessity, use, and qualification of expert witnesses are addressed. Technical, complex, yet crucial, legal doctrines regarding proof of the violation of the standard of care and the required causation between such a violation and the ultimate harm to the patient are explained.

The work demonstrates that certain standards of care, and thus types of negligence, are specific to nurses. Accordingly, the second major part of the work examines the rights, responsibilities, and potential tort liability of nurses with respect to frequently encountered categories of nursing negligence, such as the failure to observe, to assess, to communicate, to follow orders, and to intervene.³

II. THE TORT OF NEGLIGENCE

A. Introduction

Negligence is defined as a duty or obligation to conform to a certain standard of conduct; a breach of that duty; a causal connection between the breach and an injury; and the presence of actual injury.⁴ In order for a patient-plaintiff to prevail, he or she must prove that the defendant-nurse⁵ was negligent—i.e., he must prove all of the elements of negligence. Until the plaintiff can do so, the nurse is presumed to be free from negligence and therefore free from any tort liability.⁶ The negligence plaintiff must prove his case by a "preponderance of the evidence," that is, sufficient, credible, probative evidence to convince a jury that the essential allegations in the lawsuit are more probably true than not.⁷

³For the purposes of this work, the term "nurse" refers to a registered professional nurse, licensed to practice nursing under applicable state law, as well as nurses practicing in expanded roles such as nurse practitioners and nurse anesthetists.

⁴For a general discussion of tort law see W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 30, at 164-65 (5th ed. 1984).

⁵See, e.g., *White v. Touro Infirmary*, 633 So.2d at 755; *Simmons v. United States*, 841 F. Supp. 748, 750 (W.D. La. 1993); *Berdyck v. Shinde*, 613 N.E.2d 1014, 1020 (Ohio 1993); *Miles v. Box Butte County*, 489 N.W.2d 829, 838 (Neb. 1992); *Anderson v. St. Francis - St. George Hospital*, 614 N.E.2d 841, 847 (Ohio Ct. App. 1992); NURSE'S HANDBOOK OF LAW & ETHICS 202 (Stanley Loeb & Matthew Cahill eds., 1992); Elizabeth J. Armstrong, Note, *Nursing Malpractice in North Carolina: The Standard of Care*, 65 N.C.L. REV. 579, 580 (1987).

⁶*Gibson v. Bossier City Gen. Hosp.*, 594 So.2d 1332, 1342 (La. Ct. App. 1991) (parents of deceased baby failed to sustain burden that neonatal nursery nurses failed to properly monitor and observe baby and failed to timely diagnose and treat baby's hypoglycemia); *Cohen v. Albert Einstein Medical Ctr.*, 592 A.2d 720, 723 (Pa. Ct. Super. 1991) ("In order to establish liability . . . , the plaintiff was required to establish by competent evidence that the alleged injection was given in a manner which was negligent and that the injection was a legal cause of the injury.").

⁷See *Dixon v. Taylor*, 431 S.E.2d 778, 782 (N.C. Ct. App. 1993); *White*, 633 So.2d at 759 (acknowledging that plaintiff's burden in a medical malpractice case is to prove by a preponderance of the evidence that the treatment fell below the ordinary standard of care and that there was a causal relationship between the negligent treatment and a resulting injury).

B. Duty

1. Introduction

The existence of a legally recognized duty is essential in any negligence claim. Some relationship must exist between the defendant and the aggrieved plaintiff for a court to find that the defendant was under a legal duty to conform to a certain standard of conduct and to exercise reasonable care to safeguard the plaintiff's person and property.⁸ Accordingly, before a nurse can be deemed negligent for his or her action or inaction, there must be a determination that the nurse owed a duty of care to the plaintiff.⁹

⁸See, e.g., *Poluski v. Richardson Transp.*, 877 S.W.2d 709, 713 (Mo. Ct. App. 1994) ("In order to prove actionable negligence, a plaintiff must establish the existence of a duty on the part of a defendant to protect the plaintiff from injury."); *Porter v. Lima Memorial Hospital*, 995 F.2d 629, 633 (6th Cir. 1993) (finding no liability where nurses had no independent duty after the accident); *Simmons*, 841 F. Supp. at 750 ("Medical professionals owe a duty to avoid acts or omissions which they reasonably foresee could result in injury."); *Downey v. Mitchell*, 835 S.W.2d 554, 555-56 (Mo. Ct. App. 1992); *Koeniger v. Eckrich*, 422 N.W.2d 600, 602 (S.D. 1988); *Vassey v. Burch*, 262 S.E.2d 865, 867 (N.C. Ct. App. 1980); KEETON ET AL., *supra* note 4, § 53, at 356-59.

⁹In *Poluski*, 877 S.W.2d at 713, an argument against liability was made based upon the absence of a duty by and between plaintiff and defendants. In particular, defendant nurses argued that the plaintiff had been discharged and, as such, the patient was no longer under the nurse's care. The court found that even though the patient was leaving the premises, the nurses still had a duty to intervene when they saw the patient being improperly transported by the ambulance service. *Id.* In *Downey*, 835 S.W.2d at 555-56, the plaintiff alleged that three registered nurses failed to review a patient's medical records which indicated that the patient did not consent to the performance of a tubal ligation. When the tubal ligation began, the nurses did not intervene. *Id.* at 556. The court found that . . . "Nothing in [precedent] imposes a duty upon the nurses to review the records of a patient's consent to surgery and to intervene during the course of the surgery if the surgeon begins to exceed the bounds of such consent." *Id.* Because the plaintiff's . . . petition failed to allege facts showing a duty on the part of the nurses, the trial court did not err in dismissing the complaint."

In *Walling v. Allstate Ins. Company*, 455 N.W. 2d 736, 738 (Mich. Ct. App. 1990), the decedent, a minor, was taken to the hospital after consuming liquor, becoming ill, and vomiting several times. *Id.* An emergency room nurse noted that, although decedent appeared to be in pain, she had no trouble speaking and her speech was clear. *Id.* The nurse subsequently informed the decedent that the hospital would need permission from her parents before she would be treated. *Id.* The decedent, however, refused to disclose her parents' telephone number, and the nurse, hoping the girl would change her mind, left her alone. *Id.* Once the nurse left the room, the decedent left hospital and subsequently died in a house fire that night. *Id.* The court held that the trial court did not err in finding that defendant hospital had no common law duty to treat plaintiff's decedent, holding: "The question whether a duty exists is one of law to be decided by the court. The record clearly establishes that, although decedent walked into defendant's emergency room with some difficulty, she did not require medical assistance while there. Decedent was conscious and coherent. The evidence before the trial court was insufficient to create a genuine issue as to whether decedent's condition constituted an unmistakable emergency." *Id.* See also *Kimball v. St. Paul Ins. Co.*, 421 So.2d 309, 310 (La. Ct. App. 1982) (holding that no duty for nurse to assist plaintiff in either walking or sit-

A duty of care is based on the existence of the nurse-patient relationship, which is a legal status created when the nurse is legally obligated to provide, or actually does provide, nursing care to a patient or other person.¹⁰ A typical example occurs when an emergency room nurse does not respond carefully when confronted with an emergency situation.¹¹ Another common example occurs when a unit nurse fails to execute a direct, explicit, and proper order from a physician.¹² Although a nurse's status as an employee is an important source for the nurse-patient relationship, the relationship is not dependent upon the nurse's employment status. The providing of nursing care is itself legally sufficient to create the relationship to which the legal duties are attached.¹³ The existence and extent of one's legal duty is a question of law for a judge to decide and not an issue for the jury.¹⁴

2. Nonfeasance

As a general rule, there is no duty to aid another in peril.¹⁵ A nurse, for example, who by chance comes upon the scene of an accident is not under any legal duty to render emergency medical care because there is no established

ting because, despite being 79 years old, plaintiff had no prior history of health problems, did not ask for assistance, and did not appear visually incapacitated).

¹⁰*Clough v. Lively*, 387 S.E.2d 573, 574-75 (Ga. Ct. App. 1989) (No nurse-patient relationship existed between the plaintiff and the defendant, an emergency room nurse, when an arresting officer brought plaintiff to the emergency room and told the nurse that the plaintiff was there to have a blood sample taken for alcohol and drug content because, after the officer submitted the proper written request and the plaintiff consented to giving the blood sample, the defendant nurse asked plaintiff if he needed or desired medical treatment and the plaintiff stated that he did not).

¹¹*See, e.g., Gilbert v. Hall*, 620 So.2d 533, 534 (Miss. 1993) (alleging that nurses failed to perform emergency room duties by failing to obtain a pertinent history, failing to note, record, and document patient's status in emergency room admission sheet, failing to perform a neurological exam, and failing to inform the emergency room physician of the patient's status); *Feeney v. New England Medical Ctr., Inc.*, 615 N.E.2d 585, 587 (Mass. Ct. App. 1993) (allowing nurse's failure to observe and monitor the patient, particularly the patient's respiratory rate and breathing patterns). *Donna Lee Guarriello, Nursing Malpractice Litigation: Toward Better Patient Care*, 18 TRIAL 78, 81 (1982).

¹²*See infra* notes 291-96.

¹³*Vassey*, 262 S.E.2d at 867 ("A nurse who undertakes to render professional services [regardless of employment status] is under a duty to exercise reasonable care and diligence in the application of her knowledge and skill to the patient's case and to use her best judgment in the treatment and care of patients."); ELI BERNZWEIG, *THE NURSE'S LIABILITY FOR MALPRACTICE* 32, 33 (5th ed. 1990).

¹⁴*See, e.g., Mercil v. Mathers*, 517 N.W.2d 328 (Minn. 1994) (court declined to identify or impose a legal duty on nurses "to insist or even order the doctors to conduct an 'on hands' examination of the patient").

¹⁵KEETON ET AL., *supra* note 4, § 56.

nurse-patient relationship.¹⁶ However, once a nurse provides nursing services at the emergency scene, regardless of whether said services are requested, the nurse-patient relationship is established.¹⁷

3. The Duty of Care: To Whom Owed

Although there is no general requirement that a person act to assist another, when action is taken, the law will demand that the actor perform as would a reasonably prudent person. If a reasonably prudent person would not have foreseen harm to anyone from his or her action, there is no legal duty owed to anyone who is unexpectedly injured by the conduct.¹⁸ A defendant nurse's duty, therefore, extends only to foreseeable plaintiffs: that is, those victims located in a predictable scope of danger caused by the nurse's careless conduct; and if a reasonable person would have foreseen the risk of harm to a patient, then the nurse owes a duty of care to that patient.¹⁹

C. The Reasonable Person

1. Introduction

The doctrine of negligence is founded upon the existence of a uniform, external, and objective standard of conduct.²⁰ The legal system supplies this standard by creating a fictitious person—the reasonably prudent person.²¹ This fictitious person is a composite of the community's judgment as to how the typical community member should behave. Accordingly, each person in the community owes a legal duty to behave as the reasonably prudent person would have behaved in the same or similar circumstances. Negligence is a failure to do what the reasonably prudent person would have done.²²

¹⁶BERNZWEIG, *supra* note 13, at 32-33, 38.

¹⁷*Id.*

¹⁸KEETON ET AL., *supra* note 4, § 43.

¹⁹*See, e.g., Berdyck*, 613 N.E.2d at 1015 (finding liability for injuries resulting from risks and dangers if the injuries were reasonably foreseeable"); *Lucas*, 562 So.2d at 1003 (holding that duty owed by nurse to patient encompassed risk of harm encountered by patient); *Belmon v. St. Francis Cabrini Hosp.*, 427 So.2d 544, 545 (La. Ct. App. 1983) (finding that risk of bleeding, and the nurse's failure to closely monitor the patient was within the scope of protection or the duty of care imposed); *Daniel v. St. Francis Cabrini Hosp.*, 415 So.2d 586, 590 (La. Ct. App. 1982) (holding that the scope of protection afforded by the nurse-patient relationship encompasses a duty to assist a patient when sitting or standing, where physical and mental incapacities require such assistance); *Kimball*, 421 So.2d at 310 (finding no duty for nurse to assist plaintiff in either walking or sitting because, despite being 79 years of age, plaintiff had no prior history of health problems, did not ask for assistance, and did not appear visually incapacitated).

²⁰KEETON ET AL., *supra* note 4, § 32, at 173-75.

²¹*Id.*

²²*Id.*

The reasonably prudent person standard is not an internal, subjective, or personal one.²³ The defendant's beliefs and particular limitations are irrelevant. Instead, the issue is whether the defendant acted as the reasonably prudent person would have acted in the same or similar circumstances; a conclusion reached by comparing the defendant's conduct with the hypothetical conduct of a hypothetical person. All people are held to this level of care, regardless of whether they are capable of meeting it.²⁴

While the "reasonable person" standard of care remains applicable under all circumstances, the specific required conduct of the reasonable person, however, may vary with the situation with which he or she is confronted and the positions which he or she holds.²⁵

2. The Nursing Standard of Care

A nurse is expected to possess and use the knowledge, skill, care, and diligence ordinarily possessed and employed by members of the nursing profession. A nurse will be liable in tort if harm ensues because he or she does not have or use such knowledge, skill, care, or diligence.²⁶

When a nurse acts and harm results from his or her action, his or her actions are evaluated not based upon what a reasonably prudent person would have done in the situation, but upon what a reasonably prudent nurse would have done. This special standard affords the nursing profession, as well as other professions, the opportunity to set their own legal standards of conduct by employing their own customary practices.²⁷

²³*Id.*

²⁴*Id.* at 173-74.

²⁵*Flowers v. Torrance Memorial Hosp. Medical Ctr.*, 884 P.2d 142, 144-45 (Cal. 1994); *KEETON ET AL.*, *supra* note 4, § 32, at 173-75.

²⁶*See, e.g.*, *Berdyck*, 613 N.E.2d at 1017, 1023 (arguing that "Because nurses are persons of superior knowledge and skill, nurses must employ that degree of care and skill that a nurse . . . of ordinary care, skill, and diligence should employ in like circumstances."); *Feeney v. New England Med. Ctr.*, 615 N.E.2d 585, 587 (Mass. Ct. App. 1993) (Emergency Room nurse committed malpractice by failing to observe and monitor the patient, particularly patient's respiratory rate and breathing patterns); *Wheeler v. Yettie Kersting Mem. Hosp.*, 866 S.W.2d 32, 46-47 (Tex. Ct. App. 1993) (nurses committed malpractice by failing to assess correctly the condition and well-being of a pregnant patient, failing to use equipment to ascertain fetal heart tones, and failing to inform physician of the reasons for the lack of information, including failure to obtain patient's obstetrical history); *Harrington v. Rush-Presbyterian-St. Lukes Hosp.*, 569 N.E.2d 15, 18 (Ill. Ct. App. 1990) (nurses committed malpractice by failing to monitor and observe patient, chart and record information, advise physician of significant changes in patient's condition, and by failing to administer medication); *KEETON ET AL.*, *supra* note 4, § 32.

²⁷*See Gill v. Foster*, 597 N.E.2d 776, 782 (Ill. Ct. App. 1992), *aff'd*, 626 N.E.2d 190 (Ill. 1993) (examining the nursing standard of care and requiring expert testimony to establish that standard); *Hurlock v. Park Lane Med. Ctr.*, 709 S.W.2d 872, 881 (Mo. Ct. App. 1985) ("[M]embers of . . . hospital's nursing staff were required, by accepted nursing practice, to 'document' in [patient's] medical records compliance with the

Accordingly, the nurse owes to the patient a duty to conduct himself or herself in the manner that a nurse of ordinary and reasonable prudence would conduct himself or herself in the same or similar circumstances²⁸—the "reasonably prudent nurse."²⁹

Of note, a nurse is neither a guarantor nor an insurer against harm to the patient.³⁰ The nurse is not liable for an honest mistake in judgment or an incorrect exercise of professional knowledge where the proper conclusion or course of action is open to reasonable interpretation. Not every unsuccessful course of treatment or detrimental medical consequence is preventable, and every such incidence does not automatically result in the nurse's liability.³¹ Yet,

admitting physician's order to turn the patient every two hours."); KEETON ET AL., *supra* note 4, § 32, at 189; Armstrong, *supra* note 5, at 587-88.

²⁸ See, e.g., McClain v. Glenwood Regional Medical Ctr., 602 So.2d at 240, 243 (La. Ct. App. 1992) (nurse met standard of care for observing patient's condition, charting patient's condition and complaints of pain, and informing physician thereof); Deese v. Carol City County Hosp., 416 S.E.2d 127, 128 (Ga. Ct. App. 1992) (nurse complied with applicable standard of care for giving intravenous injections); Parker v. Southwest Louisiana Hospital Ass'n, 540 So.2d 1240, 1274 (La. Ct. App. 1989) (nurses complied with standard of care for observing new-borns); Sparks v. St. Luke's Regional Medical Ctr., 768 P.2d 768, 772-73 (Idaho 1989) (nurse not only met but "exceeded" standard of care regarding the monitoring of urinary output in cardiovascular surgery); LOEB & CAHILL, *supra* note 5, at 21; Paula Sweeney, *Proving Nursing Negligence*, 27 TRIAL 34 (May 1991); BERNZWEIG, *supra* note 13, at 50, 54, 324; Erline Reilly, *Nurses and the Law*, 26 NEW HAMPSHIRE B.J. 7, 17-18 (Fall 1984); William Morris, *The Negligent Nurse - The Physician and the Hospital*, 33 BAYLOR L. REV. 109, 111 (1981) and cases cited therein.

²⁹ Armstrong, *supra* note 5, at 587 and cases cited therein; Guarriello, *supra* note 11, at 78.

³⁰ See, e.g., Deese, 416 S.E.2d at 128; Kimball, 421 So.2d at 310 (because a health care provider not an "insurer" of a patient's safety, there is no liability when an elderly patient, who was healthy, not incapacitated, and who did not request any assistance, fell).

³¹ See, e.g., Gibson, 594 So.2d at 1337, 1342 ("An unsuccessful course of treatment is not per se an indication of malpractice."). The Gibson court noted that "Although the infant had risk factors associated with the development of neonatal hypoglycemia, the evidence did not establish that nurse . . . was negligent in failing to make this diagnosis. The infant did not display the classic presenting signs of hypoglycemia and responded well to oxygen, indicating the problem was due to mucus, a common complication." *Id.* See also Eversole v. Oklahoma Hosp. Founders Ass'n, 818 P.2d 456, 461 (Okla. 1991) (holding that, although heavily medicated patient fell while nurse was assisting him to the bathroom, a jury verdict exonerating the nurse was permissible because "[t]he jury could have concluded from the evidence, including testimony of [the] nurse . . . that she had acted according to the training given to her, according to her best judgment."); Parker, 540 So.2d at 1274 (nurses not liable because complied with hospital's circulation and observation policies and acted "within any known and accepted standard of care"); Northern Trust Company v. Louis A. Weiss Memorial Hosp., 493 N.E.2d 6, 10 (Ill. Ct. App. 1986) (nurse met standard of care in observing new-born, "conscientiously" charting baby's progress, and communicating baby's deteriorating condition to physician); Battles v. Aderhold, 430 So.2d 307, 313-14 (La. Ct. App. 1983) (nurses met standard of care in observing patient who had undergone a thyroidectomy, communicating patient's breathing problems to physician, and by complying with

by undertaking to provide nursing services, a nurse is viewed as holding himself or herself out as having the standard skills and knowledge of the profession.³²

3. Role of Judge and Jury

The existence, definition, and pronouncement of the standard of care are regarded as questions of law and thus within the province of the judge. Whether particular behavior contravened this standard is regarded as a question of fact, usually left to the jury to resolve.³³

4. Sources of the Standard

Determining and defining the relevant standard of care is of primary importance in a negligence case. A jury acts independently and renders its own decision as to what the reasonably prudent nurse would have done in any particular situation. Over time these jury determinations have had the effect of establishing the nursing standard of care for a particular activity.

When trial court decisions are appealed, moreover, appellate courts are permitted to state, as a matter of law, whether certain nursing conduct was or was not negligent. These pronouncements serve as legal precedents to be referred to in future cases involving the same or similar facts,³⁴ thereby functioning as authoritative precedents and establishing legal criteria for the future conduct of nurses in performing specific nursing activities.³⁵

Federal and state statutes and administrative regulations also prescribe standards of care for the protection of others. The statute or regulation can be introduced into evidence to establish the standard of careful behavior.³⁶ For example, every jurisdiction that licenses nurses has a Nurse Practice Act which is designed to protect the public by defining the scope of nursing. These statutes typically state nursing responsibilities, functions, and procedures; they define important terms such as the "practice" of nursing and set forth specific legal

hospital's "Quickstep" emergency procedure when patient went into respiratory distress; KEETON ET AL., *supra* note 4, § 32.

³²See, e.g., Berdyck, 613 N.E.2d at 1020-21; Harrington, 569 N.E.2d at 18; KEETON ET AL., *supra* note 4, § 32, at 185-87.

³³See *George v. LDS Hosp.*, 797 P.2d 1121, 1171 (Utah Ct. App. 1990) ("The jury must be allowed to decide whether the [hospital's] failure to notify the doctors of [patient's] change in medical status, which may have indicated either hypoxia or sepsis, was a breach of duty owed to [patient]."); KEETON ET AL., *supra* note 4, § 37, at 235-38.

³⁴See, e.g., Feeney, 615 N.E.2d at 587 (court enunciated "minimum standard of care" for ER nurses monitoring and observing patients).

³⁵See, e.g., White, 866 S.W.2d at 47 (court enunciated standard of care for transferring pregnant patient); Simmons, 841 F. Supp. at 750 (court enunciated precise standards of "proper prophylactic care" to prevent risk of infection from intravenous needle use).

³⁶KEETON ET AL., *supra* note 4, § 36, at 220-21.

standards for nursing practice.³⁷ Such legislative pronouncements can be used, therefore, to define the nursing standard of care.³⁸

In addition to the Nurse Practice Act, state legislatures regulate the nursing profession by creating state boards of nursing with broad regulating power.³⁹ These administrative agencies promulgate and enforce regulations which have the force of law and which more precisely define the content and practice of nursing.⁴⁰ Charged with broad power, nursing boards often enact rules regarding educational requirements and admission criteria for licensure, specify the activities that nurses and nurse practitioners are permitted to engage in, and establish procedures for administering the rules and disciplining nurses who violate the rules.⁴¹

Private entities can also establish and define the nursing standards of care. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private nongovernmental agency that establishes standards for the operation of hospitals, has promulgated *A Guide to JCAHO Nursing Services Standards*⁴² to govern nurses at JCAHO hospitals or facilities. These guidelines provide evidence of the appropriate standard of care⁴³ even at facilities which are not accredited by JCAHO.⁴⁴

³⁷See, e.g., FLA. STAT. ANN. § 464.001 *et. seq.* (West 1994 and Supp. 1995); Berdyck, 613 N.E.2d at 1021 n.1 (definition of practice of professional nursing pursuant to Ohio statute).

³⁸See, e.g., FLA. STAT. ANN. § 464.003 (West 1994 and Supp. 1995); Berdyck, 613 N.E.2d at 1017 ("[S]tatutory standards for licensure are relevant to the standard of conduct required of licensed nurses in Ohio and may be used to prove that standard."); LOEB & CAHILL, *supra* note 5, at 4; Sweeney, *supra* note 28, at 34; GEORGE POZGAR, LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION 225 (5th ed. 1990); BERNZWEIG, *supra* note 13, at 269; Gail Vallot, *Nurse Liability*, 24 TRIAL 99 (Jan. 1988); Armstrong, *supra* note 5, at 580, 590-91; Carole Kehoe, *Contemporary Nursing Roles and Legal Accountability: The Challenge of Nursing Malpractice for the Law Librarian*, 79 LAW LIB. J. 419, 426 (1987); Reilly, *supra* note 28, at 17; Mary E. Kelly & Thomas R. Garrick, *Nursing Negligence in Collaborative Practice: Legal Liability in California*, 12 LAW, MEDICINE, AND HEALTH CARE 260, 263 (1984); Scanlan, *The Nurse and Malpractice: Legal Problems in the Nursing Profession*, 9 W. ST. U.L. REV. 227, (1982).

³⁹See, e.g., FLA. STAT. ANN. § 464.004 (West 1994 and Supp. 1995); LOEB & CAHILL, *supra* note 5, at 9; POZGAR, *supra* note 38, at 228.

⁴⁰See, e.g., FLA. STAT. ANN. § 464.006 (West 1994 and Supp. 1995); 16 FLA. ADMIN. CODE ANN. Chapters 595-1 *et. seq.* (1995); LOEB & CAHILL, *supra* note 5, at 9; POZGAR, *supra* note 38, at 228; Guarriello, *supra* note 11, at 78; Reilly, *supra* note 28, at 11.

⁴¹See, e.g., FLA. ADMIN. CODE ANN. Chapters 595-1 *et. seq.* (1995); LOEB & CAHILL, *supra* note 5, at 9; POZGAR, *supra* note 38, at 228.

⁴²LOEB & CAHILL, *supra* note 5, at 17, 22-28; Sweeney, *supra* note 26, at 34; Armstrong, *supra* note 5, at 590-91; Reilly, *supra* note 28, at 17; Guarriello, *supra* note 11, at 78.

⁴³Sweeney, *supra* note 28, at 34; Armstrong, *supra* note 5, at 590-91; Reilly, *supra* note 28, at 17; Guarriello, *supra* note 11, at 78.

⁴⁴Sweeney, *supra* note 28, at 34.

Nursing organizations such as the American Nurses Association (hereinafter ANA), and various specialty organizations such as the Emergency Nurses Association (hereinafter ENA), promulgate their own rules of conduct which serve as guidelines for acceptable nursing practice.⁴⁵ The ANA's standards are generally applicable to nurses in all settings, whereas each of the ANA's divisions, such as medical-surgical, maternal-child, geriatrics, and mental health, have established their own distinct specialty standards.⁴⁶ Nursing Codes of Ethics, such as those produced by the ANA, ENA, and individual hospitals, also contain standards of care which are applicable to nurses practicing in the profession.⁴⁷

Lastly, procedures, rules, regulations, and by-laws of various health care institutions can be used to define the nursing standard of care.⁴⁸ For example, a hospital's procedure manual for nurses or a nurse's job description may set forth in detail specific rules of conduct for nurses.⁴⁹ A nurse that works for a hospital is legally obligated to be aware of these policies and procedures and to comply with the institution's rules and regulations.⁵⁰ Other practitioners in

⁴⁵*Koeniguer*, 422 N.W.2d at 602 ("standards published by American Nurses Ass'n and various general practice treatises" can be utilized to resolve nursing malpractice case); *LOEB & CAHILL*, *supra* note 5, at 16-17, 18-21; *Sweeney*, *supra* note 28, at 34; *POZGAR*, *supra* note 38, at 230-31; *Kehoe*, *supra* note 38, at 425-26; *Armstrong*, *supra* note 3, at 590-91; *Dolores Garlo*, *Recognition of the Growing Responsibilities and Accountability in the Nursing Profession*, 11 J. OF CONTEMP. L. 239, 257 (1984); *Reilly*, *supra* note 28, at 11; *Guarriello*, *supra* note 11, at 78.

⁴⁶*LOEB & CAHILL*, *supra* note 5, at 16-17.

⁴⁷*LOEB & CAHILL*, *supra* note 5, at 17; *Reilly*, *supra* note 28, at 11.

⁴⁸In *Taylor v. City of Beardstown*, 491 N.E.2d 803, 811 (Ill. Ct. App. 1986), the court stated "not only may expert medical testimony establish the applicable standard of care, but regulations, standards, and hospital bylaws are also admissible on the issue."

In *Alvis v. Henderson Obstetrics*, 592 N.E.2d 678, 682 (Ill. Ct. App. 1992), nurses failed to detect a baby's breech position in time for a doctor to perform a cesarean delivery, resulting in severe injuries to the baby's kidneys. At the time of occurrence the hospital had a written policy requiring that its labor and delivery nurses be able to determine the presenting part of the baby by doing a vaginal exam.

Battles, 430 So.2d at 314 (nurses not negligent in instituting and complying with hospital's "Quickstep" procedure, designed to notify certain personnel that an emergency has occurred and to secure the presence of these personnel, together with certain emergency equipment, at the scene of the emergency); *JANINE FIESTA*, 20 LEGAL PITFALLS FOR NURSES TO AVOID 24-25 (1994) and cases cited therein; *LOEB & CAHILL*, *supra* note 5, at 102; *BERNZWEIG*, *supra* note 13, at 269; *Vallot*, *supra* note 38, at 99; *Armstrong*, *supra* note 5, at 590-91; *Guarriello*, *supra* note 11, at 78; *Morris*, *supra* note 28, at 113.

⁴⁹*FIESTA*, *supra* note 48, at 24-25; *Armstrong*, *supra* note 5, at 590-91; *Reilly*, *supra* note 28, at 17; *Morris*, *supra* note 28, at 113.

⁵⁰*See, e.g., St. Elizabeth Hospital v. Graham*, 883 S.W.2d 433, 437 (Tex. Ct. App. 1994) (nurses failed to comply with hospital's policies and rules in failure to restrain case); *Tobia v. Cooper Hospital Univ. Medical Ctr.*, 643 A.2d 1, 4 (N.J. 1994) (nurses committed malpractice by not complying with hospital policy of not leaving patients unattended on emergency room stretchers with side rails down); *Scribner v. Hillcrest Med. Ctr.*, 866 P.2d 437, 441 (Okla. App. 1992) (evidence clearly demonstrated that nurses were either

the same or related professions can provide evidence of customary and current nursing practice by means of their testimony as expert witnesses.⁵¹

Although all of the preceding sources provide evidence of the appropriate standard of care, these standards represent only minimal criteria, and a court or a jury may impose higher legal standards.⁵²

5. Negligence v. Malpractice

If a person acquires special knowledge, skill, or competence in a particular area or field, the law requires that person act consistently with his or her superior knowledge or skills.⁵³ If a nurse performs a service in a recognized profession, she is held to the special standard of knowledge and ability customarily exercised by qualified members of her profession, regardless of whether she actually possesses such knowledge and skills.⁵⁴

The negligent conduct of a person practicing a profession is usually designated "malpractice."⁵⁵ The term does not imply a greater degree of fault; the reasonable person standard is still utilized to indicate culpability.⁵⁶ However, professionals, including nurses, are judged by the standard of conduct of their profession since the public properly relies on the special expertise of the profession. Their failure to utilize the degree of care and skill that a reasonably prudent qualified member of the profession would exercise subjects them to "malpractice" tort liability.⁵⁷

ignorant of or failed to adhere to hospital policies concerning patient identification); LOEB & CAHILL, *supra* note 5, at 102.

⁵¹See, e.g., *Biddle v. Sartori Memorial Hosp.*, 518 N.W.2d 795, 799-800 (Iowa 1994) (supporting use of physician and nurse expert witnesses in failure to document, communicate, and diagnose case); *Feeney*, 615 N.E.2d at 587 (discussing nurse expert witness testimony as to standard of care in observing and monitoring patient's respiratory rate and breathing patterns); *Berdyck*, 613 N.E.2d at 1022-23; LOEB & CAHILL, *supra* note 5, at 21; *Sweeney*, *supra* note 28, at 34; BERNZWEIG, *supra* note 13, at 269; *Armstrong*, *supra* note 5, at 590-91; *Kelly*, *supra* note 38, at 263; *Morris*, *supra* note 28, at 113.

⁵²*Reilly*, *supra* note 28, at 17.

⁵³KEETON ET AL., *supra* note 4, § 32, at 185.

⁵⁴*Id.*

⁵⁵"A professional malpractice action is merely a professional negligence action and calls into question the conduct of a professional in his area of expertise." *Candler General Hosp., Inc. v. McNorrill*, 354 S.E.2d 872, 876 (Ga. Ct. App. 1987). A medical malpractice case involves three component duties: 1) duty to possess requisite knowledge and skill possessed by average member of the profession; 2) duty to exercise reasonable and ordinary care in the application of such professional knowledge and skill; and 3) duty to use best judgment in the application thereof. *Gould v. New York City Health and Hosp.*, 490 N.Y.S.2d 87, 89 (N.Y. Sup. Ct. 1985).

⁵⁶See, e.g., *Gibson*, 594 So.2d at 1337.

⁵⁷See, e.g., *Tobia*, 643 A.2d at 4 (patient fall case, nurse violated hospital policy regarding siderails on stretchers); *Feeney*, 615 N.E.2d at 587 (failure to observe and

In the health care field, the term malpractice traditionally encompassed only the negligent wrongs of a physician. Because nurses were generally not involved in diagnosis and treatment and were considered physician's servants with servile tasks understandable by most lay persons, the law imposed liability against nurses pursuant to the basic theory of negligence, i.e., what would the reasonable person (as opposed to the reasonable nurse) have done in the same or similar circumstances?⁵⁸

No longer physician's servants, nurses' responsibilities have expanded and intensified and they now frequently exercise independent professional judgment. Today, nurses commonly assume functions previously reserved to the physician practitioner. As they have begun to do so, liability for basic nursing negligence has shifted to its "professional" counterpart—malpractice liability.⁵⁹ The appropriate cause of action against a nurse is a malpractice action.⁶⁰

The shift from negligence to malpractice has significant consequences. Malpractice clearly involves the imposition of a more demanding professional standard of care by which to measure a nurse's conduct. The courts increasingly look to the nursing profession to provide the appropriate criteria to formulate

monitor); *Wheeler*, 866 S.W.2d at 46-47 (failure to take history, use equipment, assess, and communicate with physician); *Alvis*, 592 N.E.2d at 682 (failure to assess); *Galloway v. Baton Rouge General Hosp.*, 602 So.2d 1003, 1010 (La. 1992) (failure to monitor and assess); *Fairfax Hospital System, Inc. v. McCarty*, 419 S.E.2d 621, 625 (Va. 1992) (failure to monitor, assess, and notify physician); *Alef v. Alta Bates Hospital*, 6 Cal. Rptr.2d 900, 904-05 (Cal. Ct. App. 1992) (failure to monitor, assess, and properly use equipment); *Brown v. E.A. Conway Memorial Hosp.*, 588 So.2d 1295, 1300 (La. Ct. App. 1991) (failure to chart); *Harrington*, 569 N.E.2d at 17-18 (failure to monitor, chart, advise physician, and administer medication); *Koeniguer*, 422 N.W.2d at 602-05 (failure to question physician's order and to intervene).

⁵⁸LOEB & CAHILL, *supra* note 5, at 201, and cases cited therein; Carlo, *supra* note 45, at 253.

⁵⁹In *Ramage v. Central Ohio Emergency Services*, 592 N.E.2d 828, 833 (Ohio 1992), Emergency Room nurses failed to observe a child and report his symptoms to physician. The court stated the following:

Although this court has previously held that an action filed against a nurse in his or her professional capacity does not fall within the traditional definition of 'malpractice,' (Citation omitted.), we conclude that expert testimony is necessary to establish the prevailing standard of care where the professional skills and judgment of a nurse are alleged to be deficient.

See also *Lamb v. Candler General Hosp., Inc.*, 413 S.E.2d 720, 722 (Ga. 1992) ("[T]he breach of a duty requiring ordinary care, albeit in a medical context, is not medical malpractice").

⁶⁰Rixey v. West Paces Ferry Hosp., Inc., 916 F.2d 608, 615 (11th Cir. 1990) (ICU nurses failed to properly monitor patient's condition and failed to detect presence of subcutaneous air); *Harrington*, 569 N.E.2d at 17-18 (failure to monitor, chart, advise physician, and administer medication); LOEB & CAHILL, *supra* note 5, at 201; Benninger, *Nursing Malpractice-The Nurse's Duty to Follow Orders*, 90 W.VA. L. REV. 1291, 1296-97 (1988) and cases cited therein; Morris, *supra* note 28, at 110-111 and cases cited therein.

this standard of care.⁶¹ Consequently, expert testimony, particularly from expert nurse witnesses, will be required to establish the standard and educate the lay jury.⁶²

In addition, employment of the malpractice theory involves several issues including the applicable statute of limitations. Statutes of limitations are state statutes which require a party to commence his or her legal action within a specified period of time; otherwise, the party's lawsuit will be barred by the "running" of the statute of limitations.⁶³ Some states have promulgated special statutes of limitations for medical malpractice actions.⁶⁴ Of significance, these statutes generally have time periods shorter than those for ordinary negligence actions.⁶⁵ Consequently, it is of critical importance to determine how the tort lawsuit against the nurse is characterized, since the nurse may be subject to the shorter statute of limitations as well as any other special legal provisions contained in the malpractice action.⁶⁶ Presently, there are cases that classify the tort action against the nurse as malpractice and that apply the shorter statute.⁶⁷

⁶¹ See, e.g., *Feeney*, 615 N.E.2d at 587 (using expert nurse witnesses to establish standard of care for Emergency Room nurse observing and monitoring patient); *Koeniguer*, 422 N.W.2d at 602 (expert nurse witness used in failure to document, inform physician, and question physician's order malpractice case); *Kehoe*, *supra* note 38, at 419-20.

⁶² See, e.g., *Feeney*, 615 N.E.2d at 587 (precise standard of care in failure to observe and monitor case derived from expert nurse witness); *Leonard v. Providence Hosp.*, 590 So.2d 906, 908 (Ala. 1991) (expert witness required to determine whether "proper nursing practice and care" mandated that siderails be raised); *Koeniguer*, 422 N.W.2d at 602 (expert nurse witness utilized where plaintiff alleged a failure to document, inform physician, and question physician's order); *Candler*, 354 S.E.2d at 876 (holding that expert testimony is necessary to establish acceptable professional conduct and deviations therefrom); *Gould*, 490 N.Y.S.2d at 88-89 ("Simple negligence cases are those where the alleged negligent act is readily determined by the trier of fact based upon common knowledge, while malpractice involves the issue of treatment received by the patient and usually requires a decision to be based upon testimony of conflicting medical experts."); *Kehoe*, *supra* note 38, at 419-20; *Morris*, *supra* note 28, at 111.

⁶³ See, e.g., FLA. STAT. ANN. § 95.11 (West 1995); *Morris*, *supra* note 28, at 140.

⁶⁴ See, e.g., FLA. STAT. ANN. § 95.11(3)(4) (West 1995); *LOEB & CAHILL*, *supra* note 5, at 201, 209-10; *BERNZWEIG*, *supra* note 11, at 30; *Duffy*, *Statute of Limitations Controlling Medical Malpractice Claims Applies to Negligence of Nurses*, 19 SUFFOLK U. L. REV. 469, 471-72 (1985); *Morris*, *supra* note 28, at 140.

⁶⁵ See, e.g., FLA. STAT. ANN. § 95.11(3)(4) (West 1995); *LOEB & CAHILL*, *supra* note 5, at 201, 209-10; *Scanlan*, *supra* note 38, at 231; *Morris*, *supra* note 28, at 140-41.

⁶⁶ See, e.g., *Flowers*, 884 P.2d at 145 ("Any distinction between 'ordinary' and 'professional' negligence has relevance primarily when the Legislature has statutorily modified, restricted, or otherwise conditioned some aspect of an action for malpractice not directly related to the elements of negligence itself. For example, the statute of limitations for professional negligence against a health care provider can extend up to three years . . . in contrast to the one year applicable to ordinary negligence (citation omitted). . . . The Medical Injury Compensation Reform Act (MICRA) contains numerous provisions effecting substantial changes in negligence actions against health care providers. . . ."); *Putnam County Hosp. v. Sells*, 619 N.E.2d 968, 971-72 (Ind. Ct.

Unfortunately, there is an absence of uniformity among the jurisdictions as to whether the unintentional tort action involving the careless nurse is "negligence" or "malpractice."⁶⁸ The courts have not used the terms consistently. Both terms have been used to classify the tort; the terms have been

App. 1993) (cause of action viewed as medical malpractice action and dismissed because plaintiff did not comply with Medical Malpractice Act and obtain an opinion by a medical review panel); *DeLeon v. Hosp. of Albert Einstein College*, 566 N.Y.S.2d 213, 214-15 (N.Y. 1991) ("[T]he essential question to be answered in determining the applicable statute of limitations is whether 'the conduct at issue constituted an integral part of the process of rendering medical treatment to . . . the patient.' For a cause of action to survive the shorter statute of limitations applicable to medical malpractice and continue to be viable under the longer statute of limitations applicable to negligence, the gravamen of the complaint should not be negligence in furnishing medical treatment or conduct which bear a substantial relationship to the rendition of medical treatment. . . ."); *Morris v. Children's Hosp. Medical Ctr.*, 597 N.E.2d 1110, 1113 (Ohio Ct. App. 1991), (where a patient suffered a laceration to her arm as result of nurse placing a split plastic cup over an intravenous site as a guard her cause of action was characterized as negligence and thus the statute of limitations for medical malpractice did not apply); *Gould*, N.Y.S.2d at 88-90 (characterizing cause of action as "simple negligence" where plaintiff alleged failure to secure the plaintiff to hospital bed by use of siderails); *Vigue v. John E. Fogarty Memorial Hosp.*, 481 A.2d 1, 3-4 (R.I. 1984) (discussing issue as to which statute of limitations should apply—the two year period provided for medical malpractice actions or the three year period specified for negligence actions); FLA. STAT. ANN. § 766.101 *et. seq.* (West 1995) (statutory medical malpractice requirements); *Duffy*, *supra* note 68, at 471-72 and cases cited therein; *Scanlan*, *supra* note 38, at 231 and cases cited therein; *Morris*, *supra* note 28, at 140.

⁶⁷In *DeLeon*, 566 N.Y.S.2d at 214-16, the plaintiff alleged that, in order to prevent a birth with no doctor present a nurse pushed the baby back into womb, causing the child severe injuries. *Id.* Addressing the applicable statute of limitations, the court wrote as follows:

While a cause of action alleging medical malpractice on the part of a . . . nurse . . . must ordinarily be brought within the 2-1/2 year statute of limitation applicable to medical malpractice actions, a cause of action alleging that the hospital was negligent in its hiring of such an employee, who subsequently commits malpractice, is subject to the three year statute of limitations applicable to negligence actions. . . . [T]he negligent hiring sounds in negligence and thus was timely brought. However, we are of the view, and now hold that the remaining causes of action . . . do sound in medical malpractice and must therefore be dismissed as time barred by the shorter statute of limitations applicable to such actions . . . [T]he nurse's alleged conduct was within the realm of the exercise of professional judgment - whether good or bad-allegedly exercised by the nurse. The nurse's conduct must . . . be deemed to have 'constituted an integral part of the process of rendering medical at treatment.

Id. See also *Vigue*, 481 A.2d at 3-4 (declaring a test for determining the applicable statute of limitations: "If the acts complained of constituted a necessary, essential, integral part in the rendition of professional services to the patient, they are subject to the shorter statute of limitations provided for actions of professional negligence."); *LOEB & CAHILL*, *supra* note 5, at 201; *Duffy*, *supra* note 68, at 471-72 and cases cited therein; *Scanlan*, *supra* note 38, at 231 and cases cited therein.

⁶⁸*Morris*, *supra* note 28, at 110-11.

used interchangeably; or not at all.⁶⁹ In most recent cases, however, the cause of action is designated as "malpractice,"⁷⁰ underscoring the law's willingness to treat nursing as a profession.

6. The "Locality" Rule

Courts have traditionally held that a person practicing a profession be measured by the degree of knowledge, skill, and care that ordinarily would be exercised by members of the profession in the same or similar community or locality.⁷¹ Implicit in this requirement was an allowance for fluctuation in the

⁶⁹For cases classifying nursing torts as "negligence," see *Morse v. Flint River Community Hosp.*, 450 S.E.2d 253, 256-57 (Ga. Ct. App. 1994) (a failure to treat and to notify a physician is negligence); *Georgetti*, 611 N.Y.S.2d at 584 (failure to restrain and disobeying a physician's order is a "professional-negligence" cause of action); *Poluski*, 877 S.W.2d at 712-13 (failure to intervene is a negligence claim); *St. Elizabeth Hosp.*, 883 S.W.2d at 437-38 (failure to monitor and restrain is a negligence claim); *Berdyck*, 613 N.E.2d at 1022-23 (failure to observe, assess, inform physician, and follow physician's order is negligence cause of action); *Hunnicut v. Wright*, 986 F.2d 119, 123 (5th Cir. 1993) (failure to inspect equipment properly is a negligence claim); *Atkins v. Pottstown Memorial Medical Ctr.*, 634 A.2d 258, 259 (Pa. Super. 1993) ("patient fall" case is a negligence cause of action); *Gould*, 490 N.Y.S.2d at 88-90 (failure to use siderails is "simple negligence" action); *NKC Hosps., Inc. v. Anthony*, 849 S.W.2d 564, 567-69 (Ky. Ct. App. 1993) (failure to observe, assess, and question physician's order is a negligence cause of action); *Vincent v. Fairbanks Memorial Hosp.*, 862 P.2d 847, 849-51 (Alaska 1993) (failure to assess and treat is negligence cause of action); *Wingate v. Lester E. Cox Medical Ctr.*, 853 S.W.2d 912, 917 (Mo. 1993) (failure to assess claim is a negligence cause of action); *Miles*, 489 N.W.2d at 838-41 (failure to observe, assess, and communicate is to be treated as a negligence cause of action); *St. Paul Medical Ctr. v. Cecil*, 842 S.W.2d 808, 814 (Tex. Ct. App. 1992) (failure to monitor and to use equipment was properly treated as negligence case); *Anderson v. St. Francis-St. George Hospital*, 614 N.E.2d 841, 843, 847 (Ohio Ct. App. 1992) (disobeying a physician's order constitutes a negligence claim); *Lamb*, 413 S.E.2d at 722 (improper use of equipment constitutes negligence cause of action). *Lama v. Borrás*, 16 F.3d 473, 480-81 (1st Cir. 1994); *Tobia*, 643 A.2d at 4; *Feeney*, 615 N.E.2d at 587; *Vogler v. Dominguez*, 624 N.E.2d 56, 63 (Ind. Ct. App. 1993); *Baptist Med. Ctr. v. Wilson*, 618 So.2d 1335, 1338-39 (Ala. 1993); *Porter*, 995 F.2d at 632-33; *Adams v. Krueger*, 856 P.2d 864, 8965 (Idaho 1993); *Wheeler*, 866 S.W.2d at 46-47; *Alef*, 6 Cal. Rptr.2d at 904-05; *Lopez v. Southwest Com. Health Ser.*, 833 P.2d at 1183, 1187-88 (N.M. Ct. App. 1992); *Fairfax*, 419 S.E.2d at 625; *Butterfield v. Okubo*, 831 P.2d 97, 104-05 (Utah 1992); *Alvis*, 592 N.E.2d at 682; *Downey*, 835 S.W.2d at 555-56; *Galloway*, 602 So.2d at 1010; *Cohen*, 592 A.2d at 723; *Pirkov-Middaugh v. Gillette Child Hosp.*, 479 N.W.2d 63, 65 (Minn. Ct. App. 1991); *Guilbeaux v. Lafayette General Hosp.*, 589 So.2d 629, 631 (La. Ct. App. 1991); *Leonard*, 590 So.2d at 908; *Brown*, 588 So.2d at 1300; *Suire v. Lake Charles Memorial Hosp.*, 590 So.2d 619, 621-22 (La. Ct. App. 1991); *Rixey*, 916 F.2d at 615; *Harrington*, 569 N.E.2d at 17-18; *Jensen v. Archbishop Bergan Mercy Hosp.*, 459 N.W.2d 178, 181, 183 (Neb. 1990); *Koeniger*, 422 N.W.2d at 602-05; *Garcia v. United States*, 697 F. Supp. 1570, 1572-73 (D. Colo. 1988); *Hill*, 610 N.E.2d at 637; *Fein v. Permanente Medical Group*, 695 P.2d 665, 674-75 (Cal. 1985).

⁷⁰See, e.g., *Lama v. Borrás*, 16 F.3d 473, 480-81 (1st Cir. 1994) (failure to document treated as malpractice cause of action); *Tobia*, 643 A.2d at 4 (patient fall due to failure to restrain treated as malpractice case).

⁷¹See, e.g., *Alef*, 6 Cal. Rptr.2d at 904 ("It is also well established that a nurse's conduct . . . be measured by the standard of care . . . of other nurses in the same or similar locality

standard of care dependent upon the type of community in which the nurse practiced his or her profession.⁷² The courts, however, have failed to provide a clear definition of "community" as well as precise criteria for qualification as a "similar" community. Courts are also disinclined to exclude expert testimony based on dissimilar communities.⁷³

Today, considering the existence of standardized nursing education, licensing requirements, standardized medical treatment regimens, enhanced modern communication and transportation, mandatory continuing education, the ubiquitousness of information, the sophistication of equipment and technology, and the widespread dissemination of knowledge, as well as the desire to protect the health care "consumer," support for the older "locality" rule has disintegrated.⁷⁴ As a result, members of a profession in almost all localities confront the same problems, and possess access to the same knowledge and technology to solve problems.⁷⁵

In modern nursing cases the "locality" rule is disappearing.⁷⁶ Some courts have abandoned the rule in favor of a rule treating the community as merely one factor to be taken into consideration when applying the general standard of the nursing profession.⁷⁷ In most jurisdictions, however, the "locality" rule and geographic considerations have been discarded altogether in favor of general, national, professional nursing standards to be applied in all cases.⁷⁸

and under similar circumstances."); *Haney v. Alexander*, 323 S.E.2d 430, 433-34 (N.C. Ct. App. 1984).

⁷²*Bartimus v. Paxton Community Hosp.*, 458 N.E.2d 1072, 1077 (Ill. Ct. App. 1983) (discussing "long and tortured history" of locality rule); KEETON ET AL., *supra* note 4, § 32, at 187-89; Vallot, *supra* note 38, at 99; Armstrong, *supra* note 5, at 595-96 and cases cited therein; Jane Greenlaw, *Nursing Negligence in the Hospital Emergency Department*, 12 LAW, MEDICINE, AND HEALTH CARE 118, 119 (1984) and cases cited therein.

⁷³In *Harris County Hosp. Dist. v. Estrada*, 872 S.W.2d 759, 762 (Tex. Ct. App. 1993), the court held that a non-physician nurse who is familiar with the standard of care at another similar hospital, may qualify by experience to testify as a medical expert in a medical malpractice action. *Id.* The nurse need not be familiar with the standard of care in a particular locale, as long as the nurse is familiar with the standard of care at another similar hospital. Armstrong, *supra* note 5, at 595-96.

⁷⁴See *Bartimus*, 458 N.E.2d at 1077; KEETON ET AL., *supra* note 2, § 32, at 187-89. LOEB & CAHILL, *supra* note 5, at 28; Armstrong, *supra* note 5, at 595-96 and cases cited therein; Carlo, *supra* note 45, at 260-61.

⁷⁵*Bartimus*, 458 N.E.2d at 1077.

⁷⁶See, e.g., *Berdyck v. Shinde*, 613 N.E.2d 1014, 1023 (Ohio 1993). ("[W]e have serious doubts as to whether any 'locality' rule is applicable to registered nurses.").

⁷⁷KEETON ET AL., *supra* note 2, § 32, at 187-89; Morris, *supra* note 26, at 112 (and cases cited therein); *Bartimus*, 458 N.E.2d at 1078 ("Illinois courts have not chosen to follow the strict locality rule or to abandon the locality rule altogether, but have chosen rather to apply the 'similar locality' rule to determine the standard of care applicable.").

⁷⁸See, e.g., *Berdyck*, 613 N.E.2d at 1023; KEETON ET AL., *supra* note 2, § 32, at 187-89; Armstrong, *supra* note 5, at 595-96 and cases cited therein; LOEB & CAHILL, *supra* note 5,

7. The Need for Expert Witnesses

In order to prevail in a nursing malpractice or negligence action, the plaintiff must establish the particular standard of care required. Since this standard ordinarily is measured in relation to the care exercised by members of the nursing profession, the plaintiff generally will need the testimony of expert witnesses to establish the standard of care.⁷⁹ With the decline of the locality rule, experts from other communities now may testify as to the standard of care.

As a general rule, a witness can only testify as to facts and cannot give his or her opinion. A jury composed of laypersons, however, normally is not capable of evaluating issues of scientific knowledge and technique. An expert witness, therefore, is allowed to assist the jury by offering his or her opinion, even on the issue as to whether the nurse committed negligence or malpractice.⁸⁰

If the issue is regarded as simple, nonmedical, or nonprofessional and thus within the common knowledge, experience, or comprehension of laypeople, the jury is permitted to infer negligence without the aid of an expert.⁸¹ If the conduct in question is so obvious or apparent that laypeople could identify the duty of care and its breach, no expert testimony is required.⁸²

at 28; *Morris*, *supra* note 28, at 112 and cases cited therein.

⁷⁹ *See, e.g., Berdyck*, 613 N.E.2d at 1017, 1023; *Ramage v. Central Ohio Emergency Services, Inc.*, 592 N.E.2d 828, 834 (Ohio 1992); *Alef v. Alta Bates Hosp.*, 6 Cal. Rptr.2d 900, 904 (Cal. App. 1992) ("The standard of care against which the acts of a medical practitioner are to be measured is a matter peculiarly within the knowledge of experts . . ."); *Lopez v. S.W. Comm. Health. Serv.*, 833 P.2d 1183, 1187-88 (N.M. App. 1992) (holding that expert medical testimony is required in malpractice case); *Leonard v. Providence Hosp.*, 590 So.2d 900, 908 (Ala. 1991) (regarding patient fall case as a malpractice action and requiring an expert witness to testify on the issue of precautions against falls); *KEETON ET AL.*, *supra* note 4, § 32, at 188-89.

⁸⁰ *Ramage*, 592 N.E.2d at 833-34; *KEETON ET AL.*, *supra* note 4, § 32, at 188-89.

⁸¹ In *Ramage*, 592 N.E.2d at 833, the Plaintiff asserted that the case fell within the 'common knowledge exception and therefore did not require expert testimony.' As basis for the assertion, plaintiff argued that the "alleged negligence of the nurses . . . occurred merely in their observation and reporting of the decedent's condition to the doctor and that this involves matters within the common knowledge and experience of the jurors." *Id.* The court disagreed, however, holding that the allegations in the case went "to the professional skill and judgment of the nurses - matters not within the common knowledge and experience of the jurors." For further authority on the use of expert witnesses see *Lamb v. Chandler General Hosp., Inc.*, 413 S.E.2d 720, 722 (Ga. 1992); *Polonsky v. Union Hosp.*, 418 N.E.2d 620, 621 (Mass. Ct. App. 1981) (discussing whether the decision to raise bed rails involves the expert judgment of the physicians and is therefore beyond the common knowledge of the jury); *KEETON ET AL.*, *supra* note 4, § 32, at 188-89.

⁸² *See, e.g., Gill v. Foster*, 597 N.E.2d 776, 781 (Ill. App. Ct. 1992); *Smith v. Louisiana Health & Human Resources Admin.*, 637 So.2d 1177, 1187 (La. Ct. App. 1994) ("[O]nce there had been repeated episodes of (patient) leaving his ward and becoming confused, just the common sense of a reasonable lay person [as opposed to a medical professional]

In an action against a nurse, expert testimony will generally be required in order to show the nursing standard of care, how the nurse deviated from and breached that standard, and how the breach in fact caused the patient's harm.⁸³ Because nursing activities commonly involve the exercise of professional judgment and the application of advanced knowledge and skills to complex medical and technical situations, expert witnesses will be required to help the jury understand and evaluate the legal propriety of the nurse's conduct.⁸⁴ The impressions and opinions of these expert witnesses, although not controlling, can be very convincing. It remains for the jury, as the trier of fact, to assess the

would strongly militate in favor of continuous observation of [patient]"); *Leonard*, 590 So.2d at 908.

⁸³ See, e.g., *Ard v. East Jefferson Gen. Hosp.*, 636 So.2d 1042, 1045 (La. Ct. App. 1994); *Berdyck*, 613 N.E.2d at 1022-23 finding that expert testimony is required to determine whether a nurse has satisfied or breached her standard of care. *Ramage*, 592 N.E.2d at 833-34; *Alef*, 6 Cal. Rptr.2d at 904; *Gill*, 597 N.E.2d at 780-82 (requiring a plaintiff in a medical malpractice case to present expert testimony to establish the standard of care, to show that defendant deviated from that standard, and that the deviation resulted in plaintiff's injury); *Cohen v. Albert Einstein Med. Ctr.*, 592 A.2d 720, 723 (Pa. Super. Ct. 1991) (holding that "In this medical malpractice action where the events and circumstances were beyond the knowledge of the average lay person, it was necessary that the plaintiff present expert testimony to establish her cause of action."); *Candler*, 354 S.E.2d at 876 (expert testimony is necessary to establish acceptable professional conduct and deviations therefrom); *Koeniguer Eckrich*, 422 N.W.2d 600, 602 (S.D. 1988) (plaintiff used expert nurse witness in failure to document, inform physician, and question physician's order case); *Gibson v. Bosser City Central Hosp.* 594 So.2d 1132, 1337 (La. Ct. App. 1991); *Vallot*, *supra* note 38, at 99; *Armstrong*, *supra* note 5, at 587-88 and cases cited therein; *Scanlan*, *supra* note 38, at 230 and cases cited therein; *Morris*, *supra* note 28, at 114.

⁸⁴ See, e.g., *Hulman v. Evanston Hospital Corp.*, 631 N.E.2d 322, 327 (Ill. Ct. App. 1994) (certified rehabilitation registered nurse testified that nurse leaving patient alone in toilet was not a deviation from the standard of care because plaintiff had used toilet several times before and there was a call button which plaintiff knew how to operate); *Vogler & Dominguez*, 624 N.E.2d 56, 63 (Ind. Ct. App. 1993) (deeming expert necessary in malpractice case concerning surgical nurses because "[a] question about the standard of care applicable to a surgical nurse [is] something which is not a matter of common knowledge and which can only be resolved by resort to expert testimony."); *Oxford v. Upson County Hosp.*, 438 S.E.2d 171, 172 (Ga. Ct. App. 1993); *Miles v. Butte County*, 489 N.W.2d 829, 838 (Neb. 1992); *Ramage*, 592 N.E.2d at 833-34; *Gibson*, 594 So.2d at 1334; *Cohen*, 592 A.2d at 723 (finding expert testimony necessary in a malpractice case concerning an allegedly improper injection of medication because "[t]he events and circumstances were beyond the knowledge of the average person."); *Leonard*, 590 So.2d at 908 (requiring an expert in a patient fall case where there was no medical order requiring precautions); *Koeniguer*, 422 N.W.2d at 602 (using expert nurse witness where a nurse failed to document, inform physician, and question physician's order); *Keys v. Mercy Hosp. of New Orleans*, 485 So.2d 514, 517 (La. Ct. App. 1986) (anesthesiologist defined as an expert witness in a nurse anesthetist negligence case); *Hurlock v. Park Lane Medical Ctr.*, 709 S.W.2d 872, 881-82 (Mo. Ct. App. 1985); *BERNZWEIG*, *supra* note 13, at 303; *Vallot*, *supra* note 38, at 99; *Armstrong*, *supra* note 5, at 587-88 and cases cited therein.

expert's opinion and to evaluate conflicting expert views in relation to all the facts and circumstances of the case.⁸⁵

Not all nursing cases require expert testimony. If the nurse's negligence does not involve issues of professional judgment, skill, treatment, or knowledge, the jury is deemed capable, without expert guidance, of comprehending and applying the "reasonably prudent person" standard and of ascertaining negligence based on its own common knowledge, intelligence, and experience.

Once an expert is adjudged necessary, an issue often arises as to who is qualified to testify about the nursing standard of care. In some jurisdictions, physicians have been permitted to testify about the nursing standard of care and any deviations therefrom.⁸⁶ If the physician does testify, however, she must restrict her opinion to the nursing standard of care and not the physician's

⁸⁵Chircosta v. Winthrop-Breon, 635 N.E.2d 1019, 1030 (Ill. Ct. App. 1994) (upholding jury verdict exonerating the defendant nurse where numerous experts testified that the defendant met the applicable standard of care and the Plaintiff presented 'conflicting, unsupported testimony'); Biddle v. Sartori Medical Hosp., 518 N.W.2d 795, 800 (Iowa 1994) ("When evidence is in conflict, such as it was here, we entrust the weighing of testimony and decisions about the credibility of witnesses to the jury."); Gibson, 594 So.2d at 1337.

⁸⁶See, e.g., Biddle, 518 N.W.2d at 800; St. Elizabeth Hosp. v. Graham, 883 S.W.2d 433, 438 (Tex. Ct. App. 1994) (Physician "gave his expert opinion that the placing of [patient] in a recliner chair without restraints was a failure to exercise the degree of care that a reasonably prudent neuro intensive care nurse or institution would have exercised in the same or similar circumstances."); Berdyck, 613 N.E.2d at 1019; Baptist Medical Ctr. v. Montclair, 618 So.2d 1335, 1338 (Ala. 1993) (the standard of care for obstetrical nurses and how a failure to meet that standard caused the patient's injuries was properly established by testimony of the chief of obstetrics and director of maternal-fetal medicine at a university); Wheeler v. Yettie Kersting Memorial Hosp., 866 S.W.2d 32, 46 (Tex. Ct. App. 1988) (physician testifying the standard of care in certain situations requires that the nurse communicate with the physician); St. Paul Medical Ctr. v. Cecil, 842 S.W.2d 808, 814 (Tex. Ct. App. 1992) (discussing physician testimony regarding nurse's negligence in failing to monitor and detect a child's hypoxia); Alvis v. Henderson Obstetrics, 592 N.E.2d 678, 682 (Ill. App. Ct. 1992) (Physicians "[b]oth testified that a competent obstetrical and delivery nurse should be able to determine whether the baby was in breech position prior to delivery and that the doctor would rely on the nurse to make that determination and to report to him in a timely fashion."); DeLaughter v. Lawrence County Hosp., 601 So.2d 818, 825 (Miss. 1992) (including physician expert testifying that once a nurse becomes aware of any neurological symptoms, the nurse needs to have a physician evaluate the patient); Lucas v. St. Francis Cabrin Hosp., 562 So.2d 999, 1004 (La. Ct. App. 1990); Paris v. Kreitz, 331 S.E.2d 234, 245 (N.C. Ct. App. 1985) (acknowledging that "Physicians are clearly acceptable experts with regard to the standard of care for nurses."); Haney v. Alexander, 323 S.E.2d 430, 433-34 (N.C. Ct. App. 1984) (holding that "since nurses fall within the [statutory] definition of 'health care provider . . . we find that the trial court acted within its discretion in allowing plaintiff's medical witnesses [an internist and a cardiologist] to testify on the nursing standard of care." Sweeney, *supra* note 28, at 36; BERNZWEIG, *supra* note 11, at 269; Vallot, *supra* note 38, at 99; Kehoe, *supra* note 38, at 427; Armstrong, *supra* note 5, at 589-90 and cases cited therein; Scanlan, *supra* note 38, at 230-31 and cases cited therein.

standard.⁸⁷ In other jurisdictions the physician is no longer permitted to testify about the nursing standard of care since the physician is not a nurse and does not possess direct knowledge of nursing standards.⁸⁸ Even in those jurisdictions which allow a physician's testimony to establish the nursing standard of care, such testimony may not be advisable since the practices of medicine and nursing are two distinct professions and the physician may not be aware of the customary nursing practices.⁸⁹

Consequently, when a nursing malpractice or negligence case requires the use of an expert witness, the expert of preference, if not necessity, will be another nurse.⁹⁰ As the nurse's role expands and the nurse's responsibilities are defined more precisely, the testimony of the expert nurse witness will be necessary to establish and to apply the nursing standard of care.⁹¹

8. Specialists

If a profession recognizes specialization, and a member of the profession holds herself out as a specialist, the applicable standard of care is modified and the specialist is held to a higher standard of care—that to which the specialized

⁸⁷ See, e.g., *Baptist Medical Ctr.*, 618 So.2d at 1338; *Alef*, 6 Cal. Rptr.2d at 904; *Suire*, 590 So.2d at 622; *Haney*, 323 S.E.2d at 433-34; *Vassey*, 262 S.E.2d at 867; *Armstrong*, *supra* note 5, at 589-90 and cases cited therein.

⁸⁸ *Sweeney*, *supra* note 28, at 36; *Kehoe*, *supra* note 38, at 427.

⁸⁹ *Armstrong*, *supra* note 5, at 589-90 and cases cited therein.

⁹⁰ See, e.g., *Hulman v. Evanston Hosp. Corp.*, 631 N.E.2d 322, 327 (Ill. App. Ct. 1994) (certified rehabilitation registered nurse used as expert in patient fall case); *Poluski v. Richardson Transp.*, 877 S.W.2d 709, 712-13 (Mo. Ct. App. 1994); *Smith*, 637 So.2d at 1181; *Minster v. Pohl Candler Gen. Hosp.*, 426 S.E.2d 204, 207-08 (Ga. App. 1992); *Roach v. Springfield Clinic*, 585 N.E.2d 1070, 1980 (Ill. App. Ct. 1991); *Morris v. Children's Hosp. Medical Ctr.*, 597 N.E.2d 1110, 1115-16 (Ohio Ct. App. 1991); *Koeniguer*, 422 N.W.2d at 602; *Belmon*, 427 So.2d at 546; *Plutshack v. The University of Minnesota Hosp.*, 316 N.W.2d 1, 8 (Minn. 1982); *Cynthia Northrop & Elise Alpert, Nursing Malpractice*, 19 TRIAL LAW Q. 31, 33 (Winter 1989); *Kehoe*, *supra* note 38, at 427; *Reilly*, *supra* note 28, at 18; *Scanlan*, *supra* note 38, at 230-31 and cases cited therein.

⁹¹ *Berdycyk*, 613 N.E.2d at 1022-24 (OB RN testified as to standard of care of OB nurse in observing pregnant patient and in assessing signs and symptoms of preclampsia); *DeLaughter*, 601 So.2d at 825 (nurse expert witness testified as to the standard of care in a case including a nurse's failure to contact physician); *Gibson*, 594 So.2d at 1342 (where plaintiffs' alleged that neonatal nursery nurses failed to timely diagnose and treat baby's hypoglycemia, resulting in an infants death, defendants' nursing expert "testified that a number of things could have been wrong with the baby and the option that nurse . . . chose, that is, stimulating and suctioning the infant, was appropriate."); *Hatley*, 859 S.W.2d at 379 (using nurse expert witness who recommended intervention when a patient threatens suicide and has a plan for carrying out the threat); *Cohen*, 592 A.2d at 723 (using a registered nurse as an expert witness with respect to the standard of care for intramuscular injections of Demerol and Vistaril); *George*, 797 P.2d at 1120 (nurse testifying as to the duty owed to a patient when he shows discernible signs of respiratory distress); *Koeniguer*, 422 N.W.2d at 602; *Northrop & Alpert*, *supra* note 90, at 33; *Reilly*, *supra* note 28, at 18; *Garlo*, *supra* note 45, at 255; *Scanlan*, *supra* note 38, at 230-31.

subgroup is held.⁹² As medical knowledge develops and becomes increasingly more sophisticated, nursing is becoming a highly specialized profession.⁹³ For example, nursing presently encompasses numerous specialty areas such as emergency, critical care, obstetrics, pediatrics, geriatrics, community health, operating and recovery room, and anesthesiology.⁹⁴ These specialists have acquired the additional necessary education and training and, accordingly, have their own specialist standard of care in addition to the general standards of care applicable to the nursing practice in general.⁹⁵

Consequently, the nurse specialist, performing services within his or her speciality, will be held to a higher standard of care—that of the reasonably prudent nurse specialist under the circumstances.⁹⁶ In order to explicate the standard and identify any deviation from it, an expert witness of the appropriate speciality must be qualified by the courts.⁹⁷ The "locality" rule is

⁹² See, e.g., *Berdyck*, 613 N.E.2d at 1017; *Alvis*, 592 N.E.2d at 682 (labor and delivery specialists); *Gibson*, 594 So.2d at 1342-43 (neonatal specialists); *Keys*, 485 So.2d at 516-18 (nurse anesthetist); FLA. STAT. ANN. § 766.102(2) (West Supp. 1995) (establishing specialty standard); KEETON ET AL., *supra* note 4, § 32, at 185-87.

⁹³ FLA. STAT. ANN. § 464.003(c) (West Supp. 1995) (definition of "advanced" or "specialized" nursing practice); *Sweeney*, *supra*, note 28, at 34; *Northrop & Alpert*, *supra* note 90, at 32; *Scanlan*, *supra* note 38, at 232.

⁹⁴ See, e.g., *Cangelosi v. Our Lady of the Lake Regional Med. Ctr.*, 564 So.2d 654, 661 (La. 1989); *Ann R. Heitland, et al., The Legal Limits of Advanced Nursing Specialty Practice in Illinois*, 81 ILL. B.J. 22-24 (Jan. 1993) (examination of types, functions, and authority of nurse specialists pursuant to Illinois law); *BERNZWEIG*, *supra* note 13, at 56; *Northrop & Alpert*, *supra* note 90, at 32.

⁹⁵ See, e.g., FLA. STAT. ANN. § 464.003(c) (West Supp. 1995) ("advanced" or "specialized" nurses and nurse practitioners); *Keys*, 485 So.2d at 516-128 (nurse anesthetist); *BERNZWEIG*, *supra* note 13, at 56.

⁹⁶ See *Vogler*, 624 N.E.2d at 63; *Berdyck*, 613 N.E.2d at 1022; *Gibson*, 594 So.2d at 1341-42 (neonatal nursing standard of care); *Alvis*, 592 N.E.2d at 682 (standard of care for labor and delivery nurses); *Ewing v. Albert*, 532 So.2d 876, 880 (La. Ct. App. 1988) ("A nurse who practices her profession in a particular speciality, such as labor and delivery, owes to her patients the duty of possessing the degree of knowledge and skill ordinarily possessed by members of her profession actively practicing in such a speciality service under similar circumstances."); *Keys*, 485 So.2d at 518; *Barbara E. Calfee, Nurses in the Courtroom* (1993), at 98-102 (certified registered nurse anesthetist cases), at 111-21 (emergency department cases), at 125-42 (labor and delivery cases), at 150-75 (medical-surgical cases), and at 197-203 (operating room cases). *Sweeney*, *supra* note 28, at 34; *POZGAR*, *supra* note 38, at 234; *BERNZWEIG*, *supra* note 13, at 56; *Carlo*, *supra* note 45, at 258-59; *Reilly*, *supra* note 28, at 18.

⁹⁷ See *Vogler*, 624 N.E.2d at 63; *Wick*, 485 N.W.2d at 648 (neurologist was qualified to testify as to standard of care of nurse anesthetist); *Gibson*, 594 So.2d at 1341-42 (nurse expert testifying as to neonatal nursing standard of care); *Keys*, 485 So.2d at 516-18 (anesthesiologist qualified as expert witness in nurse anesthetist negligence case); *Sweeney*, *supra* note 28, at 34; *Armstrong*, *supra* note 5, at 592 and cases cited therein. *Reilly*, *supra* note 28, at 18.

not applied to specialists and geographic conditions do not control; the standard is a national one.⁹⁸

9. Nurse Practitioners

Many states have independent licensing procedures for nurse practitioners and have legalized expanded roles for nurse specialists.⁹⁹ Nurse practitioners frequently diagnose and treat patients and manage patients' medical care regimens; in many instances, they perform routine examinations, order routine diagnostic tests, and prescribe medication, generally without the direct supervision of a physician.¹⁰⁰ As the nation's health care delivery system relies more heavily upon specialized nurses, the nurse practitioner will increasingly function as a physician substitute.¹⁰¹ The nurse practitioner, of course, will be held to the legal standard of the reasonably prudent nurse practitioner.¹⁰² Since the nurse practitioner performs physician functions, his or her conduct will sometimes be measured against standards taken from the practice of medicine.¹⁰³ Consequently, current interpretations of nursing practice standards, as well as exposure to legal liability, will require further expansion and refinement.¹⁰⁴

10. Learners and Students

Courts generally have declined to create a legally distinct standard of care for novices. The novice, learner, student, beginner, or trainee nurse, therefore,

⁹⁸ See *Berdyck*, 613 N.E.2d at 1017; *Keys*, 485 So.2d at 516 (requiring that the field of anesthesiology is a specialty not limited by the locality rule); *Reilly*, *supra* note 28, at 18.

⁹⁹ See FLA. STAT. ANN. §§ 464.003 - 464.012 (West Supp. 1995); *Adams*, 856 P.2d at 865 (diagnosis by nurse practitioner); HEITLAND, ET. AL., *supra* note 94, at 23-24 (discussing functions and authority of nurse practitioner pursuant to Illinois law); LOEB & CAHILL, *supra* note 5, at 41; *Sweeney*, *supra* note 28, at 34; *POZGAR*, *supra* note 38, at 233.

¹⁰⁰ See, e.g., FLA. STAT. ANN. § 464.012 (West Supp. 1995); HEITLAND, ET. AL., *supra* note 94, at 24-26 (authority of nurse practitioner to diagnose and prescribe pursuant to Illinois Nursing Act); LOEB & CAHILL, *supra* note 5, at 41; *Sweeney*, *supra* note 26, at 34; *POZGAR*, *supra* note 38, at 233; Dorothy Walker, *Nursing 1980: New Responsibility, New Liability*, 16 TRIAL 43, 44 (1980).

¹⁰¹ See *Fein*, 695 P.2d at 674 ("diagnosis' of a patient cannot in all circumstances be said - as a matter of law - to be a function reserved to physicians, rather than . . . nurse practitioners"); *Carlo*, *supra* note 45, at 244; *Guarriello*, *supra* note 11, at 81.

¹⁰² See *Adams*, 856 P.2d at 865 (holding that nurse practitioner committed malpractice by misdiagnosing patient as having genital herpes instead of severe yeast infection); *BERNZWEIG*, *supra* note 13, at 42, 56 (and cases cited therein); *POZGAR*, *supra* note 38, at 234; *Armstrong*, *supra* note 5, at 592 and cases cited therein.

¹⁰³ *Adams*, 856 P.2d at 865 (misdiagnosis by nurse practitioner); *Fein*, 695 P.2d at 674 (misdiagnosis by nurse practitioner); see also *Cangelosi*, 564 So.2d at 661 ("Nurses who perform medical services are subject to the same standards of care and liability as are physicians.").

¹⁰⁴ *Guarriello*, *supra* note 11, at 81; *Scanlan*, *supra* note 38, at 232.

is held to the same standard of care as are nurses who are knowledgeable, skilled, and experienced in the nursing activity in question.¹⁰⁵ The rationale for applying the same standard to learners and students is the aversion to compelling the general public to assume the risk of the novice nurse's lack of knowledge, competence, or skill.¹⁰⁶ A patient clearly possesses the right to presume that all nursing functions will be performed in accordance with a national objective standard of nursing care.¹⁰⁷

D. Breach of Duty

1. Introduction

Once the plaintiff demonstrates that a nurse owed a duty of care to the plaintiff, the plaintiff then must show that the nurse violated or breached this duty by means of a careless act or omission which contravened the required standard of care.¹⁰⁸ To fulfill this requirement, the plaintiff must provide

¹⁰⁵In *Hampton*, 576 So.2d at 634, a student nurse anesthetist, unaccompanied by Certified Registered Nurse Anesthetist as required by hospital policy, was twice unsuccessful in intubating a "code" patient. *Id.* Two experts in anesthesiology testified that the student nurse lacked "the degree of knowledge, skill, and experience necessary to perform adequately in this situation." *Id.* Likewise, in *Central Anesthesia Assoc., P.C. v. Worthy*, 333 S.E.2d 829, 831, 833 (Ga. 1985) a student nurse anesthetist was held to the anesthetist's standard of care where he improperly administered anesthesia causing the patient to suffer cardiac arrest and subsequent brain damage.

¹⁰⁶BERNZWEIG, *supra* note 13, at 60.

¹⁰⁷*Id.*

¹⁰⁸See *Georgetti*, 611 N.Y.S.2d at 584 (finding that "[T]he plaintiff had failed to sustain his burden of proving that any alleged deviations from standard nursing practice were the proximate cause of his injuries."); *Smith*, 637 So.2d at 1186 (upholding trial court's finding that the hospital did not take adequate precautions to protect the patient); *Berdyck*, 613 N.E.2d at 1023 (where obstetrics nurses failed to observe, assess, and inform physician of signs and symptoms of preclampsia presented by pregnant patient, the nurses "failed to perform their duties according to the applicable standard of conduct" and this failure to conform to that standard of conduct is evidence that the nurses, and the hospital employing them, breached the duty they owed their patient to exercise that degree of care and skill that the condition of patient reasonably required."); *Harris County Hosp. Dist. v. Estrada*, 872 S.W.2d 759, 762-63 (Tex. Ct. App. 1993) (nurses breached duty of care by failing to properly cross-check the patient's prescription with known allergies and by failing to instruct the patient on how to proceed in the event of an allergic reaction; *Alvis*, 592 N.E.2d at 628; *Alef*, 6 Cal. Rptr.2d at 905; *Anderson*, 614 N.E.2d at 843, 847 (finding sufficient evidence for the jury to determine if the nurse breached a duty by contravening physician's order and engaging in nonconsensual treatment); *Galloway*, 602 So.2d at 1010 (nursing staff's conduct in caring for patient fell below required standard of care when nurses failed to observe and investigate recovery room patient's "noticeable" symptoms); *St. Paul Med. Ctr.*, 842 S.W.2d at 814 (nurse deemed to have breached duty by failing to monitor, assess, and properly use electronic fetal monitor); *Butterfield*, 831 P.2d at 104 (failure to chart fully and accurately breached the standard of care for nurses; *Fairfax*, 419 S.E.2d at 625; *Morris*, 597 N.E.2d at 1116-17 (plaintiff suffered laceration to her arm, as a result of a nurse carelessly placing a split plastic cup over an intravenous site); *Brown*, 588 So.2d at 1300); *Harrington*, 569 N.E.2d

evidence of what actually occurred and must prove that the nurse acted unreasonably under the specific circumstances.¹⁰⁹

In order to prove what occurred factually, as well as proving that the nurse was negligent or committed malpractice, the plaintiff utilizes direct evidence, that is, documentary evidence such as medical records and witnesses who can testify to the facts.¹¹⁰ If a plaintiff is unable to produce an eyewitnesses, she can prove the malpractice by using circumstantial evidence; evidence of one fact, or a set of facts, from which the existence of a fact to be ascertained may reasonably be inferred.¹¹¹

2. *Res Ipsa Loquitur*

a. Introduction

Occasionally, however, a plaintiff may not be able to meet his or her burden of proof because of unusual circumstances concerning the injury or because the defendant possesses the only knowledge regarding what occurred to cause the plaintiff's injury.¹¹² The law supplies a doctrine to aid the plaintiff in proving negligence or malpractice in such a case.

The doctrine of *res ipsa loquitur*, or "the thing speaks for itself," is a rule of circumstantial evidence.¹¹³ The doctrine does not change the standard of care or shift the ultimate burden of proof; it is merely a means of indirect proof of

at 18; *Lucas*, 562 So.2d at 1003-04; *George*, 797 P.2d at 1121; *Rixey*, 916 F.2d at 615; *Hill*, 610 N.E.2d at 637; *Haney*, 323 S.E.2d at 433; *Keys*, 485 So.2d at 516-18; *Azzolino*, 322 S.E.2d at 575; *Daniel*, 415 So.2d at 590; BERNZWEIG, *supra* note 13, at 288; *Benninger*, *supra* note 60, at 1294 and cases cited therein; *Kehoe*, *supra* note 38, at 426.

¹⁰⁹See *Biddle*, 518 N.W.2d at 800; *NKC Hosp., Inc.*, 849 S.W.2d at 567; *Dixon*, 431 S.E.2d at 782; *DeLaughter*, 601 So.2d at 825; *Alvis*, 592 N.E.2d at 682; *Alef*, 6 Cal. Rptr.2d at 905; *Hatley*, 859 S.W.2d at 379; *Gibson*, 594 So.2d at 1342-43; *Eyoma*, 589 A.2d at 658; *Parker*, 540 So.2d at 1274; *Koeniguer*, 422 N.W.2d at 602; *Hodges*, 355 S.E.2d at 106; *Keys*, 485 So.2d at 518; *Azzolino*, 322 S.E.2d at 575; *Plutshack*, 316 N.W.2d at 8; *Garcia*, 697 F. Supp. at 1572-73; *Belmon*, 427 So.2d at 544-45; *Vassey*, 262 S.E.2d at 868; *Polonsky*, 418 N.E.2d at 622; BERNZWEIG, *supra* note 13, at 269; *Guarriello*, *supra* note 11, at 79.

¹¹⁰See, e.g., *Ard*, 636 So.2d at 1044-46 (discussing testimony of patient's spouse regarding patient's deteriorating condition and lack of response by nurses to calls for assistance, lack of documentation in medical records, and testimony of expert nurse witness concerning six breaches of standard of care provided "[a]mple evidence to support the trial judge's conclusion the nursing staff breached the standard of care."); BERNZWEIG, *supra* note 13, at 269.

¹¹¹See *Cohen*, 592 A.2d at 723; *Lucas*, 562 So.2d at 1002-03 (where nurse perforated the patient's rectum while giving the patient a preoperational enema, circumstantial evidence was permissible so long as the "evidence taken as a whole . . . exclude(s) other reasonable hypotheses with a fair amount of certainty"); KEETON ET AL., *supra* note 4, § 39, at 242-43.

¹¹²LOEB & CAHILL, *supra* note 5, at 207-08 and cases cited therein; BERNZWEIG, *supra* note 13, at 306.

¹¹³See, e.g., *Wick v. Henderson*, 485 N.W.2d 645, 648-49 (Iowa 1992); *Lucas*, 562 So.2d at 1004-05; *Cangelosi*, 564 So.2d at 665; *Taylor*, 491 N.E.2d at 808; KEETON ET AL., *supra*

negligence; it sanctions plaintiff's primary reliance on circumstantial or inferential evidence.¹¹⁴ Of note, the doctrine does not become operative automatically—the court must determine its use.¹¹⁵

In certain situations, the very fact that a particular harm resulted may itself establish both elements of the breach requirement: (1) that the defendant nurse performed some harmful act (or neglected to perform an act); and (2) under circumstances where such action (or inaction) may be deemed unreasonable. The law will then allow a rebuttable inference that the nurse was negligent or committed malpractice.¹¹⁶

There are three elements to the doctrine of *res ipsa loquitur*: (1) the event must be of a type that normally does not occur in the absence of someone's negligence; (2) the event must be caused by an agency, instrumentality, or source under the management or within the exclusive control of the defendant; and (3) the event must not have been due to the voluntary action or contribution on the part of the plaintiff or any third person.¹¹⁷

b. *Res Ipsa: The First Requirement*

The first element of *res ipsa loquitur* requires that a harm result from an occurrence.¹¹⁸ The inference of negligence may arise either where a definite

note 4, Section 39, at 242-44.

¹¹⁴See, e.g., *Maciag v. Strato Med. Corp.*, 644 A.2d 647, 653-54 (N.J. Super. Ct. 1994); *Vogler*, 624 N.E.2d at 61; *Wick*, 485 N.W.2d at 648-49; *Lucas*, 562 So.2d at 1004-05; *Cangelosi*, 564 So.2d at 665; *Taylor*, 491 N.E.2d at 808-09.

¹¹⁵See, e.g., *Vogler*, 624 N.E.2d at 61; *Lucas*, 562 So.2d at 1004-05; BERNZWEIG, *supra* note 13, at 309.

¹¹⁶See *Maciag*, 644 A.2d at 653-54; *Vogler*, 624 N.E.2d at 61; *Lucas*, 562 So.2d at 1004-05; *Cangelosi*, 564 So.2d at 665-66, 668-69; *Taylor*, 491 N.E.2d at 808-09; BERNZWEIG, *supra* note 13, at 309.

¹¹⁷See *Vogler*, 624 N.E.2d at 61; *Wick*, 485 N.W.2d at 648-49; *Scribner*, 866 P.2d at 442; *Lucas*, 562 So.2d at 1004-05; *Cangelosi*, 564 So.2d at 665-66; *Fleming*, 742 P.2d at 1092; *Taylor*, 491 N.E.2d at 808-09; KEETON ET AL., *supra* note 4, § 39, at 244; LOEB & CAHILL, *supra* note 5, at 207-08 and cases cited therein; Jane Greenlaw, *Communication Failure: Some Case Examples*, 10 LAW, MEDICINE, AND HEALTH CARE 77, 78 (1982) and cases cited therein.

¹¹⁸See *Vogler*, 624 N.E.2d at 61 (where the plaintiff alleged an injury which occurred while he was undergoing surgery or in recovery following surgery, the court found "The evidence supports an inference that the nerve palsy suffered by [plaintiff] was not simply a bad result which is a calculated risk of the type of treatment given him, but is more probably due to the negligence of those in control."); *Wick*, 485 N.W.2d at 648-50 (applying *res ipsa loquitur* where the plaintiff sustained permanent injury to ulnar nerve, located in upper arm, during gallbladder surgery); *Scribner*, 866 P.2d at 442 (involving patient misidentification); *Lucas*, 562 So.2d at 1005 (nurse perforated patient's rectum or colon while giving a preoperational enema); *Fleming*, 742 P.2d at 1092 (patient suffered severe wound to thigh after receiving an injection for a migraine); *Cangelosi*, 564 So.2d at 666; *Taylor*, 491 N.E.2d at 809 (including a "confused and elderly" unrestrained patient

cause is known or where the cause of the event is uncertain.¹¹⁹ The plaintiff is not required to exclude all other possible causes or inferences to a certainty; he or she need only demonstrate to reasonable persons that the defendant nurse's negligence or malpractice most probably was associated with the cause of the event.¹²⁰

In an ordinary case, the common experience, knowledge, sense, and understanding of non-medical persons can provide the foundation upon which an inference of negligence can be built, thus obviating the need for expert testimony.¹²¹ In certain health care cases, however, the conduct in question is so blatantly remiss there is little doubt that a health care provider was negligent or committed malpractice. Such cases arise, for example, when foreign objects are left in the patient during surgery, when the patient suffers injuries while unconscious, or when a patient is infected by unsterile or unsafe instruments or equipment.¹²² If the inference of negligence or malpractice depends, however, upon facts beyond the common knowledge, experience, and under-

who fell from bed); 564 So.2d at 666; KEETON ET AL., *supra* note 4, § 39, at 244, 247; BERNZWEIG, *supra* note 13, at 308.

¹¹⁹See, e.g., *Wick*, 485 N.W.2d at 648-50; *Scribner*, 866 P.2d at 442 (where two shifts of nurses failed to note the move of the patient in the adjoining bed in plaintiff's room, the plaintiff sustained injuries when tests were erroneously performed on the plaintiff due to the patient misidentification); *Fleming*, 742 P.2d at 1092 (severe wound to thigh caused by injection by ER nurse); KEETON, *supra* note 4, § 39, at 247-48.

¹²⁰See *Scribner*, 866 P.2d at 442 (upholding *res ipsa* instruction in patient misidentification case where an "unnecessary trip to ultrasound lab . . . would not have occurred if hospital patient identification procedures had been followed"); *Lucas*, 562 So.2d at 1005 ("In the case at bar, the body of proof discounts other possible causes, than that of the negligence of [nurse], and would allow a conclusion by the jury, that the injury was more likely than not caused by [nurse's] negligence . . . [W]e consider it well within common experience that properly given enemas do not cause perforation of the colon. In the absence of negligence, the giving of an enema will not commonly cause such an injury."); *Cangelosi*, 564 So.2d at 666; KEETON ET AL., *supra* note 4, § 39, at 247-48.

¹²¹See, e.g., *Flowers*, 884 P.2d at 147 (*res ipsa loquitur* "common knowledge" exception occurs when a layperson is able to say as a matter of common knowledge and observation that the consequences of professional treatment were not such as ordinarily would have followed if due care had been exercised); *Vogler*, 624 N.E.2d at 61; *Wick*, 485 N.W.2d at 648, 650 ("When the foundation facts of *res ipsa loquitur* are established - whether by expert testimony or, in the proper case, by the common experience of laypersons - then the plaintiff is not required to present expert testimony on the appropriate standard of care."); *Cangelosi*, 564 So.2d at 666; *Taylor*, 491 N.E.2d at 809; KEETON ET AL., *supra* note 4, § 39, at 244-47.

¹²²See, e.g., *Maciag*, 644 A.2d at 653-55 (*res ipsa* appropriate when plaintiff's wife sustained injuries after a subclavian venous access catheter fragmented inside her); *Flowers*, 884 P.2d at 147; *Wick*, 485 N.W.2d at 648-50 (plaintiff sustained permanent injury to ulnar nerve, located in upper arm, during gall bladder surgery); *Taylor*, 491 N.E.2d at 809; *Guarriello*, *supra* note 11, at 80.

standing of the jury, expert testimony must supply a sufficient foundation (or can demolish an inference which otherwise might have arisen).¹²³

In medical malpractice cases, expert testimony generally is required to establish the likelihood that the harm resulted from some health care provider's negligence or malpractice.¹²⁴ Laypeople simply are not capable of inferring negligence or malpractice merely from the occurrence of harm in the course of complex medical procedures.¹²⁵ In such a case, the expert is allowed to testify directly to the inference itself; that is, that the plaintiff's injury would not have occurred unless the health care provider was negligent or committed malpractice.¹²⁶

c. *Res Ipsa: The Second Requirement*

For the *res ipsa loquitur* doctrine to apply, it is never sufficient for the plaintiff to prove merely that he or she was harmed by the negligence of some unidentified person; it is "still necessary to bring (the negligence) home to the defendant."¹²⁷ The inference of negligence from the first requirement must be focused on a particular health care provider. The plaintiff must show that his or her injury was caused by a specific instrumentality, condition, or source which was under the defendant's "exclusive" management or control at the relevant times.¹²⁸ "Exclusive control," however, is a very flexible and expansive concept; it may be sufficient that the defendant nurse had the right, duty, or power to control.¹²⁹ If other causes for the event are equally probable, the plaintiff needs evidence that tends to eliminate them.¹³⁰

¹²³*Cangelosi*, 564 So.2d at 666; *Taylor*, 491 N.E.2d at 809-10; KEETON ET AL., *supra* note 4, § 39, at 244-47.

¹²⁴*Id.*

¹²⁵*Cangelosi*, 564 So.2d at 667 n.11; *Taylor*, 491 N.E.2d at 809-10.

¹²⁶*Cangelosi*, 564 So.2d at 667 n.11.

¹²⁷KEETON ET AL., *supra* note 4, § 39, at 248-49; *accord*, *Lucas*, 562 So.2d at 1005; *Cangelosi*, 564 So.2d at 666.

¹²⁸*See, e.g., Vogler*, 624 N.E.2d at 61-62 (plaintiff alleged that brachial plexus stretch condition suffered by plaintiff resulted from negligent placement or manipulation of his body while he was undergoing surgery or in recovery following surgery); *Wick*, 485 N.W.2d at 649 ("It should be enough that the plaintiff can show an injury resulting from an external force applied while he lay unconscious in the hospital; this is as clear a case of identification of the instrumentality as the plaintiff may ever be able to make."); *Scribner*, 866 P.2d at 442; *Lucas*, 562 So.2d at 1005; *Fleming*, 742 P.2d at 1092; *Cangelosi*, 564 So.2d at 666.

¹²⁹Prosser & Keeton define the burden of exclusivity as follows:

[I]n proving the element of exclusive control, the plaintiff is not required to eliminate with certainty all other possible causes and inferences, but must show either that the injury can be traced to a specific instrumentality or cause for which the defendant was responsible, or that the defendant was responsible for all reasonably probable causes to which the accident could be attributed.

The "exclusive control" requirement to *res ipsa loquitur* presents a serious obstacle in a case with multiple defendants. Where there are two or more defendants, a plaintiff cannot sustain her case merely by demonstrating that she was injured by negligence of one or the other.¹³¹ Instead, she must identify one defendant as the cause of her harm. There are, however, exceptions to this rule. Where injury occurs to an "unconscious patient," courts will typically apply *res ipsa loquitur* to all health care providers connected to the operation or procedure involving the unconscious patient.¹³² This exception is based on the group nature of the enterprise, the concurrent or joint control exercised by all parties, the special relationship between the health care providers and the patient, the non-delegable responsibility for the plaintiff's health and safety assumed by everyone concerned, and the fact that at least one defendant is

(Citation omitted.)

[T]he evidence designated by the (plaintiffs) points to at least one specific instrumentality, in addition to the person of (plaintiff), over which the hospital's employees or agents shared the right or ability to control and the opportunity to exercise control. The evidence designated by the (plaintiffs) sufficiently reduces the likelihood that the nerve injury sustained by (plaintiff) had some cause in fact other than the manner in which he was positioned during surgery and affords a rational basis for concluding that the cause of the nerve injury more probably than not involved an instrumentality over which the hospital had a right or ability and opportunity to exercise control.")

KEETON ET AL., *supra*, note 4, § 39, at 248-49.

Vogler, 624 N.E.2d at 61-63 ("The element of 'exclusive control' is an expansive concept which focuses upon who has the right or power to control and the opportunity to exercise it (citations omitted). Exclusive control is satisfied if the defendant had control at time of the alleged negligence (citation omitted).")

¹³⁰KEETON, ET AL., *supra* note 4, § 39, at 250.

¹³¹*Maciag*, 644 A.2d at 653-55; KEETON ET AL., *supra* note 4, § 39, at 251-53.

¹³²See *Maciag*, 644 A.2d at 653-55 (applying *res ipsa loquitur* collectively upon a group of potential defendants, including surgical and oncology nurses); *Vogler*, 624 N.E.2d at 61-63 (*res ipsa loquitur* is "appropriate when plaintiff alleged that brachial plexus stretch condition suffered by plaintiff resulted from negligent placement or manipulation of his body while he was undergoing surgery or in recovery following surgery"). The court in *Wick*, 485 N.W.2d at 649, noted:

We think it is a just and logical conclusion that one who, while undergoing a surgical operation, sustains an unusual injury to a healthy part of his body not within the area of the operation, be not precluded from invoking the doctrine of *res ipsa loquitur* in an action against the doctors and nurses participating in the operation. The same thing must be said of the corporate hospital regarding its preceding or subsequent care of the patient. This is not altered by the fact that all the parties do not stand in such relationship to one another that the acts of one may be regarded as the acts of the other

See also *Scribner*, 866 P.2d at 442 (*res ipsa* instruction proper in patient misidentification case); KEETON ET AL., *supra* note 4, § 39, at 251-53.

liable for the plaintiff's injuries.¹³³ Although not all of the health care providers could have been responsible for the patient's injury, each provider did have some contact with the patient, and the patient suffered harm of a kind that ordinarily is imputed to someone's negligence or malpractice.¹³⁴

d. *Res Ipsa: The Third Requirement*

Res ipsa loquitur demands the absence of any conduct or responsibility on the part of the plaintiff which contributed to his or her injury.¹³⁵ Some jurisdictions have eliminated this requirement because it is inconsistent with the modern doctrine of comparative negligence, whereby a plaintiff's contributing fault is not a complete bar to recovery but rather a damage-reducing factor (unless the plaintiff's negligence is the sole cause of his or her injury).¹³⁶

e. *Procedural Issues*

An important procedural issue is the legal effect of establishing *res ipsa loquitur*. Once the plaintiff introduces sufficient evidence to raise the *res ipsa loquitur* inference, the court can instruct the jury on the doctrine and the plaintiff will escape dismissal of his or her case.¹³⁷

According to the majority of courts, *res ipsa loquitur* only creates an inference of negligence; the weight and credibility of the inference are left to the jury and the jury is permitted, but not compelled, to find negligence.¹³⁸ The jury remains free to find for the defendant nurse, even in the absence of an explanation by the nurse, unless the inference of negligence is so strong that reasonable jurors could reach no other conclusion.¹³⁹ The ultimate burden of proof, however, is neither shifted to the defendant nurse, nor is there any burden on the nurse to

¹³³See, e.g., *Maciag*, 644 A.2d at 655; *Vogler*, 624 N.E.2d at 62 ("Exclusive control may be shared control if multiple defendants each have a nondelegable duty to use due care."); *Wick*, 485 N.W.2d at 650; KEETON ET AL., *supra* note 4, § 39, at 251-53.

¹³⁴See *Maciag*, 644 A.2d at 653-55 (principal defendants included manufacturer of broken tube, the manufacturer of the completed product, the hospital, the surgeons, the oncologists, the surgical nurses, and the oncology nurses); *Vogler*, 624 N.E.2d at 61-63; *Wick*, 485 N.W. 2d at 650; KEETON ET AL., *supra* note 4, § 39, at 251-53.

¹³⁵*Lucas*, 562 So.2d at 1005 ("[I]n order for a plaintiff to utilize the doctrine of *res ipsa loquitur*, he must show . . . that the evidence sufficiently excludes the inference of his own responsibility . . . in causing the accident . . . In the case at bar, the body of proof discounts other possible causes, than that of the negligence of nurse . . ."); KEETON ET AL., *supra* note 4, § 39, at 254.

¹³⁶KEETON ET AL., *supra* note 4, § 39, at 254.

¹³⁷*Cangelosi*, 564 So.2d at 667-68; KEETON ET AL., *supra* note 4, § 40, at 257-58.

¹³⁸See *Scribner*, 866 P.2d at 442; *Lucas*, 562 So.2d at 1004; *Fleming*, 742 P.2d at 1092; *Cangelosi*, 564 So.2d at 665-66; KEETON ET AL., *supra* note 4, § 40, at 257-58.

¹³⁹See, e.g., *Scribner*, 866 P.2d at 442; *Fleming*, 742 P.2d at 1092; *Cangelosi*, 564 So.2d at 665-66; KEETON ET AL., *supra* note 4, 40, at 257-58.

introduce evidence. If the defendant nurse fails to introduce mitigating evidence, the nurse takes the chance that the jury will decide against him.¹⁴⁰

An additional issue is raised when rebuttal or explanatory evidence is offered by the defendant nurse to show that the harm was not caused by the nurse's negligence. In such a case, both the *res ipsa* inference of negligence and the nurse's exculpatory evidence are to be balanced and weighed by the jury.¹⁴¹ The jury must then determine which is stronger; the jury can either accept or reject the inference of negligence.¹⁴²

If the plaintiff introduces evidence of specific acts of negligence or malpractice by the nurse, is the plaintiff still able to rest on the inference of negligence provided by *res ipsa loquitur*? Proving some specific facts does not necessarily eliminate the natural inferences from others.¹⁴³ Accordingly, when a plaintiff proves some specific acts of negligence or malpractice to explain what occurred, and when plaintiff's proof does not destroy the inferences that are compatible with the evidence, a plaintiff can still take advantage of the *res ipsa loquitur* doctrine.¹⁴⁴

3. Negligence *Per Se*

a. Definition

A standard of care may be set by a statute or administrative regulation. When a statute mandates or proscribes specific acts, a court can interpret the statute

¹⁴⁰*Lucas*, 562 So.2d at 1004; KEETON ET AL., *supra* note 4, § 40, at 257-58.

¹⁴¹*Cangelosi*, 564 So.2d at 667 n.11, 668-69.

¹⁴²*See, e.g., Lucas*, 562 So.2d at 1004; *Cangelosi*, 564 So.2d at 668-69 (patient alleged that during intubation accompanying gall bladder surgery, a nurse anesthetist negligently caused a fracture of two tracheal rings, leading to a permanent tracheotomy; *res ipsa* was not applicable because the defendant rebutted any inference that the plaintiff's injury was caused by the negligence of any defendant); KEETON ET AL., *supra* note 4, § 40, at 260-61.

¹⁴³*Lucas*, 562 So.2d at 1005-06 ("Simply because plaintiff in this case put on some evidence to attempt to prove the negligence of nurse . . . , does not deprive her of the natural inferences of the facts. Plaintiff 'should not be denied the benefit of any natural inferences which may arise from the occurrence of the accident merely because he does not care to rest his chances upon that inference alone."); KEETON ET AL., *supra* note 4, § 40, at 260.

¹⁴⁴*See, e.g., Vogler*, 624 N.E.2d at 62 ("This is so because proof in a *res ipsa loquitur* case seldom points to a single specific act or omission (citation omitted). Typically, it points to several alternative explanations involving negligence without indicating which of them is more probable than the other (citation omitted). Hence, a plaintiff may offer such evidence as may be available tending to show specifically the items of negligence and still rely upon the inference permitted under *res ipsa loquitur*" (citation omitted); *Lucas*, 562 So.2d at 1006 ("[R]es ipsa loquitur and direct proof of negligence may be simultaneously submitted to the jury [I]t is not error to allow the jury to be instructed upon both negligence and the . . . presumption of negligence where the plaintiff has produced evidence of discrete negligence."); KEETON ET AL., *supra* note 4, § 40, at 260.

as setting a standard of care and imposing a concomitant duty on members of a particular group.¹⁴⁵ Deviating from the statutory standard of care can be construed by the court as constituting both the duty and breach elements in a negligence cause of action.¹⁴⁶ When a statute sets forth duties that a nurse is obligated to fulfill, the doctrine may be applicable to patient injuries sustained from the nurse's neglect or contravention of the statutory duties.¹⁴⁷

The doctrine may also be utilized against a nurse who lacks the necessary and proper statutory authority to perform an act that results in harm to the patient.¹⁴⁸

b. Requirements

A plaintiff must meet three requirements to invoke the doctrine of *negligence per se*: (1) the statute must create a clear and definite duty of conduct and must specify from whom such duty is required; (2) the statute must evidence a legislative purpose of protecting a limited class or persons of which plaintiff is a member; and (3) the harm suffered by the plaintiff must be of the type that the statute aimed at preventing.¹⁴⁹ A statute is presumed to anticipate all risks that reasonably can be foreseen as likely to result from its violation.¹⁵⁰

c. The Effect of Negligence Per Se

Three widespread views discuss the legal effect of the violation of a statutory duty. The majority of courts hold that once a statute is determined to be applicable and a transgression of the statute is established, the issue of negli-

¹⁴⁵See, e.g., *Lama v. Borrás*, 16 F.3d 473, 480 (1st Cir. 1994); *Sweet v. Sisters of Providence*, 881 P.2d 304, 311 (Alaska 1994); *Central Anesthesia Assocs.*, 833 S.E.2d at 831, 833; KEETON ET AL., *supra* note 4, § 36, at 220-21.

¹⁴⁶See *Lama*, 16 F.3d at 480 (evidence of duty and breach elements were sufficiently proven via nurse's failure to properly document surgical wound infection as required by Puerto Rico Health Dept. Reg.); *Central Anesthesia Assocs.*, 333 S.E.2d at 831, 833; KEETON ET AL., *supra* note 4, § 36, at 220-27; BERNZWEIG, *supra* note 13, at 73-74.

¹⁴⁷See *Lama*, 16 F.3d at 480-81 (patient developed infection after surgery for herniated disc; nurse failed to document post-surgical wound infection symptoms in contravention of a Puerto Rico Health Dept. regulation that required "qualitative nursing notes" for each nursing shift); *Central Anesthesia Assocs.*, 833 S.E.2d at 831, 833 (student nurse anesthetist improperly administered anesthesia in contradiction of a state statute); BERNZWEIG, *supra* note 13, at 73-74; Kelly, *supra* note 38, at 266.

¹⁴⁸For example, in *Central Anesthesia Assocs.*, 333 S.E.2d at 831, a noncertified nurse administered anesthesia in violation of a state statute requiring administration of anesthesia only by a certified registered nurse anesthetist only under the direction and responsibility of a duly licensed physician. BERNZWEIG, *supra* note 13, at 73-74; POZGAR, *supra* note 38, at 227 (a nurse may be deemed negligent if he or she performed functions restricted by law to physicians); Kelly, *supra* note 38, at 266 and cases cited therein.

¹⁴⁹KEETON ET AL., *supra* note 4, § 36, at 220-27.

¹⁵⁰*Id.* at 220-27.

gence is conclusively decided as a matter of law.¹⁵¹ Other courts, however, view the doctrine as creating a rebuttable presumption of negligence. Lastly, some courts hold that the statutory violation is merely evidence of negligence, upon which the jury may deliberate in order to determine the appropriate standard of care and whether or not it was breached.¹⁵²

d. Causation and Damages

The effect of negligence *per se* is to brand the defendant as negligent. A nurse's demonstrated violation of a statute however, does not automatically equate to legal liability.¹⁵³ Although the duty and breach elements are established by the doctrine, the plaintiff must also prove that the nurse's violation of the statute was the cause of plaintiff's injuries or harm and plaintiff must still prove actual damages.¹⁵⁴

E. Causation

1. Introduction

A basic and indispensable element to the plaintiff's negligence or malpractice action is the existence of a causal connection between the alleged negligent act or omission of the defendant and the harm to the plaintiff.¹⁵⁵ The causation element should be separated into two distinct causation requirements: 1) causation in fact and 2) proximate cause, both of which must be established before liability is imposed.¹⁵⁶

¹⁵¹*Id.* at 229-31.

¹⁵²*Id.*

¹⁵³See *Lama*, 16 F.3d at 480; *Central Anesthesia Assocs.*, 333 S.E.2d at 831, 833; *BERNZWEIG*, *supra* note 13, at 73-74.

¹⁵⁴*Lama*, 16 F.3d at 481 (We hold that plaintiffs met their burden of proof as to the allegation that the Hospital's [nurses'] substandard record-keeping procedures delayed the diagnosis and treatment of [patient's] wound infection at a time when controlling the wound infection was likely to prevent the development of the more serious discitis."); *Central Anesthesia Assocs.*, 333 S.E.2d at 833 ("[A] jury would be authorized to find from plaintiff's expert's testimony that if such [state mandated physician] direction and responsibility had been provided to, or sought by, nurse . . . and endotracheal tube would have been used instead of a mask, the patient would have been properly oxygenated."); *KEETON ET AL.*, *supra* note 4, § 36, at 220-27; *BERNZWEIG*, *supra* note 13, at 73-74.

¹⁵⁵*Gibson v. Bossier City Gen. Hosp.*, 594 So.2d 1332, 1343 (La. Ct. App. 1991) ("[A] plaintiff [must] not only prove a breach of the standard of care but also a causal relationship between that breach and the injuries."). See *KEETON ET AL.*, *supra* note 4, § 41, at 263.

¹⁵⁶*Vincent*, 862 P.2d at 851 & n.7; *BERNZWEIG*, *supra* note 13, at 270.

2. Causation in Fact

The defendant's negligent act or omission must be the "cause in fact" of the plaintiff's injuries in order to impose liability.¹⁵⁷ Most courts express this requirement in the form of a rule known as the "but for" test.¹⁵⁸ Pursuant to this test, a nurse's careless act or omission is a "cause in fact" of a plaintiff's injuries if the harm would not have occurred but for the nurse's conduct. Conversely, a nurse's careless act or omission is not a cause in fact of the plaintiff's injuries if the harm would have occurred anyway.¹⁵⁹ If the patient's recovery was highly unlikely from the inception of care, or if the ultimate result would have been the same regardless of whether the nurse had exercised due care, then the nurse's careless act or omission is not a cause in fact of the patient's injuries.¹⁶⁰

One problem with the "but for" test is that it can be applied accurately only when a single health care provider involved in the patient's care is proven to be the wrongdoer.¹⁶¹ At times, however, a single health care provider cannot be identified as the only party responsible for the patient's injury or harm. There can exist two or more forces, acts, or omissions that concur or contribute to cause the patient's injuries, and any one of these causes, operating alone, may have been sufficient to produce the same result.¹⁶² In such a situation, regarded as a "contributing," "concurring," or "multiple" causes case, there is a

¹⁵⁷See *Gibson*, 594 So.2d at 1343; *Rudeck v. Wright*, 709 P.2d 621, 628 (Mont. 1985); *Kimball*, 421 So.2d at 310; KEETON ET AL., *supra* note 4, § 41, at 264-68.

¹⁵⁸*Vincent*, 862 P.2d at 851; *Guilbeaux*, 589 So.2d at 631; *Rudeck*, 709 P.2d at 628; *Kimball*, 421 So.2d at 310; *Daniel*, 415 So.2d at 589; *Belmon*, 427 So.2d at 544; KEETON ET AL., *supra* note 4, § 41, at 266.

¹⁵⁹See *Ard*, 636 So.2d at 1046 (enunciating a causation test when a patient dies: plaintiff must prove there would have been a "chance of survival" and that the patient was denied this chance because of the defendant nurse's negligence); *Guilbeaux*, 589 So.2d at 631; *Rixey*, 916 F.2d at 615; *Belmon*, 427 So.2d at 544; *Kimball v. Paul Ins. Co.*, 421 So.2d 309, 310 (La. Ct. App. 1982) ("but for" test not met in patient fall case); *Daniel v. St. Francis Cabrini Hosp. of Alexandria*, 415 So.2d 586, 589 (La. Ct. App. 1982) ("but for" test met in patient fall case); KEETON ET AL., *supra* note 4, § 41, at 266; BERNZWEIG, *supra* note 13, at 272.

¹⁶⁰See *Porter*, 995 F.2d at 636 (nurse took infant's vital signs, communicated vital signs to physician, but nurse did not repeat communication; physician did not order immobilization of infant, who subsequently suffered partial paralysis); *Gill v. Foster*, 626 N.E.2d 190, 193 (Ill. App. Ct. 1993); *Myers v. Barringer*, 398 S.E.2d 615, 619 (N.C. Ct. App. 1990) (nurse failed to record and report patient's complaints of hip and leg pain following electro-convulsive therapy treatments).

¹⁶¹*Vincent*, 862 P.2d at 851-52; BERNZWEIG, *supra* note 11, at 272.

¹⁶²See *Vincent*, 862 P.2d at 851-52; *Berdyck*, 613 N.E.2d at 1018, 1024-25; *Manning v. Twin Falls Clinic & Hosp.*, 830 P.2d 1185, 1189 (Idaho 1992) (treating negligence claim as a "multiple causes or factors" case); *Alvis*, 592 N.E.2d at 682-83 (the failure by obstetrics nurses to determine that a baby was in the breech position was regarded not as the "sole cause" of injury, but as a "natural and continuous" "concurring cause" which produced the injury); *Lopez*, 833 P.2d at 1187-88; *Rudeck*, 709 P.2d at 628-29.

need for a broader rule than the "but for" test—if the "but for" test is strictly applied, the defendant nurse and any other careless, third party health care providers avoid liability.¹⁶³ To avoid such a result, a nurse's conduct will be the cause in fact of the resulting harm if it was a "substantial factor" in producing the harm.¹⁶⁴ A nurse whose careless conduct was a substantial factor in causing a patient's injuries is not exonerated because the negligence or malpractice of another health care provider is also a contributing or concurring cause;¹⁶⁵ and that third person can be held concurrently liable.¹⁶⁶

¹⁶³*Manning*, 830 P.2d at 1189 (holding that application of the "but for" test was inappropriate in those cases involving multiple causes or factors). In *Vincent*, 862 P.2d at 852-53 the patient was admitted to the emergency room for after complaining of severe abdominal cramps. An emergency room nurse assessed the patient's condition as not extraordinary, although patient appeared to need fluids. *Id.* A physician ordered another emergency room nurse to administer Mepergan intravenously and after doing so, the nurse briefly left the patient's room. *Id.* When the nurse returned she found the patient convulsing. *Id.* The patient subsequently experienced cardiac arrest and sustained permanent, debilitating brain damage. *Id.* The patient alleged that this injury was caused by emergency room nurses failure to assess and treat her extreme fluid loss. *Id.* In response, the defendant's expert, a toxicologist, testified that patient had experienced a rare allergic reaction to Mepergan. *Id.* After a jury verdict in favor of defendants, plaintiff appealed, arguing that the jury was given inconsistent definitions of a controlling legal rule. The appellate court disagreed:

Had the evidence in the instant case been limited to alleged negligence by nurses and doctors employed by (hospital), then . . . a 'but for' instruction would have been correct. (The hospital), the named defendant, would bear the legal responsibility for all such acts (citation omitted). [The hospital], however, introduced evidence and argued that factors unique to (patient's) physiology were involved in the emergency room injury. In light of this evidence of another emergency room force, (patient's) allegedly 'extraordinary' physiology, . . . a concurrent cause instruction was proper (citation omitted).

Id.; see also *Rudeck*, 709 P.2d at 628-29 ("Bear in mind that the present case involves an original tort-feasor [surgeon], concurrent tort-feasor [surgical nurses] and a subsequent tort-feasor [radiologist]. . . . We conclude that the instant case is just such an infrequent case where the 'but for' is inapplicable and the 'legal cause' ('substantial factor') rule is the correct instruction to give to the jury."); *KEETON ET AL.*, *supra* note 4, § 41, at 266-68.

¹⁶⁴*Simmons*, 841 F. Supp. at 750 ("[T]o recover for injury, plaintiff must prove that defendant's conduct was a 'substantial factor' in causing the untoward result."); *Vincent*, 862 P.2d at 851-52; *Atkins*, 634 A.2d at 259 (applying "substantial factor" tests to hospital fall case); *Manning*, 830 P.2d at 1189 (holding that a nurse's conduct "[n]eed not be the only cause. It is sufficient if it is a substantial factor concurring with some other cause acting at the same time, which in combination with it, causes the injury"); *Rudeck*, 709 P.2d at 627 (holding that "if the effect of defendant [surgeon's] negligence in leaving a foreign object inside his patient's wound actively and continuously acts to cause harm to his patient, the fact that the active and substantially simultaneous negligence of the nurses [in not counting sponges] is also a substantial factor in bringing about the harm to the patient.").

¹⁶⁵See *Berdyck*, 613 N.E.2d at 1024-25 (finding that an obstetrics nurse was negligent for failing to assess signs and symptoms of preclampsia (seizure) in a pregnant patient and for failing to inform physician, even though the physician stipulated that he was negligent and his negligence was a cause of patient's injuries); *Alvis*, 592 N.E.2d at 682-83

The plaintiff possesses the burden of proving causation in fact. To meet his burden, the plaintiff must introduce evidence that establishes a reasonably certain basis for concluding that the nurse's conduct more likely than not resulted in, was the cause of, or was a substantial factor in bringing about the harm.¹⁶⁷ Mere possibility or speculation of such causation is insufficient, while absolute certainty is not required. The law instead requires evidence which would enable reasonable persons to determine the certainty, probability, or likelihood that the harm was caused by the nurse.¹⁶⁸

(obstetrics nurses' failure to detect that the baby was in breech position, which led to difficult vaginal delivery injuring baby, was regarded as the "proximate cause of injury, though not sole cause"); *Lopez*, 833 P.2d at 1187-88 (actions of nurses can be a "contributing cause" of injuries suffered by a patient who is subsequently misdiagnosed by a physician because of faulty nursing assessment); *Rudeck*, 709 P.2d at 627-29.

¹⁶⁶See *Lopez*, 833 P.2d at 1187-88 (nurses failed to assess that patient not in labor); *Rudeck*, 709 P.2d at 627-29 (surgeon deemed negligent for leaving sponge inside patient and surgical nurses held to commit malpractice for failing to inform surgeon of unaccounted-for sponge); KEETON ET AL., *supra* note 4, § 41, at 266-68.

¹⁶⁷See *Porter*, 995 F.2d at 636 (holding that expert testimony "was legally insufficient to establish a causal connection" between the failure of nurses to repeat infant's abnormal vital signs to physician, physician's decision not to immobilize infant, and infant's eventual partial paralysis); *Harris*, 872 S.W.2d at 762-63 (finding "factually sufficient evidence" was present to conclude that the nurses' failure to cross-check a prescription with known allergies, as well as a failure to instruct the patient on how to proceed in the event of an allergic reaction, caused patient's death); *Dixon*, 431 S.E.2d at 782 ("Reasonable minds could accept from the testimony at trial that the Hospital's breach of duty [caused by nurse not properly restocking the Code cart] was a cause of [patient's] brain death, without which the injury would not have occurred."); *Wheeler*, 866 S.W.2d at 47 ("Had nurses . . . accurately assessed the status of [plaintiff's] labor and the breech position of the baby, it is highly likely that [plaintiff] would have been admitted to the [hospital] for delivery"); *Cohen*, 592 A.2d at 724 where allegation consists of improper injections, the testimony of a physician was sufficient "to permit a finding that an injection had caused the [plaintiff's] wrist drop . . ."; *Alef*, 6 Cal. Rptr.2d at 905-06 (finding "sufficient" evidence that the failure of labor and delivery nurses to perform proper Doppler monitoring of a fetus resulted in permanent brain damage); *Guilbeaux*, 589 So.2d at 631 (finding that "plaintiffs proved by a preponderance of the evidence that, but for the drain in plaintiff's back, plaintiff probably would not have had two (2) herniated discs. Although plaintiff had a pre-existing back condition, the defendants' negligence aggravated his condition and caused his herniated discs."); *Gibson*, 594 So.2d at 1343 (plaintiffs failed to sustain burden that baby's death was caused by nurses' failure to diagnose and treat as opposed to a congenital birth defect); *Nastasi v. United Mine Workers of America Union Hosp.*, 567 N.E.2d 1358, 1364 (Ill. Ct. App. 1991); *Harrington*, 569 N.E.2d at 18; *Hill*, 610 N.E.2d at 637; *Daniel*, 415 So.2d at 589; *Garcia*, 697 F. Supp. at 1572-73; *Haney*, 323 S.E.2d at 434; KEETON ET AL., *supra* note 4, § 41, at 269-70.

¹⁶⁸See *Porter*, 995 F.2d at 632 (establishing the test for causation in nursing malpractice cause of action: Did defendant's negligence, "in probability" cause plaintiff's injury); *Alef*, 6 Cal. Rptr.2d at 905-06 (defining causation test as "reasonable medical probability that plaintiff would have obtained a better result"); *Gill*, 597 N.E.2d at 783; *Guilbeaux*, 589 So.2d at 631; *Cohen*, 592 A.2d at 723-24; *Harrington*, 569 N.E.2d at 18; *Daniel*, 415 So.2d at 589; *Garcia*, 697 F. Supp. at 1572-73; *Haney*, 323 S.E.2d at 434; KEETON ET AL., *supra* note 4, § 41, at 269-70.

Direct or circumstantial evidence, expert testimony, or the common knowledge of the jury can provide the basis from which the causal connection can be established.¹⁶⁹ When the causation determination in a nursing negligence or malpractice case involves information or facts within the common knowledge or experience of the jury, no expert testimony is required to demonstrate causation.¹⁷⁰ If, however, the matter is a complex medical matter, expert testimony is required to provide a sufficient basis for the causal connection.¹⁷¹ The expert will need to testify that, in his or her professional

¹⁶⁹See, e.g., *Ard*, 636 So.2d at 1044-47 (establishing causation through testimony of patient's spouse concerning patient's deteriorating physical condition and lack of response by nurses to calls for attention); *White*, 633 So.2d at 758-59 (causation established by testimony of family members, autopsy report, and expert testimony); *Harris*, 872 S.W.2d at 762-63 (causation element established in part by testimony of physician and expert nurse witness); *Cohen*, 592 A.2d at 723-24 (causal connection established by physician testimony, plaintiff's testimony, and plaintiff's physical condition); *Hill*, 610 N.E.2d at 637 (causal connection established by physician testimony, Physicians Desk Reference which was entered into evidence, plaintiff's testimony, and plaintiff's physical condition); *Belmon*, 427 So.2d at 544 (causation issue is a question of fact for jury); KEETON ET AL., *supra* note 4, § 41, at 269-70.

¹⁷⁰KEETON ET AL., *supra* note 4, § 41, at 269-70.

¹⁷¹See *White*, 633 So.2d at 758-59 (discussing Physician's expert testimony that if patient's symptoms of breathing difficulty had not been overlooked by nurses, tests may have prompted the doctors to take steps which could have prevented disorder, which caused the patient's death.); *Ard*, 636 So.2d at 1046-47 (physician expert testified that nurses' failure to observe and assess patient lessened patient's chances for survival); *Vincent*, 862 P.2d at 849 (defendant's physician expert, a toxicologist, testified that patient's heart attack and brain damage were caused by a rare allergic reaction to medication and not by Emergency Room nurses failure to assess and treat patient's extreme fluid loss); *Baptist Medical Ctr.*, 618 So.2d at 1339 ("[Physician's] testimony . . . provided the jury with adequate evidence to allow it to find that the . . . failure to detect and to report to the [physician] the symptoms of uterine rupture and the hospital's failure to react properly to a fetal distress situation proximately caused [patient's child's] death."); *Dixon*, 431 S.E.2d at 782. Plaintiff's expert witness, (physician), testified that the hospital employees' breach of duty, in not being prepared to promptly reintubate [patient], caused [patient's] brain death; *St. Paul Med. Ctr.*, 842 S.W.2d at 814 ("[Physician], a specialist in maternal-fetal medicine, testified that the nurse was negligent in failing to render adequate care in monitoring [baby] and detecting his hypoxia which subjected him to prolonged insult and delayed his delivery. He further stated that application of the EFM by a nurse with proper training would have detected [baby's] condition and would have required his delivery"); *Butterfield*, 831 P.2d at 105; *Treinis v. Deepdale Gen. Hosp., Inc.*, 570 N.Y.S.2d 185, 187 (1991) (physician expert testified that nurses' failure to immediately administer Nipride to patient after surgery for repair of torn Achilles tendon was of no consequence and that patient's death was caused by a rare tumor that was not discovered until his death); *Guilbeaux*, 589 So.2d at 631 (physician testified that nurse's leaving strip of drainage tube in plaintiff's back probably caused plaintiff's herniated discs); *Roach*, 585 N.E.2d at 1079, 1080-81 (nurse expert testified that nurses breached standard of care by failing to notify attending physician of abnormal fetal heart tones shown by monitoring system, but "failure to notify" instruction was refused because no expert testimony was presented to show that the nurses' failure caused the baby's brain damage from lack of oxygen); *Gibson*, 594 So.2d at 1343 (physician experts testified that baby's death was caused by congenital

opinion, the nurse's negligence or malpractice, in all reasonable medical and scientific certainty or probability, caused or resulted in the patient's injury.¹⁷²

3. Proximate Cause

a. Introduction and Overview

Even if the harm would not have happened "but for" the nurse's negligence or malpractice, liability does not ensue automatically. In addition to demonstrating that the nurse's conduct was the cause in fact of plaintiff's injuries, the successful plaintiff must also show that the nurse's conduct was the "proximate" or legal cause of the injuries.¹⁷³ The proximate cause doctrine

birth defect as opposed to nurses' failure to diagnose and treat); *Cohen*, 592 A.2d at 723-24 (physician's testimony established causal connection between nurse giving an intramuscular injection of Demerol and Vistaril, allegedly by wrong technique and in wrong site, and patient's sudden wrist drop and injury to radial nerve); *George v. LDS Hosp.*, 797 P.2d 1117, 1121-22 (Utah Ct. App. 1990) (defendant argued that patient inevitably would have died of sepsis and that any negligence on the nurses' part in not notifying physician of patient's deteriorating condition was not a proximate cause of patient's death; but plaintiff's physician experts testified that sepsis may be reversible and treatable and did not occur instantaneously in patient's case); *Plutshack*, 316 N.W.2d at 8 (where a nurse assisted a physician in performing a lumbar puncture of baby to determine if the baby had Meningitis; the nurse was not liable in part because the record contained no expert testimony that the nurse's conduct, even if negligent, could have directly caused baby's cardiac arrest); *Eyoma*, 589 A.2d at 655-56; *Sweeney*, *supra* note 28, at 36-37.

¹⁷²See *Porter*, 995 F.2d at 633 (expert testimony must establish a "probability, not a mere possibility, of a causal connection. . . . The use of phrases such as 'could be,' 'could very well be,' or 'could possibly be,' is generally fatal to allegations of . . . causation."); *Baptist Medical Ctr.*, 618 So.2d at 1338-39; *Butterfield*, 831 P.2d at 105 (discussing physician testimony as to causation and "specific causal link" between nurses' negligence, physician's faulty diagnosis, and patient's death); *Alef*, 6 Cal. Rptr.2d at 905-06 (physician expert testified that had labor and delivery nurses engaged in proper monitoring of fetus, baby's brain damage "probably" would have been prevented); *Guilbeaux*, 589 So.2d at 631; *Eyoma*, 589 A.2d at 655-56 (physicians testified that the cause of respiratory arrest was improper monitoring by recovery room nurse and a failure to ascertain drugs administered); *Harrington*, 569 N.E.2d at 18 ("The plaintiff's expert specifically testified that, to a degree of medical and scientific certainty, [patient's] life could have been saved if Narcon was administered at 11 p.m. following her collapse."); *Sweeney*, *supra* note 28, at 36-37.

¹⁷³See, e.g., *Baptist Medical Ctr.*, 618 So.2d at 1339; *Dixon*, 431 S.E.2d at 781-82 (discussing nurses' breach of duty in not having the code cart properly restocked, resulting in a three minute delay in the intubation of patient, proximately caused patient's brain death); *Smith*, 637 So.2d at 1181-83 (holding that nurses' breach of duty of care in not properly observing and restraining confused, disoriented patient was proximate cause of patient's death in vehicle accident.); *Miles*, 489 N.W.2d at 838, 841; *Fein*, 695 P.2d at 675 (proximate cause present when nurse practitioner misdiagnosed patient's chest pain as muscle spasm, and patient suffered heart attack); KEETON ET AL., *supra* note 4, § 41, at 263-64.

requires the existence of a reasonably close connection between the careless act or omission of the nurse and the harm suffered by the plaintiff.¹⁷⁴ Proximate cause is not a question of factual causation since the "proximity" issue arises only after cause in fact is established.¹⁷⁵

b. The Foreseeability Approach

The most troublesome and contentious aspect of the proximate cause doctrine is the defendant's liability for unforeseeable, unusual, or remote consequences stemming from the defendant's admittedly careless act.¹⁷⁶ Since the law deems it unjust to hold a defendant legally responsible for all the consequences of his or her wrongful conduct, proximate cause serves as a legal device to limit the scope of the defendant's liability to certain consequences.¹⁷⁷ The seminal proximate cause issue, therefore, concerns how far a defendant nurse's legal liability will extend for the consequences factually caused by his or her careless conduct.

To answer this question, courts have developed the "foreseeability" rule. This rule limits the nurse's liability to the foreseeable consequences of his or her careless conduct.¹⁷⁸ It is a fundamental policy of the law that a defendant is not to be held liable for consequences which no reasonable person could anticipate or expect to follow from the conduct in question, regardless of the causation pattern.¹⁷⁹

c. Intervening Cause

Occasionally, when employing the foreseeability rule an "intervening cause" will be found to have played a part in creating plaintiff's injury. An intervening cause is some force, actor, or event of independent origin which comes into active operation after the negligence of the defendant and either extends the

¹⁷⁴*Miles*, 489 N.W.2d at 841; KEETON ET AL., *supra* note 4, § 41, at 263-64.

¹⁷⁵KEETON ET AL., *supra* note 4, § 43, at 280-81.

¹⁷⁶*See, e.g., Smith*, 637 So.2d at 1181-83 (Was unusual manner of confused, disoriented, and "bizarrely" acting patient's death caused by patient leaving ward, making his way through ER, driving away in an ambulance, and fatally crashing, proximately caused by nurses' failure to observe and restrain?); KEETON ET AL., *supra* note 4, § 43, at 280-81.

¹⁷⁷*Smith*, 637 So.2d at 1181-83; KEETON ET AL., *supra* note 4, § 41, at 263-64.

¹⁷⁸*See, e.g., Smith*, 637 So.2d at 1181, 1183; *Harris*, 872 S.W.2d at 762-63; *Dixon*, 431 S.E.2d at 781-82; *Simmons*, 841 F. Supp. at 750; *George*, 797 P.2d at 1122; *Lopez*, 833 P.2d at 1185; *Koeniguer*, 422 N.W.2d at 606; *Polonsky*, 418 N.E.2d at 622; KEETON ET AL., *supra* note 4, § 43, at 280-81; BERNZWEIG, *supra* note 13, at 68; *but see Fein*, 695 P.2d at 675 (when nurse practitioner misdiagnosed patient's chest pain as a muscle spasm in failing to order EKG. Consequently patient suffered heart attack).

¹⁷⁹*See Simmons*, 841 F. Supp. at 750; *Dixon*, 431 S.E.2d at 782; *Koeniger*, 422 N.W.2d at 606; *Polonsky*, 418 N.E.2d at 622; KEETON ET AL., *supra* note 4, § 43, at 280-81, 84.

results of defendant's negligence or combines with the defendant's negligence to produce the injury.¹⁸⁰ The intervening cause in a nursing negligence or malpractice case very likely will be careless human conduct, particularly the medical malpractice of a physician.¹⁸¹

The problem emerges as to whether a nurse is liable for harm she did in fact contribute to, but where the harm is also produced by a later intervening cause of independent origin for which the nurse was not responsible?¹⁸² The intervening cause doctrine, generally regarded as an extension of the proximate cause doctrine, provides a legal solution for determining ultimate tort responsibility.¹⁸³ The key question is whether the nurse is to be excused from responsibility because his or her culpability has been superseded by a subsequent, independent, intervening event.¹⁸⁴

One important rule for determining intervening cause is the standard of "foreseeability." Under the rule, a nurse will be held liable if the subsequent

¹⁸⁰*NKC Hosps., Inc.*, 849 S.W.2d at 567-69; *Lopez*, 833 P.2d at 1187-88; *Fairfax*, 419 S.E.2d at 625; *KEETON ET AL.*, *supra* note 4, § 44, at 301.

¹⁸¹For cases discussing the combined negligence of nurses and physicians, *NKC Hosps., Inc.*, 849 S.W.2d at 567-69 (nurses negligent for failing to observe and assess pregnant patient in "extreme" abdominal pain and for failing to question discharge of patient while patient's personal physician misdiagnosed patient's condition and ordered discharge); *Berdyck*, 613 N.E.2d at 1024-25; *Fairfax*, 419 S.E.2d at 625 (labor and delivery nurse either failed to observe or recognize signs of fetal distress; physician was alleged to be negligent in diagnosis and treatment); *Lopez*, 833 P.2d at 1187-88; *Miles*, 489 N.W.2d at 841 (nurse failed to accurately describe fetal heart rate pattern; and physician failed to diagnose baby's hypoxic state and fetal distress); *Koeniguer*, 422 N.W.2d at 602-03 (physician and nurses discharged post-operative patient with elevated temperature).

¹⁸²*See, e.g.*, *Berdyck*, 613 N.E.2d at 1024-25; *NKC Hospitals, Inc.*, 849 S.W.2d at 567-69; *Fairfax*, 419 S.E.2d at 625; *Lopez*, 833 P.2d at 1188; *Miles*, 489 N.W.2d at 841; *KEETON ET AL.*, *supra* note 4, § 44, at 301.

¹⁸³*Miles*, 489 N.W.2d at 841; *Lopez*, 833 P.2d at 1188; *Fairfax*, 419 S.E.2d at 625; *KEETON ET AL.*, *supra* note 4, § 44, at 301-02.

¹⁸⁴*See, e.g.*, *Berdyck*, 613 N.E.2d at 1024-25 (malpractice of physician); *NKC Hosps., Inc.*, 849 S.W.2d at 568 (misdiagnosis by patient's personal physician); *Miles*, 489 N.W.2d at 841 (nurse failed to accurately describe fetal heart rate pattern, but physician failed to diagnose baby's hypoxic state and fetal distress); *Lopez*, 833 P.2d at 1188; *Fairfax*, 419 S.E.2d at 625 (hospital argued that negligence of labor and delivery nurse in failing to observe or recognize signs of fetal distress was "remote" and that negligence of physician was the "intervening and independent" conduct that was the "immediate cause" of the injury); *Koeniguer*, 422 N.W.2d at 602-03 (patient recovering from urological surgery discharged with elevated temperature. "There is contradictory expert testimony as to whether the surgery, the infection, or a combination of the two resulted in [patient's] death . . . Hospital had the burden and did not demonstrate that the physician's alleged negligence superseded any negligence by the Hospital [nurses] and was the sole proximate cause of [patient's] death"); *KEETON ET AL.*, *supra* note 4, § 44, at 301-02; *BARBARA E. CALFEE, NURSES IN THE COURTROOM* 210-11 (1993).

intervening cause is deemed reasonably foreseeable.¹⁸⁵ If the intervening cause is one which the nurse reasonably ought to have anticipated and taken into account, the intervening cause cannot be deemed "supervening," "efficient," or "superseding"; and the nurse is liable.¹⁸⁶ Similarly, if the intervening cause is within the scope of the original risk entailed by the nurse's conduct, or reasonably connected to it, or reasonably influenced by it, the intervening cause is not a "superseding," "supervening," or "efficient" one; and the nurse's liability is not terminated.¹⁸⁷ However, if an independent intervening cause is present, and it is one which the nurse neither could foresee nor control, the nurse's conduct, even if careless, cannot be deemed to be the sole, self-producing, immediate, "efficient," and thus "proximate" cause of the patient's injury.¹⁸⁸

d. The Jury's Role

Proximate cause and intervening cause issues require the application of legal standards, such as the "foreseeability" test, to the facts of the case. Accordingly, they are regarded as factual questions for the jury to decide.¹⁸⁹

¹⁸⁵*NKC Hosps., Inc.*, 849 S.W.2d at 568 ("[I]f the resultant injury is reasonably foreseeable from the view of the original actor, then the other factors causing to bring about the injury are not a superseding cause."); *Fairfax*, 419 S.E.2d at 625 ("remoteness" test); *KEETON ET AL.*, *supra* note 4, ¶ 44, at 302.

¹⁸⁶*NKC Hosps., Inc.*, 849 S.W.2d at 568-69 ("[F]oreseeability by the original or antecedent actor negates an otherwise superseding cause [the physician]; *Miles*, 489 N.W.2d at 841 ("An efficient intervening cause is the intervening negligence of a third person who has full control of the situation, and whose negligence could not have been anticipated, and which negligence breaks the causal connection between the original negligence and the injury" (citation omitted)); *KEETON, ET AL.*, *supra* note 4, § 44, at 303-04.

¹⁸⁷*See, e.g., Berdyck*, 613 N.E.2d at 1024-25; *Lopez*, 833 P.2d at 1185, 1187-88; *Koeniguer*, 422 N.W.2d at 602-03; *KEETON, ET AL.*, *supra* note 4, § 44, at 302-04.

¹⁸⁸*See Berdyck*, 613 N.E.2d at 1024-25 ("In order to break the [causation] chain, the intervening negligence of the physician must be disconnected from the negligence of the [nurse] and must be of itself an efficient, independent, and self-producing cause of the patient's injury.").

¹⁸⁹*See, e.g., Miles*, 489 N.W.2d at 841 (where nurse failed to accurately describe fetal heart pattern, and physician failed to diagnose baby's hypoxic state and fetal distress, "presented a question of fact as to proximate cause."); *Fairfax*, 419 S.E.2d at 625 ("[T]here was abundant, credible evidence which the jury was entitled to accept, establishing that [nurse's] breach of the standard of care was a proximate cause of the injuries and damages sustained. . . . It was for the jury to say whether these breaches by [nurse] constituted an efficient cause of the loss suffered by the plaintiffs."); *Koeniguer*, 422 N.W.2d at 606 (proximate cause regarded as question of fact for jury); *Polonsky*, 418 N.E.2d at 622 (jury could infer that elderly patient under medication and unrestrained would become confused and disoriented and that nurse should have anticipated fall); *KEETON, ET AL.* *supra* note 4, § 45, at 320.

F. Damages

Negligent conduct, in and of itself, does not establish the the nurse's liability. Once the negligent act and causation elements are established, the plaintiff must still show the essential element of damages in order to prevail. Although a nurse may have breached a duty owed to a patient, no liability for negligence will be imposed if the plaintiff has not sustained damages; i.e., an injury or harm.¹⁹⁰

Damages are designed to compensate, that is, to restore the plaintiff patient, inasmuch as possible, to his or her condition before the harm occurred.¹⁹¹ Damages are defined as (1) special damages such as economic losses, medical and hospital expenses, future medical care, lost wages and wage earning capacity, business profits, future expenses, and loss of support, companionship, and comfort; and (2) general damages or damages deemed inherent in the injury itself, such as pain and suffering, mental anguish, emotional distress, and awards for disfigurement, physical impairment and disability.¹⁹²

If a nurse acts in a grossly negligent, wanton, reckless, consciously indifferent, malicious, or oppressive manner, a jury may impose additional damages on the nurse to punish him and to deter others from engaging in such flagrant misconduct.¹⁹³

¹⁹⁰See *Wyatt v. St. Paul Fire and Marine Ins. Co.*, 868 S.W.2d 505, 509 (Ark. 1994) (where nurse disclosed information to a third party that either patient had AIDS or was being tested for it, there was no cause of action for medical malpractice since revealing confidential information not regarded as a "medical injury"); *Benninger, supra* note 12, at 1295.

¹⁹¹BERNZWEIG, *supra* note 13, at 273.

¹⁹²See, e.g., *St. Elizabeth Hosp.*, 883 S.W.2d at 442 (awarding damages for pain and mental anguish, loss of earning capacity, disfigurement and physical impairment, and future medical care); *Manning*, 830 P.2d at 1188 (allowing for an award of emotional damages in cases where nurses, despite requests and strenuous urgings of family members present, refused to provide elderly "no code" patient with a portable oxygen unit during relatively short move to a private room, and patient died shortly thereafter); *Eyoma*, 589 A.2d at 658-62 (damages included loss of earning capacity, out-of-pocket expenses, and awards for disability and impairment, pain and suffering, and loss of enjoyment of life).

¹⁹³See, e.g., *Manning*, 830 P.2d at 1190-91 (holding that the punitive damage standard encompasses conduct which is an extreme deviation from reasonable standards, conduct which shows a disregard for likely consequences, and malicious, oppressive, fraudulent, or grossly negligent conduct.); *Hodges v. Virginia Employment Comm'n*, 355 S.E.2d 104, 107 (employing a "conscious indifference to consequences" standard, the court found that a jury "could reasonably conclude from the evidence presented that the failure of the nurses to convey actual knowledge of [patient's] heart condition and medication evinces that entire want of care which would raise the presumption of a conscious indifference to the consequences."); *Scribner*, 866 P.2d at 440-41 ("A party may be held liable for punitive damages under the 'wanton or reckless disregard' standard if the party is shown to be 'aware of or culpably indifferent to unnecessary risk of injury.'"); *FIESTA, supra* note 48, at 158-59 and cases cited therein.

Punitive damages, however, are relatively rare in nursing negligence cases since the nurse is inspired by a desire to help, comfort, and heal patients. A nurse's conduct, even if careless, is seldom sufficiently flagrant to warrant the imposition of punitive damages.¹⁹⁴

G. Defenses

Contributory negligence is careless conduct on the part of the plaintiff that contributes to his or her own injury. In those states still employing it, contributory negligence is a harsh doctrine that acts as a complete defense to recovery regardless of how slight the plaintiff's negligence.¹⁹⁵

In most jurisdictions, however, the defense of contributory negligence has been abolished and replaced by the doctrine of comparative negligence.¹⁹⁶ Comparative negligence acts not as a complete bar to recovery but rather as a method of reducing plaintiff's recoverable damages. The jury first makes a finding of each party's fault, assigns a percentage of fault to each party, and the plaintiff's damages are reduced by the percentage of fault attributable to plaintiff.¹⁹⁷

When a patient is wholly or partly responsible for causing his or her own injury, a nurse may raise these legal defenses to preclude or lessen liability.¹⁹⁸ A competent patient, for example, may not cooperate, refuse to follow a physician's or nurse's order or instruction, leave the hospital against medical advice, refuse or neglect prescribed treatment or medication, meddle with equipment, provide false, misleading, or incomplete information, or otherwise engage in careless, non-compliant, reckless, or fraudulent conduct.¹⁹⁹ A

¹⁹⁴FIESTA, *supra* note 48, at 158.

¹⁹⁵BERNZWEIG, *supra* note 13, at 293-94, 96.

¹⁹⁶KEETON, ET AL., *supra* note 4, § 67, at 468-70.

¹⁹⁷BERNZWEIG, *supra* note 13, at 296.

¹⁹⁸See, e.g., *Oxford*, 438 S.E.2d at 172 (comparative negligence charge appropriate in a medical malpractice cause of action where plaintiff fails to disclose fully all information relevant to her condition); *Jensen*, 459 N.W.2d at 186 ("Consequently, to be considered as and constitute contributory negligence in a medical malpractice action, a patient's negligence must have been an active and efficient contributing cause of the injury, must have cooperated with the negligence of the malpractitioner, must have entered proximate causation of the injury, and must have been an element in the transaction on which the malpractice is based."); *Bartimus*, 458 N.E.2d at 1080; Patricia W. Iyer & Nancy Hand Camp, *Legal Aspects of Charting Techniques*, NURSING DOCUMENTATION: A NURSING PROCESS APPROACH 90-91 (1991) (importance and procedure of documenting patient's potentially contributorily negligent acts); Jane Greenlaw, *Failure to Use Siderails: When Is It Negligence*, 10 LAW, MEDICINE, AND HEALTH CARE 125, 126-27 (1982) and cases cited therein; Walker, *supra* note 100, at 46.

¹⁹⁹See, e.g., *Oxford*, 438 S.E.2d at 172 (discussing patient's failure to provide relevant information to nurses); *Hackathon v. Lester E. Cox Medical Ctr.*, 824 S.W.2d 472, 475 (Mo. Ct. App. 1992) (as a result of patient's refusal to allow a nurse to check heat pad, patient was burned); *Bartimus*, 458 N.E.2d at 1080 (where evidence showed that the plaintiff may have failed to use due care in leaving the hospital . . . against the advice

plaintiff may be wholly or partly responsible for causing her injury when, contrary to instructions, she gets out of bed unattended or tries to climb over siderails.²⁰⁰ Comparative and contributory negligence will likely fail as defenses when a patient is confused, disoriented, dazed, or otherwise impaired since the patient's condition is a key fact that the nurse knows or should know, thereby requiring the reasonable nurse to take special precautions to safeguard the patient.²⁰¹ Moreover, a patient will not be deemed contributorily negligent when his or her conduct supplies the reason for the medical treatment, which later becomes the subject of the lawsuit, or when the patient contributes to a medical condition which causes the patient to seek medical care, which later becomes the subject of the lawsuit.²⁰²

H. Vicarious Liability

Vicarious liability is the legal doctrine which decides that, by reason of some relation existing between two parties, the negligence of one party is to be charged against the other party even though the latter party has played no part in the careless conduct, has done nothing whatsoever to aid or encourage it, or indeed has done all it possibly could to prevent the harm.²⁰³ The doctrine is sometimes called imputed negligence or *respondeat superior*.²⁰⁴

The most common relationship cited to invoke vicarious liability is that between employer and employee. Once it is determined that a person at work is an employee, the employer becomes subject to vicarious liability for the employee's torts committed within the course or scope of employment.²⁰⁵

As most nurses work for hospitals or other health care providers that possess the power and right to control and supervise the nurse's actions, a nurse will be regarded as an employee of the hospital or health care provider.²⁰⁶ The

of [physician] . . . the evidence supported the court's decision to instruct the jury on comparative negligence.); FIESTA, *supra* note 48, at 3 and cases cited therein; Walker, *supra* note 100, at 46.

²⁰⁰Greenlaw, *supra* note 198, at 126-27 and cases cited therein.

²⁰¹See, e.g., *Tobia*, 643 A.2d at 2, 4 ("We hold that when a health-care professional's duty includes exercise of reasonable care to prevent such a patient [85 year old] from engaging in self-damaging conduct, the health care professional may not assert contributory negligence as to a claim arising from the patient's self-inflicted injuries."); Greenlaw, *supra* note 198, at 127.

²⁰²Jensen, 459 N.W.2d at 187 ("Any conduct on [patient's] part before he was admitted to [hospital] and which may have causally contributed to his demise was not a proximate cause [of the] alleged malpractice in medical treatment at hospital.").

²⁰³KEETON, ET AL., *supra* note 4, § 69, at 499-501.

²⁰⁴*Id.* at 499.

²⁰⁵*Id.* at 501.

²⁰⁶Morris, 597 N.E.2d at 1113; FIESTA, *supra* note 48, at 34-35; Sweeney, *supra* note 28, at 37; Morris, *supra* note 28, at 128-29.

liability for a nurse's negligence or malpractice, therefore, is not a matter that pertains only to the nurse. The nurse's employer²⁰⁷ may also be liable for the nurse's careless acts or omissions.

Although the nurse will be sued in an individual capacity for the harm resulting from his or her negligence or malpractice, it is also likely that the plaintiff will attempt to reach the more financially capable employer by means of the vicarious liability doctrine.²⁰⁸ The careless nurse, however, is not relieved of liability. The hospital is permitted, and may attempt in a separate lawsuit, to recover from the nurse employee any monetary damages vicariously incurred by the hospital in connection with the nurse's negligence or malpractice.²⁰⁹ Vicarious liability, therefore, is not a shield to nursing negligence and malpractice liability.

III. TYPES OF NURSING NEGLIGENCE

A. Introduction

Nurses perform a variety of advanced medical procedures for their patients. Any one of these nursing activities may result in harm to a patient and thus may be the subject of a lawsuit. This section will focus on particular problematic aspects of the nursing profession. Caselaw will be examined and analyzed to ascertain the distinct and exacting duties of care that a nurse owes to a patient, to illustrate the recurring practical problems that nurses presently confront, and to explain the nurse's potential tort liability based on these specific responsibilities.

B. Administration of Medication

The administration of medication is one of the most frequent functions of the nurse, and no other aspect of nursing care involves more risk. Consequently, medication errors are a common area of nursing negligence and malpractice and thus comprise a major source of legal action against nurses.²¹⁰

²⁰⁷For information concerning hospital liability see *Berdyck*, 613 N.E.2d at 1020; *DeLaughter*, 601 So.2d at 824-25; *Butterfield*, 831 P.2d at 104; *McClain*, 602 So.2d at 242; *Morris*, 597 N.E.2d at 1112; *Brown*, 588 So.2d at 1299; *Rixey*, 916 F.2d at 615; *Daniel*, 415 So.2d at 589; *Sweeney*, *supra* note 28, at 37; *Vallot*, *supra* note 38, at 99 and cases cited therein; *Greenlaw*, *supra* note 72, at 118 and cases cited therein; *Carlo*, *supra* note 45, at 270-72 and cases cited therein. For information concerning other employees see *Adams*, 856 P.2d at 865 (physician employer liable for misdiagnosis by nurse practitioner employee who diagnosed patient's condition as genital herpes instead of severe yeast infection); *Hill*, 610 N.E.2d at 636 (medication technique error by nurse employee of university); *HEITLAND, ET AL.*, *supra* note 94 (responsibility of physician for malpractice of nurse specialist pursuant to Illinois law).

²⁰⁸*Scanlan*, *supra* note 38, at 227; *Morris*, *supra* note 28, at 123.

²⁰⁹*Carlo*, *supra* note 45, at 273.

²¹⁰*Gayle Hacker Sullivan*, *Five "Rights" Equal 0 Errors*, RN 17 Aug. 1994 (Supp.); *LOEB & CAHILL*, *supra* note 5, at 123 and cases cited therein; *FIESTA*, *supra* note 48, at 49-50 (and

Medication errors arise in a wide variety of circumstances. A nurse may commit an error in policy or practice by failing to follow procedural safeguards.²¹¹ He or she may, for example, fail to review a patient's record to determine whether a drug order has been modified,²¹² fail to read the drug label three times,²¹³ fail to confirm on a twenty-four hour basis that a physician's order for medication remains operative,²¹⁴ or fail to contact a physician to re-issue, confirm, or alter a preoperative medication order after the patient undergoes surgery.²¹⁵ A nurse must possess a basic knowledge about medications; he or she must be familiar with drug warning indications, effects, complications, risks, and contraindications. A nurse who ignores or lacks such fundamental information and knowledge about a medication he or she administers subjects himself or herself to liability.²¹⁶ A nurse is also legally liable for giving the wrong medication to a patient,²¹⁷ giving the right medication to the wrong patient,²¹⁸ administering medication at the wrong time, at incorrect intervals, or on a delayed basis.²¹⁹

A nurse is expected to know the correct dosages of medication and is liable if the wrong dose is given to a patient.²²⁰ The prudent nurse should compare

cases cited therein); POZGAR, *supra* note 38, at 238-43 and cases cited therein.

²¹¹See *Hodges*, 355 S.E.2d at 106-07 (emergency room nurses failed to take history of medications and to obtain information on medication regularly being taken by patient); *Sweeney*, *supra* note 28, at 34-36; *Reilly*, *supra* note 28, at 16 and cases cited therein.

²¹²POZGAR, *supra* note 38, at 241-42 and cases cited therein.

²¹³*Reilly*, *supra* note 28, at 16 and cases cited therein.

²¹⁴*Sweeney*, *supra* note 28, at 36.

²¹⁵*Id.*

²¹⁶See, e.g., *Belmon*, 427 So.2d at 544-45 (finding that "[t]he nurse [did not] approach her duties with a proper understanding of the hemorrhage-prone vulnerability of a Heparinized patient." *Polonsky*, 418 N.E.2d at 622 (nurse negligent in not understanding damages incurred when administering the sleeping drug Dalmane to an elderly patient recovering from a heart attack); *FIESTA*, *supra* note 48, at 50-51 (and cases cited therein); *LOEB & CAHILL*, *supra* note 5 at 29-30, 125 [and cases cited therein]; Michael A. Salatka, *Professional Liability in Critical Care Nursing*, 19 OHIO N.U.L. REV. 85, 94-95 (1992); *Sweeney*, *supra* note 28, at 34-36; *Reilly*, *supra* note 28, at 16 and cases cited therein.

²¹⁷*FIESTA*, *supra* note 48, at 50-51 and cases cited therein; *LOEB & CAHILL*, *supra* note 5, at 216; *POZGAR*, *supra* note 38, at 239-40 and cases cited therein; *Vallot*, *supra* note 38, at 99 and cases cited therein; *Guarriello*, *supra* note 11, at 79.

²¹⁸*LOEB & CAHILL*, *supra* note 5, at 216; *Salatka*, *supra* note 216, at 94-95; *POZGAR*, *supra* note 38, at 243; *Guarriello*, *supra* note 11, at 79.

²¹⁹*Harrington*, 569 N.E.2d at 17-18 (Failure to give patient medication at prescribed intervals was breach of standard of care); *Guarriello*, *supra* note 11, at 79-80.

²²⁰*Jensen*, 459 N.W.2d at 181 (involving nurse's failure to correct a physician's incorrectly ordered dosage); *FIESTA*, *supra* note 48, at 50-51 [and cases cited therein]; *LOEB & CAHILL*, *supra* note 5, at 216; *Sweeney*, *supra* note 28, at 34, 36; *POZGAR*, *supra* note 38,

the dosage prescribed by the physician with the dosage indicated on the medication administration record.²²¹

The correct mode, route, site, or technique for administering medications must be used in order to avoid liability.²²² The prudent nurse should ascertain the route or technique ordered by the physician, or contemplated by the nurse, and compare it with the route or technique indicated in a physician's or nursing medication reference source.²²³

Misreading a drug order,²²⁴ failing to observe or to obtain the effects of a medication,²²⁵ and failing to discontinue medication²²⁶ are also other sources of liability for the nurse.

In addition, failing to properly document the administration of medication subjects the nurse to liability.²²⁷ Each medication ordered by the physician should be transcribed onto the medication administration record and charted accordingly, including the dose and time given.²²⁸ Failure to chart the medica-

at 240 and cases cited therein; Vallot, *supra* note 38, at 101 and cases cited therein; Guarriello, *supra* note 11, at 80.

²²¹Guarriello, *supra* note 11, at 80.

²²²*See, e.g., Hill*, 610 N.E.2d at 637 (finding nurse committed malpractice by injecting Kenalog with wrong technique and in wrong route); *Deese*, 416 S.E.2d at 128 (no negligence where nurse complied with applicable standard of care regarding site selection when giving intravenous injections); *Morris*, 597 N.E.2d at 1116-17; *Fleming*, 742 P.2d at 1090, 1099 (alleging that injection of Talwain and Atarax by emergency room nurse precipitated patient's injury because injection was not given deep into the muscle as intended); *Sweeney*, *supra* note 28, at 34-36; *POZGAR*, *supra* note 38, at 241 (and cases cited therein); *Vallot*, *supra* note 38, at 99 [and cases cited therein]; *Reilly*, *supra* note 28, at 16 [and cases cited therein]; *Guarriello*, *supra* note 11, at 80.

²²³*See Hill*, 610 N.E.2d at 637 ("The Physicians Desk Reference . . . which was entered into evidence, states that '(u)nless a *deep* intramuscular injection is given, local atrophy is likely to occur.' Additionally, this reference material recommends the use of 'alternate sites for subsequent injections [of Kenalog.]' [T]he plaintiff testified that both injections were given in the same general area of the upper quadrant of the right buttock."); *Guarriello*, *supra* note 11, at 80.

²²⁴*See LOEB & CAHILL*, *supra* note 5, at 29-30 and cases cited therein; *Reilly*, *supra* note 28, at 16 and cases cited therein.

²²⁵*See, e.g., Hodges*, 355 S.E.2d at 106-07 (finding that emergency room nurses breached their standard of care by not taking the vital signs of patient after the administration of medication); *Belmon*, 427 So.2d at 544-45 (nurse failed to observe and recognize hemorrhage at needle puncture sites, which is a "major known complication" and "well known" risk of use of the anticoagulant drug Heparin); *Polonsky*, 418 N.E.2d at 622; *Sweeney*, *supra* note 28, at 34, 36; *POZGAR*, *supra* note 38, at 243.

²²⁶*POZGAR*, *supra* note 38, at 242.

²²⁷*See Suire*, 590 So.2d at 622 (involving nurse's failure to the administration of the drug Mandol); *FIESTA*, *supra* note 48, at 50-51 and cases cited therein; *Vallot*, *supra* note 38, at 99; *Guarriello*, *supra* note 11, at 79.

²²⁸*Guarriello*, *supra* note 11, at 79.

tion indicates that it was not given.²²⁹ If the nurse properly administers the correct medication and the patient reacts adversely thereto, the nurse must document the patient's reactions thoroughly and also include information regarding any nursing interventions performed.²³⁰ In evaluating a medication negligence or malpractice case, documentation, or the absence thereof, is an extremely important factor in determining liability.²³¹

If a drug order is incomplete, confusing, illegible, or otherwise unclear, the prudent nurse will not attempt to interpret the order, but will instead seek out the physician and clarify.²³² The nurse's duty is to detect ambiguities, inconsistencies, and contradictions and to bring them to the attention of the physician.²³³ Failure to check with the physician for clarification or corrections of a medication order exposes the nurse to liability.²³⁴ If a drug order is contradicated because it contains abnormally high dosages, incompatible medications, or conflicts with the patient's allergies or physical condition, the prudent nurse will refuse the order and immediately seek corroboration from the prescribing physician or other health care provider as indicated by hospital policy.²³⁵

Physicians often call in telephone orders. Such verbal orders are particularly dangerous when the order concerns the administration of medication. A nurse should document the order as precisely as the physician gives it and then repeat the order back to the physician so as to confirm the order.²³⁶

Many other safeguards exist that are designed to protect against medication errors and these safeguards are commonly recognized as part of nursing practice. There is the long-standing "five rights" safeguard, advising the nurse

²²⁹See *Suire*, 590 So.2d at 622; *Harrington*, 569 N.E.2d at 17-18 (absence of entries on patient's medical chart indicates that no medications were given to the patient during the night); *FIESTA*, *supra* note 48, at 50-51.

²³⁰LOEB & CAHILL, *supra* note 5, at 126.

²³¹Vallot, *supra* note 38, at 99 and cases cited therein.

²³²Sullivan, *supra* note 210, at 17; *FIESTA*, *supra* note 48, at 57; LOEB & CAHILL, *supra* note 5, at 125; Sweeney, *supra* note 28, at 36; POZGAR, *supra* note 38, at 240; BERNZWEIG, *supra* note 13, at 175.

²³³*Harris*, 872 S.W.2d at 762-63; Sullivan, *supra* note 209, at 17; Sweeney, *supra* note 28, at 36.

²³⁴*Harris*, 872 S.W.2d at 762-63; LOEB & CAHILL, *supra* note 5, at 29-30 and cases cited therein; BERNZWEIG, *supra* note 13, at 172; POZGAR, *supra* note 38, at 240 and cases cited therein; Reilly, *supra* note 28, at 16 and cases cited therein.

²³⁵*Harris*, 872 S.W.2d at 763 (Expert nurse witness "[t]estified that after a doctor has seen a patient and written a prescription, it is the discharge nurse's independent duty to compare the prescription with the patient's chart for contradictions and to bring any inconsistencies to the attention of the doctor to clarify or correct."); Sullivan, *supra* note 210, at 18; LOEB & CAHILL, *supra* note 5, at 126; Sweeney, *supra* note 28, at 36.

²³⁶Sullivan, *supra* note 210, at 17; *FIESTA*, *supra* note 48, at 120-121; LOEB & CAHILL, *supra* note 5, at 124; Sweeney, *supra* note 26, at 36; POZGAR, *supra* note 38, at 249.

to administer the right drug, to the right patient, at the right time, in the right dosage, and by the right route.²³⁷ In addition, there is the "three checks" safeguard, which counsels the nurse to check the medication before removing it from its container, check the medication before administering it, and check the medication after giving it.²³⁸ Ignoring or contravening any of these safety procedures can subject the patient to detrimental medical consequences and the nurse to adverse legal consequences.

The administration of medications is an integral part of the health care delivery system. The law recognizes the nurse's essential role in the administration of medication and requires that the nurse discharge his or her responsibility in a careful manner.

C. Observation and Monitoring

In the course of discharging their functions, nurses are exposed to a great deal of information regarding a patient. Nurses are often in an exclusive position with regard to receiving patient information. Physicians obviously cannot observe or monitor patients on a regular basis. Nurses, however, serve as adjuncts to physicians by observing and monitoring patients.²³⁹ Accordingly, nurses have a duty to carefully monitor and observe the patient and to report any signs, symptoms, abnormalities, deterioration, or changes in the patient's condition and behavior.²⁴⁰ This duty extends to listening to a

²³⁷Sullivan, *supra* note 210, at 17; LOEB & CAHILL, *supra* note 5, at 122; Sweeney, *supra* note 28, at 34-36.

²³⁸Sweeney, *supra* note 28, at 34, 36.

²³⁹See *Sweet*, 881 P.2d at 307 (narrative nursing notes referred to as "eyes and ears of the doctor"); *Harrington*, 569 N.E.2d at 18 ("There is no dispute that [nurses] had a duty to monitor [patient's] vital signs, to observe [patient's] breathing patterns . . . during the night and to advise [patient's] physician of any significant changes."); Sweeney, *supra* note 28, at 36.

²⁴⁰See, e.g., *Feeny*, 615 N.E.2d at 587 ("The minimum standard of care on the nursing side called for monitoring the respiratory rate of this [manifestly drunk] patient every 15 minutes; this 'would more likely have permitted the nursing staff to observe changes in this patient's breathing patterns and/or the onset of respiratory arrest,' [according to expert nurse witness]."); *Vogler*, 624 N.E.2d at 63 ("[T]he failure to recognize and report abnormalities in the treatment and condition of patients may constitute a breach of the duty of reasonable care."); *Alef*, 6 Cal. Rptr.2d at 905 (labor and delivery nurses failed to perform proper monitoring of fetus and failed to recognize abnormalities in patient's labor); *Gibson*, 594 So.2d at 1342 (parents of deceased baby alleged that neonatal nursery nurses failed to properly observe and monitor baby and failed to timely diagnose and treat their baby's hypoglycemia); *Harrington*, 569 N.E.2d at 18 ("[nurses] had a duty to monitor [patient's] vital signs, to observe [patient's] breathing patterns during the night and to advise [patient's] physician of any significant changes."); *Parker*, 540 So.2d at 1274 (nurses complied with duty to circulate throughout nursery and to observe newborns); *Garcia*, 697 F. Supp. at 1572-73 ("Plaintiff had undergone major surgery earlier on the day and constant monitoring was necessary. When plaintiff . . . took a turn for the worse [around 7:00 p.m.], a serious medical emergency was clearly evident."); *Haney*, 323 S.E.2d at 433 (emergency room nurse failed to monitor plaintiff's blood pressure and other vital signs when plaintiff's condition worsened); *Belmon*, 427 So.2d at 54-45; *Battles*,

patient and not ignoring information provided by the patient and his or her family.²⁴¹ The failure to adequately observe and monitor, therefore, is a form of negligence or malpractice for which the nurse is liable.²⁴²

D. Assessment and Diagnosis

A medical diagnosis is an evaluation of a patient's health condition for the purpose of instituting an affirmative course of treatment or therapeutic measures.²⁴³ Such a diagnosis is clearly within the realm of the practice of medicine and reserved for physicians, and is not the responsibility of the nurse,²⁴⁴ except in limited emergency situations or if specifically authorized

430 So.2d at 314; *FIESTA*, *supra* note 48, at 126 and cases cited therein; *Sweeney*, *supra* note 28, at 36; *Scanlan*, *supra* note 38, at 235 and cases cited therein.

²⁴¹See, e.g., *White*, 633 So.2d at 758-59 (nurses committed malpractice by overlooking family members' communications that patient was experiencing recurring breathing difficulty and that the patient had collapsed and lost consciousness); *Ard*, 636 So.2d at 1045-46 (alleging that nursing staff did not timely respond to wife's calls for assistance, during which time patient's condition deteriorated); *McClain*, 602 So.2d at 243 (nurse noted and communicated patient's complaints of pain); *Brown*, 588 So.2d at 1300 (alleging nurse's failure to record a "significant part of patient history"); *FIESTA*, *supra* note 48, at 134.

²⁴²See *Ard*, 636 So.2d at 1045-46; *Feeney*, 615 N.E.2d at 587 (emergency room nurse committed malpractice for failure to observe and monitor); *Smith*, 637 So.2d at 1186 (nurses breached duty of care by not continuously observing confused patient); *Berdyck*, 613 N.E.2d at 1018-19, 1023 (obstetrics nurse failed to comply with physician's order to keep patient quiet and to observe her blood pressure); *Galloway*, 602 So.2d at 1010 (nursing staff failed to observe and investigate patient's "noticeable" symptoms); *Fairfax Hosp. Sys.*, 419 S.E.2d at 624-25 ("The evidence established that [labor and delivery nurse] either failed to observe or to recognize the signs of fetal distress"); *DeLaughter*, 601 So.2d at 824-25 (nurses deemed negligent for failing to appropriately observe 70 year old woman who was admitted to ICU in confused state, with unintelligible speech, elevated blood pressure, and abnormal heart rhythms); *St. Paul Med. Ctr.*, 842 S.W.2d at 814 (failure to monitor baby and detect hypoxia); *Wick*, 485 N.W.2d at 648 (nurse anesthetist committed malpractice for not monitoring the position of plaintiff's arm during surgery); *Alef*, 6 Cal. Rptr.2d at 905-06; *Harrington*, 569 N.E.2d at 18; (ICU nurses failed to properly monitor patient's condition and failed to detect presence of subcutaneous air in patient's body); *Haney*, 323 S.E.2d at 433 (failure to monitor plaintiff's blood pressure and other vital signs when plaintiff's condition worsened); *Garcia*, 697 F. Supp. at 1572-73 (nurses negligent in part for not performing "constant monitoring" of patient who had undergone major surgery earlier in the day); *Eyoma*, 589 A.2d at 658; *Belmon*, 427 So.2d at 544-45; *FIESTA*, *supra* note 48, at 126 and cases cited therein; *Sweeney*, *supra* note 28, at 36; *Reilly*, *supra* note 28, at 16-17 and cases cited therein; *Scanlan*, *supra* note 38, at 235 and cases cited therein.

²⁴³*Berdyck*, 613 N.E.2d at 1023; *BERNZWEIG*, *supra* note 13, at 156, 248.

²⁴⁴See, e.g., *Biddle*, 518 N.W.2d at 799-800 (no liability on part of emergency room nurses because nurses do not have a duty to determine whether a patient should be admitted, order tests, diagnose a patient, or document what they believe is an incorrect diagnosis); *Berdyck*, 613 N.E.2d at 1023 ("The law imposes on the physician the exclusive duty to diagnose the patient's adverse health condition and to prescribe a course of treatment for its management and care The standard of conduct required of a nurse

by statute, such as in the case of the nurse practitioners.²⁴⁵ Traditionally, it has long been unlawful for a nurse to make a medical diagnosis of a patient's condition. A nurse that does so runs the risk of having illegally exceeded the scope of his or her license to practice.²⁴⁶

A nurse is, however, authorized to make a nursing diagnosis or assessment.²⁴⁷ A nursing diagnosis or assessment is the nurse's evaluation and interpretation of the patient's signs and symptoms, changes, abnormalities, deterioration, actual or potential health problems, risk factors, responses and reactions to treatment or any nursing or medical regimen, factors (physical, mental, behavioral, socioeconomic) that may influence the physician's diagnosis and treatment and the patient's recovery, and a determination of what further nursing intervention is necessary.²⁴⁸

A nursing diagnosis is not a medical diagnosis; the nurse is neither initiating a medical examination, making a medical judgment about a patient's condition or disorder, ordering tests, recommending appropriate procedures or treatment, nor altering the patient's medical treatment or regimen.²⁴⁹ With this

cannot include the process of medical diagnosis and treatment, which is reserved to the physician."); *Ewing*, 532 So.2d at 881 ("[I]t is not a nurse's job to diagnose arrest of labor . . . [M]aking a diagnosis invades the function of a physician."); *Paris*, 331 S.E.2d at 245 (Nurse's . . . duty to disobey [the instructions of a physician] does not extend to situations where there is a difference of medical opinion. . . . Any disagreement or contrary recommendation [a nurse] may have had as to the treatment prescribed would have necessarily been premised on a separate diagnosis, which she was not qualified to render."); *Vassey*, 262 S.E.2d at 867 (contending that emergency room nurses committed malpractice by not making a diagnosis of appendicitis).

²⁴⁵See *Adams*, 856 P.2d at 865 (misdiagnosis by nurse practitioner); *Heitland*, *supra* note 94, at 26 (authority of nurse practitioner to diagnose and prescribe pursuant to Illinois Nursing Act); *BERNZWEIG*, *supra* note 13, at 156, 248.

²⁴⁶*HEITLAND ET AL.*, *supra* note 94, at 24-26; *POZGAR*, *supra* note 38, at 227; *BERNZWEIG*, *supra* note 13, at 156, 248.

²⁴⁷See FLA. STAT. ANN. § 964.003(3)(a)(1) (West Supp. 1995) ("practice of professional nursing" includes "assessment" and "nursing diagnosis"); *Gibson*, 594 So.2d at 1342-43; *LOEB & CAHILL*, *supra* note 5, at 14; *Salatka*, *supra* note 216, at 86; *BERNZWEIG*, *supra* note 13, at 156-57.

²⁴⁸See, e.g., *Berdyck*, 613 N.E.2d at 1022; *Garcia*, 697 F. Supp. at 1572-73 ("The nursing staff should have recognized the emergency nature of the situation . . . and deteriorating condition . . ." of patient who had undergone major surgery earlier in the day.); FLA. STAT. ANN. § 464.003(d) (West Supp. 1995); *LOEB & CAHILL*, *supra* note 5, at 14; *BERNZWEIG*, *supra* note 13, at 156-57; *Reilly*, *supra* note 28, at 10; *Garlo*, *supra* note 45, at 277-78 and cases cited therein; *Salatka*, *supra* note 216, at 86.

²⁴⁹*Downey*, 835 S.W.2d at 556 ("nothing in [precedent] imposes a duty on nurses to review the records of a patient's consent to surgery and to intervene during the course of the surgery if the surgeon begins to exceed the bounds of such consent. *Gill*, 597 N.E.2d at 782 ("[n]urses do not diagnose patients' maladies or practice medicine . . ."; *Vassey*, 262 S.E.2d at 867-68 (finding that it is not emergency room nurses' responsibility to make an examination of the patient, order and take blood tests, and make a diagnosis of appendicitis.); *LOEB & CAHILL*, *supra* note 5, at 14, 38; *BERNZWEIG*, *supra* note 13, at 157.

distinction in mind, a prudent nurse will avoid giving his or her opinion when a patient questions the nurse about the patient's medical problem and will avoid offering information or suggestions as to possible courses of treatment.²⁵⁰

When a nurse makes a nursing diagnosis or assessment, he is expected to do so carefully and his failure to do so properly is a form of negligence or malpractice.²⁵¹

The nursing/physician dichotomy presents two problems for nurses: the law fails to define precisely what a nursing diagnosis or assessment means; and the law fails to distinguish clearly between a medical and nursing diagnosis.²⁵² As nurses assume more responsibility for patient care, the amount of indepen-

²⁵⁰See *Vassey*, 262 S.E.2d at 867-68 (emergency room nurse incorrectly concluded that patient was not suffering from appendicitis and nurse stated this erroneous conclusion to physician, but there was no nursing liability because diagnosing is a physician duty); *LOEB & CAHILL*, *supra* note 5, at 216-17.

²⁵¹See, e.g., *Ard*, 636 So.2d at 1045-46 (nurses breached standard of care by failing to properly assess the patient); *Berdyck*, 613 N.E.2d at 1022 (obstetrics nurse failed to recognize signs and symptoms of preclampsia [seizures] in pregnant patient); *Simmons*, 841 F. Supp. at 750 (concluding that evidence showed nurses failed to "be alert to recognize infections" at intravenous needle sites, but that no liability would adhere because the plaintiff failed to present evidence on causation); *Wheeler*, 866 S.W.2d at 46, n.19 (nurses committed malpractice by failing to make correct assessment of pregnant patient's condition); *Lopez*, 833 P.2d at 1185, 1187-88 (nurses committed malpractice by failing to assess patient correctly); *Fairfax*, 419 S.E.2d at 625 (labor and delivery nurse failed to recognize signs of fetal distress); *Alvis*, 592 N.E.2d at 682 (failure to detect baby's breech position in time for doctor to perform a cesarean delivery); *Alef*, 6 Cal. Rptr.2d at 904-06 (labor and delivery nurses failed to recognize that patient's labor was abnormal); *St. Paul Medical Ctr.*, 842 S.W.2d at 814 (nurse failed to detect baby's hypoxia, resulting in "prolonged hypoxia insult," delayed delivery, and brain damage); *Eyoma*, 589 A.2d at 658 (nurse failed to detect that patient had stopped breathing); *George*, 797 P.2d at 1120 (nurse expert "[t]estified that the nurses breached their duty by failing to perform a neurological assessment of [patient] when [patient] showed discernable signs of respiratory distress. . . ."); *Garcia*, 697 F. Supp. at 1572-73 (finding that nursing staff should have recognized the emergency nature of the situation and that the lack of expeditious medical attention to this seriously ill patient was below applicable standard of nursing care); *Bartimus*, 458 N.E.2d at 1076 (emergency room nurse failed to properly assess plaintiff's condition); *Belmon*, 427 So.2d at 544-45; Barbara E. Calfree, "Litigation Lessons," *NURSING* 94 Jan. 1994, at 47 and cases cited therein; *Calfee*, *supra* note 96, at 40-42 and cases cited therein; *Sweeney*, *supra* note 28, at 36; *BERNZWEIG*, *supra* note 13, at 157; *Garlo*, *supra* note 45, at 277-78 and cases cited therein; *Greenlaw*, *supra* note 117, at 79; but see *Gibson*, 594 So.2d at 1342-43 ("After reviewing the record, we find the evidence does not support a finding that nurse . . . breached the applicable standard of care . . . There was no evidence . . . that nurse . . . had overlooked [baby's] risk factors.")

²⁵²See, e.g., *Lopez*, 833 P.2d at 1185, 1187-88 (nurses committed malpractice by failing to "assess" that patient was not in labor); *Gibson*, 594 So.2d at 1342-43 (terms "assessment" and "diagnosis" used by court in a nursing malpractice case concerning the failure of neonatal nursery nurses to detect hypoglycemia in infant); *LOEB & CAHILL*, *supra* note 5, at 14, 38.

dent patient diagnosis judgment afforded nurses surely will increase.²⁵³ The result may be an overlap of medical and nursing functions.²⁵⁴

Critical care and emergency room nurses already have assumed a diagnostic role to ensure that their units are functioning properly.²⁵⁵ In the emergency room, for example, the triage nurse is responsible for determining, based on his or her nursing assessment and diagnosis, which patients immediately need to be evaluated by a physician and which can wait for an evaluation. The existence of "standing orders," moreover, may permit nurses to make a medical diagnosis and initiate and alter treatment.²⁵⁶ The blurring of medical and nursing functions raises the issue as to whether the nurse is engaging in a medical procedure and, if so construed, the nurse must be aware that he or she will be held to the standard of care, not for nurses, but for physicians.²⁵⁷

E. Communication, Notification, and Reporting

In the course of observing and monitoring patients and equipment, nurses have come to possess a great deal of information regarding patients. Because of their proximity to the patient, nurses frequently are in exclusive control of patient information and thus are the only health care providers that can communicate the information.²⁵⁸ Effective communication, therefore, is an essential aspect of the nurse's responsibilities. Accordingly, a nurse has a duty

²⁵³LOEB & CAHILL, *supra* note 5, at 38; Scanlan, *supra* note 38, at 232.

²⁵⁴*See, e.g., Berdyck*, 613 N.E.2d at 1023 (nevertheless, "the fact that a particular act is within a physician's duty of care does not necessarily exclude it from the duty of care owed to the patient by the nurse. Depending on the facts and circumstances, the same act may be within the scope of their separate duties of care because it is, coincidentally, within their respective standards of conduct."); *see also Fein*, 695 P.2d at 674 ("the 'examination' or 'diagnosis' of a patient cannot in all circumstances be said—as a matter of law—to be a function reserved to physicians, rather than registered nurses or nurse practitioners."); LOEB & CAHILL, *supra* note 5, at 38; Salatka, *supra* note 216, at 96-97 and cases cited therein; POZGAR, *supra* note 38, at 227; Greenlaw, *supra* note 72, at 120.

²⁵⁵LOEB & CAHILL, *supra* note 5, at 38; Salatka, *supra* note 216, at 96-97 and cases cited therein; POZGAR, *supra* note 38, at 227; Greenlaw, *supra* note 72, at 120.

²⁵⁶LOEB & CAHILL, *supra* note 5, at 39; Garlo, *supra* note 45, at 256.

²⁵⁷*See Alvis*, 592 N.E.2d at 682 (physicians testifying as to standard of competency of OB nurses regarding ability to determine if baby in breech position); *Gibson*, 594 So.2d at 1342; *Cangelosi*, 564 So.2d at 661 ("Nurses who perform medical services are subject to the same standards of care and liability as are physicians."); *Keys*, 485 So.2d at 517-18 (nurse anesthetist held to intubation standards as set forth by physician anesthesiologist); *Belmon*, 427 So.2d at 544 ("Nurses . . . who undertake to perform medical services are subject to the same rules relating to the duty of care. . . . as are physicians in the performance of those professional services."); Greenlaw, *supra* note 72, at 120.

²⁵⁸*Roach*, 585 N.E.2d at 1080 (nurses failed to notify attending physician of abnormal fetal heart tones shown by monitoring system); *Harrington*, 569 N.E.2d at 18; Greenlaw, *supra* note 117, at 79; Scanlan, *supra* note 36, at 236-37.

to communicate relevant information regarding the patient to the physician or other health care providers.²⁵⁹

As the nurse's role expands, the nurse will be deemed responsible for collecting, processing, and evaluating a mass of critical information and findings concerning a patient.²⁶⁰ The nurse is then legally responsible for exercising careful judgment to decide what information should be reported to a physician or other health care provider.²⁶¹ For example, the nurse has a duty to report, to the more remotely located physician, vital information regarding the patient and to promptly notify the physician of any abnormalities, deterioration, or significant changes in the patient's condition or behavior.²⁶²

²⁵⁹ See, e.g., *Berdyck*, 613 N.E.2d at 1021-22; *Brown*, 588 So.2d at 1300; *Roach*, 585 N.E.2d at 1080 ("Nurse . . . was qualified by plaintiffs as an expert on obstetrical nursing practice. She testified after having examined monitoring data with regard to [patient]. . . . She expressed an opinion that . . . proper nursing procedure would have required nurses in attendance to immediately notify the physician involved of the irregularities in the fetal heart beats being recorded. This testimony provided expert proof of the standard of care involved and of breach of that standard."); *Harrington*, 569 N.E.2d at 18 ("There is no dispute that [nurses] had a duty to monitor [patient's] vital signs, to observe [patient's] breathing patterns during the night, and to advise [patient's] physician of any significant changes."); *George*, 797 P.2d at 1121 ("Courts have also recognized that a nurse may have a duty to notify her supervisor that a life threatening situation exists and that failure to perform this duty may be a proximate cause of plaintiff's additional injury" (citation omitted)); *Garcia*, 697 F. Supp. at 1572-73. *Contra Battles*, 430 So.2d at 314; *FIESTA*, *supra* note 48, at 118-19 and cases cited therein; *BERNZWEIG*, *supra* note 13, at 162, 164 and cases cited therein; *POZGAR*, *supra* note 38, at 248-49 and cases cited therein; *Greenlaw*, *supra* note 117, at 77-79; *Guarriello*, *supra* note 11, at 80; *Scanlan*, *supra* note 38, at 236-37; *Morris*, *supra* note 28, at 120-21 and cases cited therein; *but see Miles*, 489 N.W.2d at 839 ("When a physician is present at a hospital and is seeing a patient and when the physician is clearly aware of available information which may be relevant to the diagnosis and treatment of that patient, it is unreasonable to require hospital personnel to make sure that the physician does, in fact, review that information.").

²⁶⁰ *BERNZWEIG*, *supra* note 13, at 162, *Greenlaw*, *supra* note 117, at 79.

²⁶¹ See *Vassey*, 262 S.E.2d at 868 (holding that emergency room nurse did not commit malpractice by failing to communicate to physician that plaintiff's mother "suggested" appendicitis as plaintiff's disorder, even though nurse erroneously concluded otherwise.)

²⁶² See, e.g., *Vogler*, 624 N.E.2d at 63 (failure to report "abnormalities" in the treatment or condition of patients or "changes in a patient's condition" may constitute a breach of the duty of reasonable care); *Roach*, 585 N.E.2d at 1079-81 (evidence and testimony that nurses breached standard of care by not notifying attending physician of "irregularities" and "abnormalities" in fetal heart tones shown by monitoring system); *Harrington*, 569 N.E.2d at 18 (nurses breached standard of care by failing to inform patient's physician that patient, dependent on Darvocet after leg amputation and admitted in "poor" and "groggy" condition in order to undergo detoxification program, had collapsed and passed out on bathroom floor during the night; *Haney*, 323 S.E.2d at 433 (emergency room nurse failed to report a rise in patient's pulse); *Garcia*, 697 F. Supp. at 1572 ("The nursing staff should have recognized the emergency nature of the situation and taken prompt steps to notify attending physicians); *Battles*, 430 So.2d at 314 (nurses contacted head nurse after observing that patient, who had undergone a thyroidectomy, had

This duty need not be premised on the physician explicitly telling the nurse to keep him or her informed; the physician *must* be advised of vital information, changes, or abnormalities regardless.²⁶³ The failure of a nurse properly to communicate relevant information to a physician or other health care provider is a breach of the nurse's duty of care—subjecting him to liability for negligence or malpractice.²⁶⁴

Communication, therefore, is an essential component of nursing practice and successful health care. The reasonably prudent nurse must possess careful observation skills as well as the capability to assess carefully the patient's condition and to know when a change therein warrants the prompt notification of the physician.²⁶⁵ In order to ensure reasonable care and to avoid legal

developed restlessness and a "slight wheeze"; head nurse detected stridor, indicating breathing problems, and "immediately" contacted anesthesiologist; and "within one minute" of conversation with physician, emergency room physician was summoned by nurse); FIESTA, *supra* note 48, at 118-19 and cases cited therein; POZGAR, *supra* note 38, at 248-49 and cases cited therein; BERNZWEIG, *supra* note 13, at 162, 164 and cases cited therein; Guarriello, *supra* note 11, at 80; Greenlaw, *supra* note 117, at 77; Scanlan, *supra* note 38, at 236-37; Morris, *supra* note 28, at 120-21 and cases cited therein.

²⁶³ See *Hodges*, 355 S.E.2d at 106-07; Guarriello, *supra* note 11, at 80.

²⁶⁴ See *Berdyck*, 613 N.E.2d at 1017, 1021-22 (finding nurse negligent for failing to report to physician pregnant patient's severe upper abdominal pain, nausea, headaches, inability to pass urine, and elevated blood pressure); *Baptist Medical Ctr.*, 618 So.2d at 1338-39; *Wheeler*, 866 S.W.2d at 46-47 (nurses committed malpractice by failing to inform physician of the reasons for the absence of information regarding pregnant patient and by failing to discuss with physician nurse's inability to determine baby's position or presenting part); *Myers*, 398 S.E.2d at 619 (nurses failed to record and report patient's complaints of hip and leg pain following electroconvulsive therapy treatments—no liability because the patient made the very same complaints of pain to his treating physician); *Rixey*, 916 F.2d at 615 (ICU nurses failed to advise treating physician of existence of subcutaneous air reflected in patient's x-ray as well as the increasing quantities of subcutaneous air in patient's body); *Harrington*, 569 N.E.2d at 18 (Nurses breached standard of care by failing to inform patient's physician of patient's collapse); *George*, 797 P.2d at 1121 (physician not notified that patient, taken to ICU for an angiogram, was incoherent, disoriented, febrile, having difficulty breathing, and in deteriorating mental and physical condition, that patient's blood pressure was unable to be determined, and that nurses had difficulty in making patient bleed for a glucose test); *Hodges*, 355 S.E.2d at 106-07 ("nurses . . . failed to record and relay to the physician information concerning the decedent's complaints of stomach pain, that decedent had a heart condition, and that decedent had taken a nitroglycerin pill shortly before her arrival at the hospital"); *Haney*, 323 S.E.2d at 433 (nurse breached standard of care by failing to report a rise in the patient's pulse and by erroneously telling a physician that the patient had not been given Librium when in fact he had); *Rudeck*, 709 P.2d at 627-29 (surgical nurses committed malpractice by failing to inform surgeon of unaccounted-for sponge); *Garcia*, 697 F. Supp. at 1572-73; POZGAR, *supra* note 38, at 248-49 and cases cited therein; Greenlaw, *supra* note 117, at 79; Scanlan, *supra* note 38, at 236-37; Morris, *supra* note 28, at 122.

²⁶⁵ See *Rixey*, 916 F.2d at 615; *Garcia*, 697 F. Supp. at 1572-73 (finding that "standard and appropriate medical attention dictated immediate notification of the physicians."); FIESTA, *supra* note 48, at 118-19, 121 and cases cited therein; BERNZWEIG, *supra* note 13, at 164 and cases cited therein.

liability, the nurse must discharge his or her communication duty and the nurse should document these communication efforts.²⁶⁶

Communication is a fundamental component to nursing practice. Regardless of how competent the physician or other health care provider, a patient's safe and successful treatment and care cannot be ensured unless the nurse capably fulfills his or her communication function.

F. Following and Questioning Orders

A physician treating a patient customarily writes orders to direct the patient's medical care plan. The responsibility of the nurse to execute such orders has long been recognized as a basic nursing duty.²⁶⁷ A physician who gives a direct and explicit medical order to a nurse is entitled to count on his or her order being complied with in a prompt and competent manner.²⁶⁸ Accordingly, a nurse is expected to obey a physician's order without question.²⁶⁹

Fundamental nursing responsibility dictates that the nurse be held to a general legal duty to execute a physician's order.²⁷⁰ The failure to carry out a physician's order, as a general rule, is a form of nursing negligence or malpractice.²⁷¹ When the nurse does follow a physician's order, however, the nurse generally is protected from liability.²⁷² These two related general rules

²⁶⁶See *Morse*, 450 S.E.2d at 256-57; *Suire*, 590 So.2d at 621; *Garcia*, 697 F. Supp. at 1573 ("Reasonable care for a patient in plaintiff's [post-operative] condition requires communication, coordination, and documentation by health care professionals - physicians and nursing staff.").

²⁶⁷*Jensen*, 459 N.W.2d at 182-83; *Sparks*, 768 P.2d at 775 ("The record is replete with evidence indicating that the standard of care applicable to St. Luke's personnel . . . is simply to follow the attending physician's orders.").

²⁶⁸See *Eyoma*, 589 A.2d at 658; *Jensen*, 459 N.W.2d at 181-83.

²⁶⁹Benninger, Note, *Nursing Malpractice—The Nurse's Duty to Follow Orders*, 90 W.VA.L. REV. 1291, 1293 (1988); Carlo, *supra* note 45, at 257.

²⁷⁰See, e.g., *Anderson v. St. Francis-St. Gary Hosp.*, 614 N.E.2d 841, 847 (Ohio Ct. App. 1992); *Jensen*, 459 N.W.2d at 183 ("As a general rule, hospital staff members lack authority to alter or depart from an attending physician's order for a hospital patient and lack authority to determine what is a proper course of medical treatment for a hospitalized patient"); *Eyoma v. Fako*, 589 A.2d 653, 658 (N.J. Super. 1991); *Hurlock*, 709 S.W.2d at 881 ("[M]embers of . . . hospital's nursing staff were required, by accepted nursing practice, to 'document' in [patient's] medical records compliance with the admitting physician's order to turn the patient every two hours.").

²⁷¹See, e.g., *Anderson*, 614 N.E.2d at 843, 847; *Berdyck*, 613 N.E.2d at 1018-19, 1023 (OB nurse failed to comply with physician's order to keep patient quiet and to observe her blood pressure closely); *Eyoma*, 589 A.2d at 658; BERNZWEIG, *supra* note 13, at 143; POZGAR, *supra* note 38, at 246 and cases cited therein; Benninger, *supra* note 60, at 1294, 1300 and cases cited therein; Carlo, *supra* note 45, at 255; Reilly, *supra* note 28, at 16 and cases cited therein; Scanlan, *supra* note 38, at 232-33 and cases cited therein.

²⁷²See *Georgetti v. United Hosp. Medical Ctr.*, 611 N.Y.S.2d 579, 584 (1992) ("It is clear that when an attending physician gives direct and explicit orders to hospital staff, nurses

would seem to indicate that since a failure to comply with orders is evidence of negligence or malpractice, the reasonably prudent nurse merely should follow such orders²⁷³ and should document compliance in the medical records.²⁷⁴

Merely following orders, however, may be insufficient for the nurse to meet her duty of care—the law may require more than blind, rigid, obedience to a physician's order.²⁷⁵ In certain exceptional situations the nurse's compliance with an order may be deemed unreasonable conduct, and thus evidence of nursing negligence or malpractice.²⁷⁶ The nurse may be liable even if he or she contacts the physician who restates the order²⁷⁷ or relies on the physician's assertion that the physician will take full responsibility.²⁷⁸

The law requires that the nurse exercise his or her independent professional judgment and intelligence, investigate and inspect for potential dangers, perform a competent nursing assessment of the patient's condition, evaluate the appropriateness and reasonableness of a physician's order, and evaluate the order's potential for causing harm to the patient.²⁷⁹ The nurse, rather, is held to a superseding, independent, legal duty to safeguard the well-being of the patient.²⁸⁰ In certain exceptional circumstances the law will impose a duty on the nurse to refrain from carrying out a physician's order,²⁸¹ to question the

are not authorized to unilaterally depart from them, and, thus, a hospital is normally protected from tort liability if its staff follows orders (citation omitted); *Sparks*, 768 P.2d at 775, 779.

²⁷³*BERNZWEIG*, *supra* note 13, at 69; *Benninger*, *supra* note 60, at 1300-01.

²⁷⁴*Hurlock*, 709 S.W.2d at 881.

²⁷⁵*NKC Hosps., Inc.*, 849 S.W.2d at 569 ("The defense that the hospital's nurses were only following a 'chain of command' by doing what [was] . . . ordered is not persuasive."); *Berdyck*, 613 N.E.2d at 1023 ("[M]erely following the orders of a physician is not the full extent of the duty of care owed to a patient by a nurse (citation omitted). In order to satisfy that duty to its full extent, a nurse must perform a competent nursing assessment of the patient's condition according to the standards of conduct required of a nurse . . ."); *FIESTA*, *supra* note 48, at 102, 106; *BERNZWEIG*, *supra* note 13, at 69, 144; *Benninger*, *supra* note 269, at 1300-01, 1305-06 and cases cited therein; *Guarriello*, *supra* note 9, at 81; *Walker*, *supra* note 100, at 45 and cases cited therein.

²⁷⁶*See, e.g., NKCHosp., Inc.*, 849 S.W.2d at 568-69; *FIESTA*, *supra* note 46, at 104-06 and cases cited therein; *BERNZWEIG*, *supra* note 11, at 69, 144; *Benninger*, *supra* note 269; *Walker*, *supra* note 100, at 45 and cases cited therein.

²⁷⁷*Guarriello*, *supra* note 11, at 81.

²⁷⁸*FIESTA*, *supra* note 48, at 102.

²⁷⁹*NKC Hosps., Inc.*, 849 S.W.2d at 568-69; *Berdyck*, 613 N.E.2d at 1023; *Koeniguer*, 422 N.W.2d at 604; *Vallot*, *supra* note 36, at 99; *Benninger*, *supra* note 269; *Armstrong*, *supra* note 5, at 586-87 a cases cited therein.

²⁸⁰*Id.*; *BERNZWEIG*, *supra* note 13, at 69; *Vallot*, *supra* note 38, at 99; *Benninger*, *supra* note 269.

²⁸¹*NKC Hosps., Inc.*, 849 S.W.2d at 569 (physician misdiagnosed patient's condition and ordered discharge of patient in "extreme pain," despite nurse's "grave

order,²⁸² and at times to actually disobey a physician's order.²⁸³ If the nurse knows, or should know, that the order is likely to cause the patient harm, a nurse cannot claim that he or she was just doing his or her duty by following the order.²⁸⁴

If an order is incomplete, uncertain, inaccurate, or unclear, a nurse must refrain from executing the order.²⁸⁵ When an order is obviously improper, inappropriate, erroneous, or wrong, the nurse must not comply with the order.²⁸⁶ If an order is not in accord with accepted medical standards, practices, customary procedures, hospital policies, or regulations, the nurse must defer, question, and even contravene the order.²⁸⁷ Should a nurse believe that executing an order would pose a clear risk of harm to the patient, he must not comply with the order.²⁸⁸

Clarification, correction, or completion of the order from the physician may resolve potential problems.²⁸⁹ In doing so, of course, the nurse must follow any

reservations.") "The [nurses] . . . could readily foresee the injury would directly flow from [physician's] negligent conduct and the [nurses] had all the time and means in which to correct it."); BERNZWEIG, *supra* note 13, at 69; Benninger, *supra* note 269, at 1303 and cases cited therein.

²⁸²BERNZWEIG, *supra* note 13, at 144; POZGAR, *supra* note 36, at 249; Benninger, *supra* note 269; Walker, *supra* note 100, at 45 and cases cited therein.

²⁸³See, e.g., *Berdyck*, 613 N.E.2d at 1024 (Nurse-expert witness "testified that a reasonably prudent nurse who observed these repeated high blood pressures would take action to override the physician's orders and invoke the necessary treatment protocol"); FIESTA, *supra* note 48, at 104-06 and cases cited therein; LOEB & CAHILL, *supra* note 5, at 248; *but see Paris v. Kreitz Jr., P.A.*, 331 S.E.2d 234, 245 (N.C. Ct. App. 1985) ("While a nurse may disobey the instructions of a physician where those instructions are obviously wrong and will result in harm to the patient (citations omitted), the duty to disobey does not extend to situations where there is a difference of medical opinion. . .").

²⁸⁴NKC *Hosps., Inc.*, 849 S.W.2d at 569; BERNZWEIG, *supra* note 13, at 69; Benninger, *supra* note 269.

²⁸⁵FIESTA, *supra* note 48, at 102; LOEB & CAHILL, *supra* note 5, at 216; Benninger, *supra* note 269.

²⁸⁶See *Paris*, 331 S.E.2d at 245 (applying "obviously wrong" standard); LOEB & CAHILL, *supra* note 5, at 216, 248; BERNZWEIG, *supra* note 13, at 143, 150; POZGAR, *supra* note 38, at 249; Benninger, *supra* note 269; Guarriello, *supra* note 11, at 81.

²⁸⁷See, e.g., *Vogler*, 624 N.E.2d at 63 ("If a nurse . . . fails to . . . question a doctor's order when [it is] not in accord with standard medical practice and the omission results in injury to the patient, the hospital will be liable for its [nurse] negligence."); *Paris*, 331 S.E.2d at 245; FIESTA, *supra* note 48, at 102; Benninger, *supra* note 269; POZGAR, *supra* note 38, at 249.

²⁸⁸See, e.g., *Koeniguer*, 422 N.W.2d at 604 (applying "danger sign to the well-being of any patient" standard); *Paris*, 331 S.E.2d at 245; FIESTA, *supra* note 48, at 102; LOEB & CAHILL, *supra* note 5, at 216; BERNZWEIG, *supra* note 13, at 143, 148, 150; POZGAR, *supra* note 38, at 249; Benninger, *supra* note 269.

²⁸⁹LOEB & CAHILL, *supra* note 5, at 216, 247-48; BERNZWEIG, *supra* note 11, at 150; POZGAR, *supra* note 38, at 239; Benninger, *supra* note 269; Reilly, *supra* note 28, at 16 and

hospital policies regarding clarification and should document his or her efforts to clarify.²⁹⁰ If after attempting clarification and confirmation, the order is not properly clarified, confirmed, or corrected, the nurse is obligated not to carry the order out.²⁹¹ If the physician insists that the nurse obey the order, despite being advised of potential problems, the nurse should delay executing the order and immediately report the matter to the nurse's supervisor, and, if necessary, to another physician or another responsible hospital official.²⁹² To do so, of course, a nurse must be familiar with the relevant hospital procedures,²⁹³ documenting all of his or her communication with the physician and others and making a record of her refusal to comply and the reasons therefor.²⁹⁴

The duty to question and to refuse the order of a physician adds a new dimension to the responsibilities of the nurse. As nurses continue to possess greater degrees of education, training, knowledge, and skill, the law is permitting and requiring that nurses exercise their independent professional judgment in an arena previously unsanctioned—that is, to assess the adequacy of care provided by a physician. This new responsibility certainly enhances the status and prestige of the nursing profession, but also significantly increases the nurse's legal duties and potential for negligence and malpractice liability.

G. Intervention and Advocacy

Nurses have a duty to avoid causing harm, or allowing harm, to a patient.²⁹⁵ A nurse's actions in implementing a medical regimen, therefore, may be insufficient to fulfill this duty.²⁹⁶

A nurse has a specific duty to intervene and act as a patient advocate if the care provided to a patient is lacking, inadequate, or detrimental.²⁹⁷ In executing

cases cited therein; Scanlan, *supra* note 38, at 233 and cases cited therein.

²⁹⁰LOEB & CAHILL, *supra* note 5, at 216, 247-48; Iyer and Camp, *supra* note 198, at 82.

²⁹¹Reilly, *supra* note 28, at 16 and cases cited therein.

²⁹²NKC Hosps., Inc., 849 S.W.2d at 567-69; FIESTA, *supra* note 48, at 102, 106; BERNZWEIG, *supra* note 13, at 145, 148, 158; POZGAR, *supra* note 38, at 249; Benninger, *supra* note 269; Guarriello, *supra* note 11, at 81.

²⁹³FIESTA, *supra* note 48, at 106.

²⁹⁴LOEB & CAHILL, *supra* note 5, at 148; Iyer & Camp, *supra* note 198, at 90-91 (discussion of questioning and refusing medication orders and the documentation thereof).

²⁹⁵Sweeney, *supra* note 28, at 36.

²⁹⁶Benninger, *supra* note 269, at 1306-07 (and cases cited therein).

²⁹⁷See, e.g., Poluski, 877 S.W.2d at 712-13; Berdyck, 613 N.E.2d at 1024; Hatley, 859 S.W.2d at 367, 379; DeLaughter, 601 So.2d at 824-25; Koeniguer, 422 N.W.2d at 602; FIESTA, *supra* note 48, at 102; Sweeney, *supra* note 28, at 36; Benninger, *supra* note 269, at 1306-07 and cases cited therein; Reilly, *supra* note 28, at 17 and cases cited therein; Guarriello, *supra* note 11, at 81; Walker, *supra* note 100, at 45 and cases cited therein.

this duty the nurse may need to call the absence, inadequacy, or impropriety of care, to the attention of health care providers and authorities.²⁹⁸ The failure to notify the proper providers and authorities that, as a result the lack of proper care, a patient is being harmed, or is threatened with harm, is a form of nursing negligence or malpractice.²⁹⁹

Nursing intervention and advocacy, particularly when questioning the competency of a physician, is a very sensitive legal, moral, and practical issue. Nonetheless, the nursing standard of care may demand such intervention and advocacy—even if the physician is the one unwilling or unable to act.³⁰⁰

In discharging his or her legal duty, the prudent nurse will comply with any relevant hospital guidelines.³⁰¹ Typically, he or she should confront the treating, attending, or managing physician and, in the absence of a satisfactory response, the nurse should advise and consult with the charge nurse, the nursing supervisor, the director of nurses, other hospital administrators, the patient's personal physician, other managing physicians, or other staff physicians.³⁰²

H. Documentation and Charting

The patient's medical records are an integral and essential part of the patient's health care. A primary purpose of the records is to document patient care. The records also serve as an important means of communication and guide among all the health care providers involved in the patient's treatment and care. The duty to maintain thorough and accurate records describing the patient's condition, treatment, and care has long been recognized as one of the nurse's fundamental responsibilities.

²⁹⁸*Id.*

²⁹⁹*Id.*; see also Gill, 597 N.E.2d at 782.

³⁰⁰See, e.g., DeLaughter, 601 So.2d at 824-25; POZGAR, *supra* note 38, at 246-47; Sweeney, *supra* note 28, at 36; Reilly, *supra* note 28, at 17 and cases cited therein; Walker, *supra* note 110, at 45 and cases cited therein; but see Berdyck, 613 N.E.2d at 1024 ("A nurse who concludes that an attending physician has misdiagnosed a condition or has not prescribed the appropriate course of treatment may not modify the course set by the physician simply because the nurse holds a different view. To permit that conduct would allow the nurse to perform tasks of diagnosis and treatment denied to the nurse by law" (citation omitted); see also Downey, 835 S.W.2d at 555-56.

³⁰¹POZGAR, *supra* note 38, at 248.

³⁰²See, e.g., Berdyck, 613 N.E.2d at 1024 ("[T]he nurse is not prohibited from calling on or consulting with nurse supervisors or with other physicians on the hospital staff."); Hatley, 859 S.W.2d at 379 (psychiatric charge nurse failed to follow the "nursing chain of command" and contact a nursing supervisor or doctor when "overmedicated and depressed" patient threatened suicide with a specific plan for carrying out the threat); DeLaughter, 601 So.2d at 825 (expert nurse witness testified that if a nurse has a problem in getting a physician, the nurse should call a "backup" physician or the patient's own personal physician; and if there is still not a satisfactory response after this sequence of events, the nurse is then to call the Director of Nurses); Sweeney, *supra*, note 28, at 36; Benninger, *supra* note 269, at 1306-07.

Documentation is so vital to health care that, from a legal standpoint, the documentation of care has become equivalent to the care itself.³⁰³ If an action has not been documented, the law may presume or infer that the action was not performed.³⁰⁴ Documenting in an inadequate, inaccurate, or incomplete manner may, therefore, result in legal liability.³⁰⁵

³⁰³See, e.g., *Harrington v. Rush-Presbyterian-St. Lukes*, 569 N.E.2d 15, 17-18 (1990) (noting that the absence of entries in a patient's medical records indicates that nothing had been done for the patient during the night); *Garcia*, 697 F. Supp. at 1573 ("[T]he lack of information on the charts contributes to this court's conclusion that [patient's] status was not timely and sufficiently communicated to the attending physicians."); *Koeniguer*, 422 N.W.2d at 602 (nurses are liable for failing to document the patient's elevated temperature); Fran Martin, *Documentation*, NURSING 94 June 1994, at 63 (describing documentation as the "pivotal part of lawsuit" and the "best way" for a nurse to refute a charge of malpractice); LOEB & CAHILL, *supra* note 5, at 217, 238-39; Reilly, *supra* note 28, at 18.

³⁰⁴See *Sweet*, 881 P.2d at 308 ("Just as the missing records may have impaired the [plaintiff's] ability to prove medical negligence, they would in the same way impair the [plaintiffs'] ability to prove a causal connection between any negligence and [patient's] injuries. It is for this very reason that a number of courts in other jurisdictions have created a rebuttable presumption shifting the burden of persuasion to a health care provider who negligently alters or loses medical records relevant to a malpractice claim" (citations omitted); *DeLaughter*, 601 So.2d at 329; *Harrington*, 569 N.E.2d at 17-18 (finding that absence of entries in patient's chart indicated that nothing had been done for patient during the night; nurses committed malpractice for failing to monitor, contact physician, and give medication); *Koeniguer*, 422 N.W.2d at 602 (nurse's liable in part for failing to document that patient's elevated temperature was reported to physician on day of patient's discharge); *Hurlock*, 709 S.W.2d at 881 (finding that failure to 'document' compliance with the admitting physician's order gave rise to the inference that [patient] was not turned every two hours [pursant to physician's order] by virtue of the adage or maxim "if it wasn't written down, it wasn't done."); LOEB & CAHILL, *supra* note 5, at 217, 238-39; Reilly, *supra* note 28, at 18; but see *Biddle*, 518 N.W.2d at 800 ("For the hospital, expert emergency room physicians . . . and emergency nurse . . . , each testified that the nursing staff's documentation exceeded the requisite standard of care for an emergency room setting. They asserted that in the emergency room the primary communication between doctors and nurses is verbal, not written.").

³⁰⁵See, e.g., *White*, 633 So.2d at 758-59 (nurses committed malpractice by failing to record that patient experiencing recurring breathing problems, including coughing and struggling to catch breath, and that patient collapsed and lost consciousness); *Butterfield*, 831 P.2d at 105 (emergency room nurses failed to document a complaint of blue discoloration and the necessity to stimulate the child in order to make her breathe); *Brown*, 588 So.2d at 1300 ("possibility that the knife blade had broken off in [patient's] shoulder was a significant part of patient history that should have been charted by [nurse] to whom [patient] and his parents said they reported it."); *Garcia*, 697 F. Supp. at 1573-74 ("While the insufficiency of these charts did not by themselves cause [patient's] injuries, the lack of information on the charts contributes to this court's conclusion that [patient's] status was not timely and sufficiently communicated to the attending physicians."); *Koeniguer*, 422 N.W.2d at 602 (finding that a nurse failed to document that the condition of and drainage from patient's incision was reported to physician and that patient's elevated temperature on day of discharge was reported to physician); Mary P. Neubauer, *Careful Charting Your Best Defense*, RN, Aug. 1994 at 19-20. Martin, *supra* note 303, at 63-64 discusses four common problem areas in documentation:

Few would dispute that there are many difficulties involved in documentation. What a nurse writes in a chart often ends up as an issue in a negligence or malpractice case. To avoid potential liability, the prudent nurse should always be aware of relevant documentation standards.³⁰⁶ Accrediting bodies such as the JCAHO, professional organizations such as the ANA, and specialty groups such as the Association of Critical Care Nurses, the Association of Operating Room Nurses, and the Emergency Nurses Association have established standards for nursing documentation.³⁰⁷ Hospitals, moreover, customarily develop their own standards for documentation, which are often found in their policy and procedure manuals.³⁰⁸

Documentation should be legible, accurate, complete, and factual, yet not excessively detailed.³⁰⁹ The patient's chart should include all significant information that the nurse or other health care providers will require to assess, treat, and care for the patient, as well as all relevant information received from, and reported to, the physician.³¹⁰ The chart should be subject to expeditious reading and analysis and, if necessary, immediate response by other health care providers.³¹¹ When complying with a physician's order, particularly a verbal order, the nurse must document the adherence to the order.³¹²

The prudent nurse will avoid documenting any irrelevant comments concerning the patient's personality as well as any personal opinions regarding staffing problems, the level of care provided to the patient, the status of the

1. Not charting correct time when events occurred; 2. Failing to record verbal orders and have them signed; 3. Charting actions in advance to save time; 4. Charting incorrect data).

³⁰⁶See LOEB & CAHILL, *supra* note 5, at 242-43; Iyer & Camp, *supra* note 198, at 77-93.

³⁰⁷LOEB & CAHILL, *supra* note 5, at 242-43.

³⁰⁸*Id.*

³⁰⁹See, e.g., *Butterfield*, 831 P.2d at 105; *Garcia*, 697 F. Supp. at 1573-74 ("The medical chart should be just that - a concise, factual memorandum of the medical progress, vital signs, and information notes on the patient. . . ."); *Martin*, *supra* note 303, at 63; *FIESTA*, *supra* note 48, at 168-69; *BERNZWEIG*, *supra* note 13, at 360.

³¹⁰See, e.g., *N. Trust Co.*, 493 N.E.2d at 10 (nurse met standard of care in observing new-born, "conscientiously" charting baby's progress, and communicating baby's deteriorating condition to physician); *Koeniguer*, 422 N.W.2d at 602; *Hodges*, 355 S.E.2d at 106-07; *Neubauer*, *supra* note 305, at 20 ("Record all relevant details of a patient's care and response to care, observations about his condition and change of status, and nursing problems and solutions."); *FIESTA*, *supra* note 48, at 173-74; *LOEB & CAHILL*, *supra* note 5, at 240; *Iyer & Camp*, *supra* note 198, at 89-90.

³¹¹See *Garcia*, 697 F. Supp. at 1573.

³¹²*Martin*, *supra* note 303, at 63-64; *Neubauer*, *supra* note 304, at 20; *Vallot*, *supra* note 38, at 99 and cases cited therein.

patient or any health care provider as potential litigants, and the presence or absence of any legal liability.³¹³

Any method of documentation that concisely produces clinically significant facts is appropriate. Charting, for example, by notes, checklists, graphs, logs, abbreviations, "flow charts," or charting "by exception" (that is, charting the abnormality or deviation rather than the ordinary or norm),³¹⁴ should be acceptable in most circumstances.³¹⁵ Long narrative commentary should be avoided, as one objective is to spend less time writing and reading; lengthy entries may be required in exceptional circumstances.³¹⁶

If a nurse forgets to document appropriate information, it is permissible for the nurse to may make a late entry, as long as the late entry is identified as such and signed and dated properly.³¹⁷ If the nurse makes an error, the error should be clearly noted as an "error," and the entry should be corrected promptly, signed or initialed, and dated.³¹⁸ The nurse should not erase, obliterate, or otherwise remove the mistaken entry.³¹⁹

³¹³Barbara Calfee, *7 Things You Never Should Chart*, NURSING 94 43 (1994); Neubauer, *supra* note 305, at 21; Iyer & Camp, *supra* note 198, at 82; BERNZWEIG, *supra* note 13, at 360.

³¹⁴*Lama v. Borrás*, 16 F.3d 473, 476 (defining charting by exception as "[a] system whereby nurses did not record qualitative observations for each of the day's three shifts, but instead made such notes only when necessary to chronicle important changes in a patient's condition."); David A. Tammelleo, *Charting by Exception: There Are Perils*, RN, Oct. 1994, at 71 ("Charting by exception is defined as much by what is omitted from the patient's record as by what is included in it . . . [T]he general principle is to chart only when something unusual or out of the ordinary happens.").

³¹⁵*See, e.g., Garcia*, 697 F. Supp. at 1573 ("The medical chart should be . . . a concise, factual memorandum . . . and informative notes on the patient . . ."); *Hurlock*, 709 S.W.2d at 881-82 (Nurses kept "patient care" or "flow charts," which documented care for time in question but which were not kept or included as a part of patient's medical records); *FIESTA*, *supra* note 48, at 174; Iyer & Camp, *supra* note 198, at 78; *but see Lama*, 16 F.3d at 481 ("[T]here was evidence from which the jury could have inferred that, as part of the practice of charting by exception the nurses did not regularly record certain information important to the diagnosis of an infection, such as the changing characteristics of the surgical wound and the patient's complaints of post-operative pain. . . . [T]he jury could have reasonably inferred that intermittent charting failed to provide the sort of continuous danger signals that would be the most likely spur to early intervention by a physician."); *Tammelleo, Restraints: A Legal Catch-22*, RN (Aug. 1994 Supp.), at 72 ("It is very important that [the nurse] pay strict attention to charting parameters - more than [one] would with copious amounts of record-keeping if [the nurse] work[s] in a hospital that has a charting-by-exception policy).

³¹⁶*See, e.g., Garcia*, 697 F. Supp. at 1573-74; *FIESTA*, *supra* note 48, at 174; Iyer & Camp, *supra* note 198, at 78.

³¹⁷*FIESTA*, *supra* note 48, at 173-74; *LOEB & CAHILL*, *supra* note 5, at 240; Iyer & Camp, *supra* note 198, at 83.

³¹⁸*LOEB & CAHILL*, *supra* note 5, at 240; Iyer & Camp, *supra* note 198, at 83-84; *BERNZWEIG*, *supra* note 13, at 360.

³¹⁹*LOEB & CAHILL*, *supra* note 5, at 240; Iyer & Camp, *supra* note 198, at 83-84;

Medical records are an extremely important source of information as to the nature and quality of care the patient received. Careful and comprehensive documentation by the nurse is not only essential to the successful diagnosis, treatment, and care of the patient, but will also serve to protect the nurse from liability.

I. Equipment and Technology

The rapid advancement and proliferation of complex medical equipment and technology have produced new areas of specialization in the health care system and have certainly enhanced the delivery and quality of health care. The increased utilization of, and dependence upon, this modern equipment and technology have added significantly to the scope and complexity of nursing responsibilities and have created a new category of potential legal liability for nurses.

Nursing negligence or malpractice concerning the use of equipment and technology can occur in several circumstances. The nurse initially must determine whether the equipment and technology essential for a particular area are in fact present.³²⁰ A nurse is expected to know the purposes, functions, capabilities, limitations, risks, and safety features of a variety of technologies.³²¹ He or she is obligated to operate equipment in conformity with the manufacturer's directions, instructions, or warnings as well as in accord with any hospital, medical, or nursing standards.³²² A knowledgeable nurse must exercise reasonable care in choosing a particular piece of equipment for

BERNZWEIG, *supra* note 13, at 360.

³²⁰See, e.g., *Dixon*, 431 S.E.2d at 781-82 (nurses breached duty of care by not having code cart properly restocked with a Number 4 MacIntosh blade); *Pirkov-Middaugh*, 479 N.W.2d at 65 (liability for failing to obtain proper equipment); *Calfee*, *supra* note 313, at 47 and cases cited therein.

³²¹See *Wheeler*, 866 S.W.2d at 46-47 (nurses committed malpractice by failing to use equipment to determine the presenting part of fetus or its position and by failing to use equipment to ascertain fetal heart tones following successive contractions); *St. Paul Med. Ctr.*, 842 S.W.2d at 814 (nurse deemed negligent for failing to monitor baby and detect baby's hypoxia) (Physician expert "further stated that application of the EFM by a nurse with proper training would have detected (baby's) condition and would have required his delivery . . . early. . . ."); *FIESTA*, *supra* note 48, at 63; *Garlo*, *supra* note 45, at 264.

³²²See *Lamb*, 413 S.E.2d 722 (finding that the patient was injured when nurses used disposable replacement parts made by one manufacturer, instead of those made by the manufacturer who manufactured the instrument designed to dissolve cataracts, despite the manufacturer's warning that only the manufacturer's disposable parts should be used); *Lucas*, 562 So.2d at 1004 (nurse used improper technique for administering an enema, despite directions which stated the proper technique; *Salatka*, *supra* note 216, at 89-90 and cases cited therein.

a specific procedure or patient³²³ and the nurse will be held liable for using the improper equipment.³²⁴ Even when the nurse selects correctly, he or she can be liable for an error in technique in using the equipment that causes harm to the patient.³²⁵

Liability can also result when a nurse uses or fails to report defective, contaminated, or otherwise unsafe equipment.³²⁶ Accordingly, nurses have a duty to make a reasonable inspection of equipment prior to its use.³²⁷ If equipment is not functioning properly, the nurse must take reasonable measures to correct any defects or failure.³²⁸

Where equipment is inoperative or malfunctions, the nurse will be expected to provide reasonable patient care and support without the equipment;³²⁹ equipment failure does not automatically and totally relieve the nurse of liability.³³⁰

Appropriate maintenance and inspection procedures may provide a defense in an equipment malfunction case.³³¹ When a nurse inspects, cleans, or

³²³See *Battles*, 430 So.2d at 314 (finding that the head nurse secured appropriate personnel and equipment for patient suffering respiratory distress); *LOEB & CAHILL*, *supra* note 5, at 120.

³²⁴See, e.g., *Alef*, 6 Cal. Rptr.2d of 904-06 (labor and delivery nurses committed malpractice in part for not utilizing electronic fetal monitoring equipment); *Lamb*, 413 S.E.2d at 722; *Central Anesthesia Assocs.*, 333 S.E.2d at 831, 833 (nurse improperly administered anesthesia by means of a mask instead of an endotracheal tube; patient suffered cardiac arrest and subsequent brain damage); *Salatka*, *supra* note 216, at 89-90 and cases cited therein.

³²⁵See, e.g., *Minster*, 426 S.E.2d at 207-08 (nurse committed malpractice in part by improperly placing a feeding tube and failing to properly verify placement of the feeding tube; improper placement caused the pneumothorax eventually leading to patient's death); *Alef*, 6 Cal. Rptr.2d at 904-06 (labor and delivery nurses committed malpractice in part by not properly utilizing Doppler monitoring equipment); *Guilbeaux*, 589 So.2d at 631 (floor nurse committed malpractice by improperly removing a Jackson-Pratt drain from patient's back; x-rays subsequently revealed that a 3.5 inch strip of tube had been left in plaintiff's back.); *Calfree*, *supra* note 313 and cases cited therein; *FIESTA*, *supra* note 48, at 64-65 and cases cited therein; *Guarriello*, *supra* note 11, at 80.

³²⁶*Salatka*, *supra* note 216, at 89-90 and cases cited therein; *POZGAR*, *supra* note 38, at 249.

³²⁷*Hunnicuttt*, 986 F.2d at 123 (nurse deemed negligent for failing to properly inspect instrument before use); *Sullivan*, *supra* note 211, at 18; *FIESTA*, *supra* note 48, at 58; *LOEB & CAHILL*, *supra* note 5, at 120; *Salatka*, *supra* note 216, at 89-90 and cases cited therein; *Carlo*, *supra* note 45, at 264; *Guarriello*, *supra* note 11, at 80.

³²⁸*LOEB & CAHILL*, *supra* note 5, at 120; *Carlo*, *supra* note 45, at 264.

³²⁹*Salatka*, *supra* note 216, at 91 and cases cited therein; *Carlo*, *supra* note 45, at 264-65 and cases cited therein.

³³⁰*Salatka*, *supra* note 216, at 91 and cases cited therein; *Carlo*, *supra* note 45, at 264-65 and cases cited therein.

³³¹*FIESTA*, *supra* note 48, at 64-66 and cases cited therein.

"trouble-shoots" equipment, she must strictly comply with the manufacturer's and hospital's guidelines, document the activity, keep records of attendance at all training sessions and, if an injury does occur, retain the piece of equipment in question.³³²

As new and complex medical equipment appears, the nurse's responsibilities increase, and his exposure to legal liability increases. The nurse's expanded technological duties will demand greater technological knowledge and the exercise of a higher and more specialized degree of care.

J. Safeguarding Patients

One of the nurse's most basic duties is to secure a patient's physical safety. Patient falls are one of the most commonly litigated patient injuries.

Nurses have a duty to assess a patient's safety needs, foresee a need to protect the patient from falls, and act as a reasonably prudent nurse would in taking precautions such as the use of siderails or restraints.³³³ Regardless of whether the physician has ordered safety measures, the nurse, who is in continual contact with the patient, is deemed responsible for making an independent evaluation of the patient's safety needs.³³⁴ The failure to safeguard a patient by not anticipating a fall and implementing safety measures subjects the nurse to negligence or malpractice liability.³³⁵

³³²FIESTA, *supra* note 48, at 64-65 and cases cited therein; LOEB & CAHILL, *supra* note 5, at 120.

³³³See, e.g., *St. Elizabeth Hosp.*, 883 S.W.2d at 437 ("The evidence of the nurses demonstrated that they had discretion to apply restraints to confused, disoriented, woozy patients or to patients who did not possess sufficient physical control to avoid falling . . ."); BERNZWEIG, *supra* note 13, at 141; Reilly, *supra* note 26, at 15; Garlo, *supra* note 45, at 268-69; Greenlaw, *supra* note 198, at 125, 127; but see *Kimball*, 421 So.2d at 310 (no duty for nurse to assist 79 year old patient in either walking or sitting when plaintiff had no prior history of health problems, did not ask for assistance, and did not appear visually incapacitated).

³³⁴Greenlaw, *supra* note 198, at 127.

³³⁵See, e.g., *St. Elizabeth Hospital*, 883 S.W.2d at 437-38 (nurses deemed negligent for placing confused, disoriented, woozy patient, lacking sufficient physical control, in recliner chair without restraints); *Gould*, 490 N.Y.S.2d at 89 (plaintiff claimed siderails of bed not properly raised which caused plaintiff to fall from bed and sustain multiple injuries including a fractured hip); *Daniel*, 415 So.2d at 590 ("[Nurse] testified that he knew that [patient] was hospitalized for weakness and vertigo as these conditions were noted on his medical chart. However, in spite of this knowledge, [nurse] left plaintiff sitting on the commode in the bathroom alone and returned to the nurses' station.") *Polonsky*, 418 N.E.2d at 622 (80 year old patient, recovering from a heart attack, was given sleeping medication Dalmane by nurse; lower siderails of bed not raised, despite drug manufacturer's warning of dizziness, staggering, and falls and despite hospital's policy of raising siderails for confused or disoriented patients; patient fell and fractured hip while attempting to go to bathroom); BERNZWEIG, *supra* note 13, at 141, 142; Reilly, *supra* note 28 at 15 and cases cited therein; Garlo, *supra* note 45, at 268-69 and cases cited therein; Greenlaw, *supra* note 198, at 125 and cases cited therein.

The exercise of reasonable care will reveal the possibility of a fall in certain high-risk patients: the elderly, those patients under sedation or anesthesia or recovering from the effects thereof, those receiving medication, patients suffering from a head injury, patients complaining of dizziness or "blacking out", those who request assistance, those who are uncoordinated, physically disabled, or lack sufficient physical control; those who are mentally incapacitated, confused, or disoriented, patients with impaired hearing, vision, or balance, and those patients thrashing about, highly agitated, or combative.³³⁶ These symptoms must be identified and necessary precautions must be taken. The failure to take precautions, since doing so involves the exercise of professional medical judgment, may be construed as a malpractice matter requiring the use of expert testimony.³³⁷ Courts, however, generally view a patient fall as a negligence issue not requiring expert testimony.³³⁸

A problem also confronts the nurse who *does* decide to utilize restraints. Restraints are designed to protect the patient from falling, but restraints also can endanger a patient. The nurse has to realize that restraints do not lessen the nurse's responsibility for the patient's safety but increase it.³³⁹ The prudent nurse must be aware of, and adhere to, the hospital's policies and regulations regarding siderails and restraints.³⁴⁰ Assurance must also be made that the

³³⁶See, e.g., *St. Elizabeth Hospital*, 883 S.W.2d at 437-38; *Atkins v. Pottstown Memorial Med. Ctr.* 634 A.2d 258, 259 (Pa. Ct. Super. 1993) (plaintiff alleged that a nurse was negligent for allowing a patient to go to bathroom after administering pre-operative shots); *Eversole v. Oklahoma Hosp. Founders Assoc.*, 818 P.2d 456, 460 (Okla. 1991) (patient taking Demoral and Tylenol with codeine fell and was injured when a nurse took the patient's right arm and, helping him to bed, attempted to support him with her left arm); *Putnam*, 619 N.E.2d at 971-72 (patient fell from hospital bed while under anesthesia and recovering from surgical procedure when bed rails not in an upright position); *Kimball*, 421 So.2d at 310 (finding no liability when patient fell because there was no prior history of health problems and the plaintiff did not ask for assistance); *Daniel*, 415 So.2d at 590 (patient, who was hospitalized for dizziness and weakness, whose left arm had been amputated, who was given medication which could cause him to feel dizzy and weak, and who had been given an enema, fell off commode, injuring himself); *Polonsky*, 418 N.E.2d at 622 ("reasonable probability" that 80 year old patient receiving sleeping drug Dalmane would become "confused and disoriented"); *FIESTA*, *supra* note 48, at 3-4; *LOEB & CAHILL*, *supra* note 5, at 119, 218; *BERNZWEIG*, *supra* note 13, at 141-42; *POZGAR*, *supra* note 38, at 250-51 a cases cited therein; *Greenlaw*, *supra* note 198, at 125 and cases cited therein.

³³⁷See, e.g., *Hulman*, 631 N.E.2d 327 (certified rehabilitation registered nurse used as expert in patient fall case); *Oxford*, 438 S.E.2d at 172; *Taylor*, 491 N.E.2d at 810; *Polonsky*, 418 N.E.2d at 621; *Garlo*, *supra* note 45, at 268-69.

³³⁸See, e.g., *Flowers*, 884 P.2d at 144-46 (failure to restrain regarded as ordinary negligence case); *Gould*, 490 N.Y.S.2d at 89; *Landes v. Women's Christian Ass'n.*, 504 N.W.2d 139, 141-42 (Iowa App. 1993); *Candler*, 354 S.E.2d at 876; *Polonsky*, 418 N.E.2d at 622; *Daniel*, 415 So.2d at 590 (patient fall case treated as negligence cause of action).

³³⁹*LOEB & CAHILL*, *supra* note 5, at 119.

³⁴⁰See, e.g., *Tobia*, 643 A.2d at 4 (nurse committed malpractice in patient fall case by disregarding hospital policy mandating that no patient should be left unattended in an

restraints fit properly and that the patient does not undo or readjust them.³⁴¹ In addition to deciding to use restraints and keeping siderails up when indicated, nurses should always orient the patient as to where he or she is, help the patient whenever he or she gets out of bed, eliminate total darkness in the patient's room, instruct the patient to notify a nurse upon awakening and not to get out of bed without assistance, institute frequent "bed checks," instruct the patient as to the correct application of restraints and siderails, and monitor the hospital's premises, facilities, and equipment for water or other substances that could cause a fall.³⁴²

The nurse, of course, should carefully document the use of any safety measures and instructions given to the patient and should state the reasons therefor.³⁴³ When a patient does fall, the nurse should immediately notify the attending physician and nursing supervisor.³⁴⁴

When the nurse is alert to the possibility of a patient fall and adheres to reasonable standards regarding safety precautions and safety instructions, falls will be avoided; even if there is a fall resulting in an injury, the reasonably prudent nurse should not be liable therefor.

IV. CONCLUSION

Nursing is a profession. Nurses now possess the authority to act as autonomous health care providers, exercising independent professional judgment in complex situations beset with medical and legal implications. The evolution and corresponding legal acknowledgement of nursing as a profession means a corresponding increase in nurses' legal liability.

Nurses presently perform functions which previously were within the exclusive sphere of physicians. No longer expected to attend upon and blindly follow the directions of a physician, the nurse today actively participates in the health care decision-making process. Consequently, a nurse's actions often result from the nurse's own assessment of a complex medical circumstance and a determination of the need for patient advocacy. The increase in decision-making autonomy has resulted in a nurse's actions being judged by standards of care adopted from typical physician medical malpractice.

Many more nurses are securing certification, and specialization within the profession is growing. The progress to advanced practice nursing means nurses will be held to progressively higher standards of care which in turn will serve as a new basis for tort lawsuits against nurses. Indeed, recognition of nurses'

emergency room stretcher with the side rails down); *Polonsky*, 418 N.E.2d at 621-22 (patient fall case).

³⁴¹LOEB & CAHILL, *supra* note 5, at 119.

³⁴²FIESTA, *supra* note 48, at 3-5 and cases cited therein; LOEB & CAHILL, *supra* note 5, at 118-119.

³⁴³FIESTA, *supra* note 48, at 2-3; LOEB & CAHILL, *supra* note 5, at 119.

³⁴⁴FIESTA, *supra* note 48, at 5.

expanded responsibilities is evidenced by the multiplying number of nurses who carry professional malpractice liability insurance and with progressively augmented amounts of coverage.

To protect herself from legal liability, the nurse must be keenly aware of her legal vulnerabilities and conduct herself accordingly. Such protection is best achieved by becoming thoroughly familiar with negligence and malpractice law—thus coming to appreciate the extent of a nurse's legal responsibility and accountability. Simply put, nurses must provide patients with nursing care in accord with the standards of the nursing profession. A thorough knowledge of the standard of care embodied in the "reasonably prudent nurse" is an absolute necessity for today's nurse.