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NOTES AND COMMENTS

THE NEGLIGENT NURSE: R_x FOR THE MEDICAL MALPRACTICE VICTIM

INTRODUCTION

Traditionally, physicians and hospitals have borne the brunt of medical malpractice liability.¹ Increasingly, however, greater attention is being focused on nurses as a potential additional source of recovery in cases of negligent medical care.² In examining this area of negligence law, this comment has three objectives: (1) to review the development of nurses' malpractice and its relationship to the general category of medical malpractice; (2) to explore the distinctive aspects extant in nurses' malpractice; and (3) to analyze the implications of the trend toward increased inclusion of nurses in malpractice actions.

To examine and fully understand the extent of a nurse's malpractice liability, it is necessary to recognize that nurses' malpractice is simply a separate branch of medical malpractice, which, in turn, is a specialized section of general negligence law.³ To prove a prima facie case of medical malpractice, a plaintiff must (1) introduce evidence that establishes both the existence of a duty owed him by the medical practitioner involved and the standard of care applicable to the situation, (2) demonstrate a failure to meet this duty and the existence of

1. In 1970, 49.4% of the malpractice claims brought named physicians as defendants, 36.2% named hospitals, and only 0.7% named nurses. APPENDIX TO THE REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, DHEW PUB. No. (OS) 73-89, at 19 (1973) [hereinafter cited as A-HEW]. In reference to doctor's malpractice, see generally M. KIMMEL, *LEGAL REMEDIES FOR MEDICAL ERRORS* (2d ed. 1970); C. KRAMER, *MEDICAL MALPRACTICE* (rev. ed. 1965); C. KRAMER, *THE NEGLIGENT DOCTOR* (1968).

2. H. Creighton, *The Malpractice Problem*, 9 *THE NURSING CLINIC OF NORTH AMERICA* 425 (1974). Creighton notes that the number of malpractice cases brought against nurses is on the increase. *Id.* at 431.

3. See generally Annot., 51 *A.L.R.2d* 970 (1957); MURCHISON & NICHOLS, *LEGAL FOUNDATIONS OF NURSING PRACTICE* (1970).

a resulting injury and (3) show that the violation was the proximate cause of the injury complained of.⁴ In this determination of negligence, a nurse essentially is treated in the same manner as a physician;⁵ however, subjecting nurses to liability raises an additional problem not common to doctor's malpractice. Because of the nature of her duties, a nurse's negligence, under agency principles, may be imputed to either the physician or surgeon in charge, the hospital employing the nurse, or to both or neither.⁶

DETERMINING THE DUTY AND STANDARD OF CARE

It is obvious that nurses and other medical personnel who undertake the obligation to treat patients have a duty to do so within the parameters of a reasonable standard of care. Establishing the existence of this duty to patients poses no problem since a duty exists in every case, either contractually or gratuitously.⁷ The difficulty arises in determining the extent of the duty owed to the patient by the nurse or physician and the standard of care applicable in a particular factual situation.⁸ Varying approaches have been utilized in attempting to establish and consistently apply a standard to determine whether or not conduct in a particular case may be adjudged negligent.

One approach which has developed for establishing the duty element and the applicable standard of care is the use of a contract theory. This view was embraced by the Oregon Supreme Court in *Giusti v. C.H. Weston Co.*,⁹ an action brought against a hospital for the misdiagnosis of an injury by its employee-physician. The court found that a contract is implied by law when a hospital undertakes the treatment of a patient with the motive of making a profit.¹⁰ Through this implied contract, the court concluded that the hospital was compelled to meet the standard of treating the patient "carefully and skillfully."¹¹ If the attendant does not meet this standard, the employer is liable for breach of the implied contract of skillful treatment. Nurses, the most com-

4. *Kosberg v. Washington Hosp. Center, Inc.*, 394 F.2d 947 (D.C. Cir. 1968).

5. See note 76 *infra* and accompanying text.

6. See notes 83-92 *infra* and accompanying text.

7. *Griffin v. Colusa Co.*, 44 Cal. App. 2d 915, 113 P.2d 270 (1941).

8. Ordinarily, a health care practitioner owes a duty of reasonable care to the patients he treats. What is reasonable depends on the factual situation involved. For example, under the Good Samaritan statutes, a nurse has only the duty to refrain from gross negligence. See generally Annot., 39 A.L.R.3d 222 (1971).

9. 165 Or. 525, 108 P.2d 1010 (1941).

10. *Id.* at —, 108 P.2d at 1012.

11. *Id.*

monly employed hospital attendants,¹² are bound under *Giusti* to treat paying patients according to the "terms" of the implied contract between the hospital and the patient.

The *Giusti* approach has inherent limitations and would raise serious conceptual problems on two grounds if applied generally to all nursing malpractice actions. First, because of its language expressly restricting the contract theory of liability only to hospitals run for profit, *Giusti* seems to provide complete protection from liability for employees of charitable or non-profit hospitals, no matter how careless or negligent their acts.¹³ Secondly, *Giusti* raises the specter of contract requirements supplanting general negligence law in determining liability for a medical error. An implied contract arises by operation of law when two parties enter into a relationship which is characterized by expectations of mutual obligations. When one party fails to perform, the law holds him liable for breach of the implied contract. While this concept has great utility in commercial settings, it is of dubious value in a malpractice case. This contractual method of delineating the standard of care applicable in a particular case unnecessarily complicates the process of establishing malpractice liability because, in effect, it relegates the malpractice issue to a secondary position while the contract aspects of the suit are litigated. While the effect of this contractual process is somewhat similar to the type of analysis ordinarily utilized in negligence cases, it nonetheless represents an unnecessary step in deciding whether medical treatment rendered meets the standard of care required.

A somewhat analogous approach to *Giusti* was taken by the Supreme Court of Virginia in *Stuart Circle Hospital Corp. v. Curry*.¹⁴ However, the court did not attempt to rely upon an expressly stated contract theory to resolve the duty and standard of care issues:

The basis of the liability [is] the undertaking of the hospital to furnish competent hospitalization; and the fact that the patient, having entrusted himself to the hospital for treatment, [has] the right to expect from it and its employees, while under its care, ordinary care and skill in nursing and

12. In 1972, of the 780,000 registered nurses in the United States, 66% were employed by hospitals. Of the 427,000 licensed practical nurses, 61% were employed by hospitals. DHEW Pub. No. (HRA) 75-4B, at 61 (1974).

13. If the standard of care is dependent on a contract, and the contract is dependent on the hospital being run for profit, it logically follows that without a contract there is no duty, and if there is no duty, there can be no liability.

14. 173 Va. 136, 3 S.E.2d 153 (1939).

treatment in such a degree of diligence as the nature of his case required.¹⁵

Although not expressly stated, the court's suggestion is that some clear, albeit unexpressed, agreement exists between the patient and the hospital that the patient shall receive proper treatment because of his unique, transitory relationship with the hospital. While this view shares some similarities with the *Giusti* analysis, it also represents a more flexible approach to the standard of care problem; there is neither the rigidity of the contract approach nor any suggestion of concrete distinctions between profit-motivated hospitals and charitable institutions. However, *Curry* falls short in developing a clear standard of care: the thrust of the court's effort is directed more at establishing the duty element than resolving the issue of how to determine the applicable standard of care.

A number of courts have attempted to avoid this issue, focusing instead on establishing a general standard by which actions in a particular case may be judged. The elusive "ordinary care" concept has been frequently used by courts in making this evaluation; a typical judicial example is provided in *South Highlands Infirmary v. Galloway*.¹⁶ In an action to recover damages suffered as a result of a fall from his bed following an operation, the patient alleged negligence on the part of the nurse in leaving him unattended while he was in a weakened post-operative condition. The court, trying to settle the negligence issue, devoted its attention to the standard of care determination:

Broadly speaking, ordinary care, that care which persons of common prudence exercise under like conditions, is the degree of care recognized by courts throughout the country. This implies a care having regard to the conditions of the particular case, and to the fact that the subjects of ministry are sick people. It implies an obligation to have such training and possess such skill as will enable the nurse to give reasonable and ordinary care to the patient.¹⁷

Courts following this view of the degree of care required simply adapt the standard of the reasonably prudent man in the ordinary negligence case to medical malpractice. Essentially, the analysis outlined in

15. *Id.* at —, 3 S.E.2d at 158. *But see* *Stone v. Sisters of Charity of House of Providence*, 2 Wash. App. 607, —, 469 P.2d 229, 233 (1970), indicating that a nurse must only "exercise reasonable care to see that no unnecessary harm comes to her patient."

16. 233 Ala. 276, 171 So. 250 (1936).

17. *Id.* at —, 171 So. 2d at 253.

South Highlands and followed by other courts¹⁸ suggests the development of a “reasonably prudent nurse” standard, applying an ordinary care concept. While this standard provides a more specific focus for measuring the nurse’s conduct, it does not indicate whether “the reasonably prudent nurse” is a general standard or one more specifically developed by a consideration of the level of nursing competence and particular practices in the locality where the alleged act of negligence occurred.

A Louisiana appellate court has attempted to clarify this ambiguity. In *Norton v. Argonaut Insurance Co.*,¹⁹ the court inferred that nurses are governed by the same rules that establish the duty and standard of care for physicians. Since Louisiana follows the “locality rule” for determining physicians’ malpractice liability,²⁰ the court concluded the same rule should apply for nurses. *Norton* seems to resolve the ambiguities implicit in *South Highlands*. It assumes that because doctors and nurses are both members of the medical profession they should be held to the same high standard of professional competence. However, by the use of *Norton’s* sweeping dicta, courts can make this standard impossible to rationally apply. This was aptly demonstrated in the subsequent case of *Thompson v. Brent*,²¹ another Louisiana decision, arising after a nurse severely cut a patient’s arm while attempting to remove a cast. In attempting to apply the *Norton* standard, the court concluded that nurses should be held to the same standard of care as physicians; therefore, it sought to apply the standard which would be applied had the doctor himself performed the procedure.²² The problem is apparent. While in *Brent* the physician-standard made no difference in the outcome, since the nurse was negligent under *any* standard, situations could arise in which a doctor would be considered

18. See *Birmingham Infirmary v. Coe*, 206 Ala. 687, 91 So. 604 (1921); *Timbrell v. Suburban Hosp., Inc.*, — Cal. App. —, 36 P.2d 435 (1934); *Duke Sanitarium v. Hearn*, 159 Okla. 1, 13 P.2d 183 (1932).

19. 144 So. 2d 249 (La. App. 1962).

20. The locality rule holds a physician to the

duty to exercise the degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing *in the same community or locality*, and to use reasonable care and diligence, along with his best judgment, in the application of his skill to the case.

Myer v. St. Paul-Mercury Indem. Co., 225 La. 618, —, 73 So. 2d 781, 782 (1953) (emphasis added).

21. 245 So. 2d 751 (La. App. 1971).

22. *Id.* at 753. In this case, it would be proper to expect the same standard of care from the nurse as from the doctor. Certain tasks, such as the removal of casts or surgical dressings, may be performed by either a doctor or a nurse. In such a case, the same standard of care should be applied.

negligent in his performance of some task where he failed to act *to the best of his ability as a physician*, while a nurse, performing the same task in the same manner, could be acting *to the best of her ability as a nurse*.

Because of this potential for inequitable application, the court in *Thompson v. United States*²³ rejected the *Brent* analysis of *Norton*. Instead, it found that *Norton* clearly held nurses to the standard of skill found in members of the *nursing profession* in the same community, rather than to the standard for physicians.²⁴ *Thompson*, in effect, adopted for nurses the standard required of physicians, substituting "nurse" for "physician" and "nursing profession" for "medical profession."²⁵ This standard enables a court to determine negligence on the basis of what is expected from a member of the nursing profession in her community, rather than holding her to the high standard required of a physician. While this is a rather simple exercise in semantics, it does eliminate all possible areas of confusion. Moreover, it is more definite than the contract theory, more likely to be evenly applied than the reasonably prudent nurse standard, and not subject to the misinterpretation of the physician's standard as exemplified in *Brent*.

An even further refinement of this standard, illustrating its inherent utility, is reflected in *Baur v. Mesta Machine Co.*,²⁶ a case involving the alleged negligence of a nurse in an industrial dispensary. The Pennsylvania Supreme Court adopted, as the standard for a nurse, the standard of care required of a physician, but modified it to apply exactly to the case at hand. While the court said the standard applicable to registered nurses was that of "a reasonably prudent registered nurse in charge of an industrial dispensary,"²⁷ it seems obvious that it did not mean to hold all nurses in all situations to the standard required

23. 368 F. Supp. 466 (W.D. La. 1973).

24. *Id.* at 468. Unfortunately, *Norton*, itself, did not *clearly* hold anything. The court, in establishing its standard of care, found:

The same rules that govern the duty and liability of physicians and surgeons in the performance of professional services are applicable to practitioners of the kindred branches of the healing profession, such as dentists, and, likewise are applicable to practitioners such as drugless healers, oculists, and manipulators of X-ray machines and other machines or devices.

144 So. 2d at 260. See also 70 C.J.S. 946. What is clear is headnote number 4 in *Norton*: "Generally, nurses must exercise degree of skill ordinarily employed under similar circumstances by members of their profession in good standing in same community or locality. . . ." 144 So. 2d at 249. Thus, the *Brent* holding relied heavily on a headnote which had little, if any, grounding in the *Norton* opinion itself.

25. 368 F. Supp. at 468.

26. 405 Pa. 617, 176 A.2d 684 (1961).

27. *Id.* at —, 176 A.2d at 688.

in an industrial dispensary. In future cases, the court would drop "industrial dispensary" and substitute the place where the defendant nurse was working at the time of the alleged malpractice. The problem of what a reasonably prudent nurse would do could be solved on the basis of expert testimony concerning the usual practice in the particular type of nursing involved in the suit. As a result, the *Baur* approach can be flexibly utilized in almost any case involving a nurse's alleged malpractice.

The most precise standard of care is that which holds a nurse to the degree of skill ordinarily exercised by members of the nursing profession performing the same function in the same general community. It presents a workable standard which can be readily applied to any situation. Moreover, it is no less restrictive than any of the more complex standards in delineating negligent acts. Because it is easier to prove whether this standard has been violated, it presents a more realistic approach to the question of the standard of care owed by a nurse to her patients.

FAILURE TO MEET THE STANDARD IMPOSED

Assuming the other elements of a negligence action are present, whenever a nurse breaches the standard of care owed to a patient, either through an affirmative act or an omission, she is negligent.²⁸ Traditionally, breaches have occurred in a number of specific areas of nursing practice. By examining the spectrum of nurses' malpractice cases, six broad categories can be established in which liability exposure is customarily greatest for the nurse: (1) foreign objects inadvertently and negligently left in a patient during an operation; (2) improper use of equipment; (3) improper exercise of a physical nursing skill; (4) the preparation and/or administration of an improper medication or other solution; (5) improper diagnosis; and (6) following the physician's orders.

Foreign Objects

A frequent source of malpractice actions against doctors results from foreign objects left in a patient during surgery.²⁹ Because of the

28. *Moore v. Guthrie Hosp., Inc.*, 403 F.2d 366 (4th Cir. 1968); *Kosberg v. Washington Hosp. Center, Inc.*, 394 F.2d 947 (D.C. Cir. 1968).

29. A study conducted by the Department of Health, Education and Welfare indicated that between 25% and 29% of the cases of alleged malpractice result from surgical material being left in the patient's body. See A-HEW, *supra* note 1, at 163.

role a nurse ordinarily plays in an operation, she also can be guilty of negligence in such instances. In an operation, it is not uncommon for the surgeon to use literally hundreds of instruments and sponges.³⁰ It requires a person of unusual mental proficiency to accurately monitor the location of each individual object while concentrating on the actual operating procedure and the patient's fluctuating physical condition. Hence, a necessary member of the surgical team is a nurse who counts every device going into and coming out of the patient at the site of the surgical procedure.³¹ Her duty, as a reasonably prudent nurse exercising that degree of skill common to her profession in the community, is to count properly. If the total number of items coming out does not equal the number of items that went in, and she fails to so inform the surgeon in charge, she has breached her duty and is negligent.³²

In a complex operation, the chief surgeon is assisted by a number of other surgeons. Each surgeon is assigned a nurse to hand him the required instruments. In such cases, it is common for one nurse to count every item given to the scrub nurses, and for another nurse to count every item coming out of the patient.³³ Each nurse reports her count to the circulating nurse,³⁴ whose responsibility is to report any discrepancy to the chief surgeon. If the nurse monitoring the number of items leaving the body fails to count properly, she is negligent. On the other hand, if she counts correctly, but the circulating nurse does not report any discrepancy between this figure and the count of the items going in, the circulating nurse, rather than the counting nurse, is negligent.³⁵

As a general rule, a surgeon's failure to remove a sponge or other device raises a rebuttable presumption of negligence on his part.³⁶ The

30. See generally L. BRUNNER, C. EMERSON, L. FERGUSON, & D. SUDDARTH, TEXT-BOOK OF MEDICAL SURGICAL NURSING, 989-1009 (2d ed. 1970).

31. This information was obtained in an interview with several registered nurses, employed by Tulsa, Oklahoma hospitals. [Hereinafter cited as Interview].

32. See *Buzan v. Mercy Hosp., Inc.*, 203 So. 2d 11 (Fla. App. 1967); *Grant v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969); *Martin v. Perth Amboy Gen'l Hosp.*, 104 N.J. Super. 335, 250 A.2d 40 (App. Div. 1969); *Harle v. Krchnak*, 422 S.W.2d 810 (Tex. Civ. App. 1967).

33. Interview, *supra* note 31.

34. Because of the limited amount of space available in close proximity to the patient, and the number of instruments involved, it is not uncommon for the nurses who do the counting to be at opposite ends of the operating room, making direct communication between them difficult, if not impossible. In addition to her other responsibilities, the circulating nurse will receive the counts from the respective nurses and determine whether or not there is a discrepancy. Interview, *supra* note 31.

35. *Piper v. Epstein*, 326 Ill. App. 400, 62 N.E.2d 139 (1945).

36. In some circumstances, the condition of the patient may call for the conscious

nurse who negligently makes an improper count usually will be jointly liable with the doctor.³⁷ Some courts, however, allow a surgeon to rely on the count made by the nurse. If the nurse makes an improper count and the surgeon relies on that count, he may be absolved of responsibility and insulated from malpractice liability.³⁸ This is of crucial importance to the nurse, since civil actions may be permitted against her alone, without other defendants with whom to share an adverse judgment. While medical malpractice suits against nurses alone are uncommon today, the general rule remains that a nurse who makes an improper count which results in an item being left in the patient is negligent, regardless of whether that negligence may be imputed to or shared by any other defendants.

Improper Use of Equipment

It is readily apparent that a prudent nurse should properly use equipment furnished her in the manner in which its use is intended. If the hospital furnishes obsolete equipment which is dangerous if used, as compared with more modern equipment, the nurse has a duty to refrain from using it, unless the patient's condition is such that the delay in treatment would cause more harm to the patient than the use of the obsolete equipment might produce.³⁹

medical decision by the surgeon to leave a foreign object in the patient. If this decision is reasonable, there is no negligence. Thus, a defendant doctor has the chance of rebutting the presumption of negligence.

A nurse, on the other hand, is not considered to have the ability to make such a decision. Thus, the presumption of negligence raised as to her act is not rebuttable. See *Spears v. McKinnon*, 168 Ark. 357, 270 S.W. 524 (1925); *Ales v. Ryan*, 8 Cal. 2d 82, 64 P.2d 409 (1936); *Key v. Caldwell*, 39 Cal. App. 2d 698, 104 P.2d 87 (1940); *Armstrong v. Wallace*, 8 Cal. App. 2d 429, 47 P.2d 740 (1935); *Smith v. Zeagler*, 116 Fla. 628, 157 So. 328 (1934); *Buzan v. Mercy Hosp., Inc.*, 203 So. 2d 11 (Fla. App. 1967); *Funk v. Bonham*, 204 Ind. 170, 183 N.E. 312 (1932); *Rule v. Cheeseman*, 181 Kan. 957, 317 P.2d 472 (1957); *Barnett's Adm'r v. Brand*, 165 Ky. 616, 177 S.W. 461 (1915); *Grant v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969); *Winchester v. Chabut*, 321 Mich. 114, 32 N.W.2d 358 (1948); *Walker v. Holbrook*, 130 Minn. 106, 153 N.W. 305 (1915); *Stawicki v. Kelly*, 113 N.J.L. 551, 174 A. 896 (1934), *aff'd*, 115 N.J.L. 190, 178 A. 754 (1935); *Ault v. Hall*, 119 Ohio St. 422, 164 N.E. 518 (1928); *Palmer v. Humiston*, 87 Ohio St. 401, 101 N.E. 283 (1913); *Davis v. Kerr*, 239 Pa. 351, 86 A. 1007 (1913); *French v. Fischer*, 50 Tenn. App. 587, 362 S.W.2d 926 (1962); *McCormick v. Jones*, 152 Wash. 508, 278 P. 181 (1929); *Paro v. Carter*, 177 Wis. 121, 188 N.W. 68 (1922); *Jackson v. Hansard*, 45 Wyo. 201, 17 P.2d 659 (1933).

37. *Buzan v. Mercy Hosp., Inc.*, 203 So. 2d 11 (Fla. App. 1967); *Piper v. Epstein*, 326 Ill. App. 400, 62 N.E.2d 1139 (1945); *Grant v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969); *Martin v. Perth Amboy Gen'l Hosp.*, 104 N.J. Super. 335, 250 A.2d 40 (App. Div. 1969); *Harle v. Krchnak*, 422 S.W.2d 810 (Tex. Civ. App. 1967).

38. *Robinson v. St. John's Med. Center*, 508 S.W.2d 7 (Mo. App. 1974).

39. *Payne v. Santa Barbara Cottage Hosp.*, 2 Cal. App. 2d 270, 37 P.2d 1061 (1934).

A nurse is not responsible for an injury resulting from the failure of equipment, unless the item is obviously unfit for its intended purpose. A nurse is not required to delve into the inner workings of the medical appliances she uses; no standard of care is abridged unless a defect is patent and readily observable.⁴⁰ However, even if the nurse operates a non-defective piece of equipment in the proper manner, she can be negligent if she fails to warn the patient of any obvious dangers arising from the equipment's operation, and he is thereby injured.⁴¹

A situation often arising from the improper use of equipment that frequently leads to malpractice actions involves the use of hot water and other warming devices designed to keep a patient's body temperature at a desired level.⁴² Commonly, the patient is burned either because the water is too hot or because the warming device is not properly insulated. Unfortunately, most burns result when a patient is unconscious, often causing serious injury.⁴³ Courts are virtually unanimous in holding that neglect resulting in such injuries constitutes actionable negligence on the part of the nurse.⁴⁴

Improper Exercise of Skills

The situation which most clearly resembles traditional medical

40. In *Butler v. Northwestern Hosp.*, 202 Minn. 290, 278 N.W. 37 (1938), a defective clamp on proctoclysis equipment allowed hot water to flow unrestricted into plaintiff, severely burning his bowel, while the nurse was out of the room. The court said:

[The nurse], although a trained professional, could reasonably rely upon the hospital's furnishing a proper clamp. We agree with defendant that if the article furnished was obviously unfit for the use for which it was furnished and intended, and the nurse used it in violation of the usual standards of due care of nursing practice, the defendant cannot be chargeable with any injurious effects therefrom. *But, the defect was not patent.* The clamp was furnished apparently ready for use and *it was not her duty to examine into its mechanical parts for the discovery of possible defects.*

Id. at —, 278 N.W. at 39 (emphasis added). See also *Ratliffe v. Wesley Hosp. & Nurses' Training School*, 135 Kan. 306, 10 P.2d 859 (1932).

41. *Welsh v. Mercy Hosp.*, 65 Cal. App. 2d 473, 151 P.2d 17 (1944).

42. A-HEW, *supra* note 1, at 163.

43. A conscious patient will usually complain about the pain, thereby giving a nurse the opportunity to correct the mistake before it reaches the level of injury which would lead to a malpractice action.

44. See *Ware v. Culp*, 24 Cal. App. 2d 22, 74 P.2d 283 (1937); *Corey v. Beck*, 58 Idaho 281, 72 P.2d 856 (1937); *Ratliffe v. Wesley Hosp. & Nurses' Training School*, 135 Kan. 306, 10 P.2d 859 (1932); *St. Paul-Mercury Indemnity Co. v. St. Joseph's Hosp.*, 212 Minn. 1, 4 N.W.2d 637 (1942); *Louzader v. James*, 107 S.W.2d 976 (Mo. App. 1937); *Iacono v. New York Polyclinic Med. School & Hosp.*, 269 App. Div. 955, 58 N.Y.S.2d 244 (1945); *Dillon v. Rockaway Beach Hosp. & Disp.*, 284 N.Y. 176, 30 N.E.2d 373 (1940); *Aderhold v. Bishop*, 94 Okla. 203, 221 P. 752 (1923); *Miller v. Mohr*, 198 Wash. 619, 89 P.2d 807 (1939); *Bise v. St. Luke's Hosp.*, 181 Wash. 269, 43 P.2d 4 (1935).

malpractice arises where a nurse improperly exercises her actual nursing skills.⁴⁵ One of the many skills a nurse must possess is proficiency in the administration of hypodermic injections. Depending upon the type of medication involved, an injection can be administered either intermuscularly, intravenously, subcutaneously, or intradermally.⁴⁶ If the nurse improperly administers an injection, she can be liable for any resulting injuries.⁴⁷ The route⁴⁸ to be used for an injection is normally ordered by the doctor prescribing the medication;⁴⁹ if the nurse fails to follow the proper route she is negligent.⁵⁰ Furthermore, negligence results if the doctor does not specify a particular route because the drug is one commonly administered and the nurse fails to follow the preferred method.⁵¹

A nurse is charged with a duty to have a basic understanding of the drugs she administers, including knowledge of their normal dosages, routes, and possible side effects. In *Norton v. Argonaut Insurance Co.*,⁵² a nurse administered a fatal dosage of medicine to an infant through an injection. The dosage would not have been fatal if it had been administered orally. Because the doctor did not specify the route, the court concluded that the nurse was liable for the death:

A nurse who is unfamiliar with the fact that the drug in question is prepared in oral form for administration to infants by mouth is not properly and adequately trained for duty in a pediatric ward. As laudable as her intentions are conceded to have been on the occasion in question, her unfamiliarity with the drug was a contributing factor in the child's death. In this regard, we are of the opinion that she was negligent in attempting to administer a drug with which she was not familiar. While we concede that a nurse does not have the same degree of knowledge regarding drugs as is possessed by members of the medical profession, nevertheless, common

45. Actual nursing skills are those which a nurse is specifically trained to perform. See generally KOZIER & DUGAS, FUNDAMENTALS OF PATIENT CARE (1967) [hereinafter cited as KOZIER & DUGAS].

46. *Id.*

47. *Bernardi v. Community Hosp. Ass'n*, 166 Colo. 280, 443 P.2d 708 (1968).

48. In medical terminology, "route" refers to the method of administration of a medication (e.g. orally, by injection, etc.). Interview, *supra* note 31.

49. *Id.*

50. *Moore v. Guthrie Hosp., Inc.*, 403 F.2d 366 (4th Cir. 1968).

51. Often medicine is available in several forms, all of which are commonly administered. For example, in a nursing home, a doctor will frequently order 5 milligrams of valium for a patient and not specify the route to be used. Whether the nurse chooses an oral form, or an intramuscular or intravenous injection, depends on how the patient's comfort and needs will best be served. Interview, *supra* note 31.

52. 144 So. 2d 249 (La. App. 1962).

sense dictates that no nurse should attempt to administer a drug under the circumstances shown in the case at bar.⁵³

While *Norton* provides a graphic example of negligence, situations where the nurse's actions are not so clearly negligent have also resulted in potential liability for the nurse. This is illustrated by a situation frequently presented to nurses—the necessity of moving patients. If, in the exercise of her nursing judgment, the nurse decides a patient should be moved and she moves him improperly, she is liable for any resulting injuries.⁵⁴ She is also subject to liability if she asks a patient to do some act which is potentially dangerous, because of side effects from a recently administered drug, and injury results.⁵⁵ This is true even though the drug was administered by another nurse or doctor, as long as she has knowledge of its administration.⁵⁶ This knowledge may be actual or constructive.

A medical chart is opened on each patient as he enters the hospital. A record is kept of each completed medical procedure, including all drugs administered during the patient's stay in the hospital, their dosages, and the time and method of their administration. Each day as she begins work, a nurse attends "report," a session in which she is briefed on each of the patients she will care for in the ensuing eight hours. At this time she also is allowed time to review the charts.⁵⁷ Because of this opportunity for review, the nurse is charged with constructive knowledge of the charts' contents.⁵⁸

Improper Medicine

When a nurse is working in conjunction with a doctor, he often will order a specific medicine in a certain dosage. If the nurse fails to provide the requested medicine in the prescribed dosage, she is liable. If the doctor administers an improper injection which the nurse has prepared, and he cannot reasonably discover the error, he is

53. *Id.* at 260. In addition, the court held the doctor liable for failing to prescribe the preferred route of administration. See generally Annot., 63 A.L.R.3d 1020 (1975).

54. *McElroy v. Employers Liab. Assurance Corp.*, 163 F. Supp. 193 (W.D. Ark. 1958).

55. *Thompson v. United States*, 368 F. Supp. 466 (W.D. La. 1973).

56. *Id.*

57. Interview, *supra* note 31.

58. A nurse will also be liable if she abuses her discretion in some other fashion. For example, if the attending physician leaves an order for a procedure to be administered as needed, or as requested by the patient, and the nurse fails to administer the procedure, she is liable for any injury that results. See *Skidmore v. Oklahoma Hosp.*, 137 Okla. 133, 278 P. 334 (1929).

absolved of responsibility, leaving only the nurse liable for the negligence.⁵⁹

A nurse is given some discretion in the tools she can use for a prescribed procedure. For example, in preparing a patient for surgery, the nurse's duty is to clean and prepare the skin surface around the point of surgical entry. She has a choice of which chemical agent she uses to perform this function; if she chooses the wrong one and injury results to the patient, she is liable.⁶⁰ Because a nurse is not competent to prescribe medicines, this general class of negligent acts is quite narrow. Unfortunately, cases of this nature occur with alarming regularity,⁶¹ making up a substantial share of the reported cases of nurses' malpractice.

Improper Diagnosis

While a nurse has no duty to diagnose the cause of a patient's discomfort,⁶² she does have a duty to observe carefully and report all relevant symptoms to the doctor.⁶³ A heart attack victim provides a classic example. While the symptoms are readily observable, the nurse cannot diagnose the cause of those symptoms. She must, however, recognize the seriousness of the symptoms and call a doctor.⁶⁴ In cases of non-serious symptoms, the nurse does not have to report them to the doctor immediately, but she is required to record her observations in the patient's chart, so that the doctor and other medical personnel will have knowledge of them.⁶⁵

59. *Hallinan v. Prindle*, 220 Cal. 46, 29 P.2d 202 (1934).

60. *Emerson v. Chapman*, 138 Okla. 180, 280 P. 820 (1929).

61. See *NURSING*, April, 1976, at 103-06.

62. A nurse is prohibited from making a diagnosis on the theory that such constitutes the unauthorized practice of medicine. H. SARNER, *THE NURSE AND THE LAW* 48-53 (1968) [hereinafter cited as SARNER].

63. In *Hansch v. Hackett*, 190 Wash. 97, 66 P.2d 1129 (1937), the court, finding a physician not guilty of negligence, stated:

There was therefore a wide open opportunity for the jury to find that Dr. Hackett was not negligent, but that (1) the nurse who received Mrs. Hansch at the hospital was negligent in not discovering the symptoms of eclampsia contravis and recording them on the hospital chart so that Dr. Hackett, when he read the chart at 8:30 a.m., might have ordered the proper and necessary treatment. In passing, it may be said that, as described, the symptoms are such as should be observed by a nurse even though she might not have known what was indicated thereby.

Id. at —, 66 P.2d at 1131. This decision, in effect, raises the custom of charting a patient's condition from mere convenience for doctors and hospital staff, to a legal obligation of the nurse to the patient.

64. *Baur v. Mesta Machine Co.*, 405 Pa. 617, 176 A.2d 684 (1961).

65. 190 Wash. at —, 66 P.2d at 1131.

Following Doctor's Orders

A nurse is granted some protection from malpractice liability if the injury to the patient results from her attempts to carry out the orders of the attending physician. The rationale of the protection is that "[n]urses are not supposed to be experts in the technique of diagnosis or the mechanics of treatment."⁶⁶ In stating this rule, the court in *Habuda v. Trustees of Rex Hospital, Inc.*,⁶⁷ held that nurses are required to use their best efforts to follow the orders of the physician unless obvious injury to the patient would result. Thus, in the absence of an obvious resulting injury, a nurse will be completely shielded from liability by following the doctor's orders. The court in *Byrd v. Marion General Hospital*⁶⁸ defined the rule more graphically:

The great weight of authority . . . establishes the principle that nurses, in the discharge of their duties, must obey and diligently execute the orders of the physician or surgeon in charge of the patient, unless, of course, such order was so obviously negligent as to lead *any reasonable person* to anticipate that substantial injury would result to the patient from the execution of such order or performance of such direction. Certainly, if a physician or surgeon should order a nurse to stick fire to a patient, no nurse would be protected from liability for damages for undertaking to carry out the orders of the physician.⁶⁹

This broad protection is tempered by the nurse's obligation to follow her best professional judgment. In today's world of specialized medicine, where nurses are becoming very sophisticated and highly trained in their various areas of expertise, it is possible that a doctor might give an order to a nurse who, because of her degree of familiarity with the area, would recognize it as an error, or at least an abnormal procedure. Because of this increased knowledge, it is probable that in future cases nurses will be held to a stricter standard of care in discerning the correctness of a doctor's orders. In their training today, student nurses are told to question any order they do not understand or agree with, on the theory that doctors sometimes make mistakes.⁷⁰ If the doctor explains his decision and the nurse still does

66. 163 F. Supp. at 198.

67. 3 N.C. App. 11, 164 S.E.2d 17 (1968).

68. 202 N.C. 337, 162 S.E. 738 (1932).

69. *Id.* at —, 162 S.E. at 740 (emphasis added).

70. Interview, *supra* note 31.

not agree with it, she is instructed to tell the physician to perform the procedure himself.⁷¹

In view of training programs and the reasonably prudent nurse standard of care, it appears that a nurse is liable for following any order of a doctor which she, because of her training and experience, knows or should know to be erroneous. Otherwise, under a literal reading of the "stick fire to the patient" rule, nurses would be exempt from careless behavior as long as the nurse's action was directed by a physician. The rule would impose liability on a nurse only where knowledge that injury would result if the order was followed would be obvious to *any reasonable person*.⁷² Even though, because of her special training, she knew injury would result, a nurse could be exempt from liability under this concept merely because no layman would consider the result obvious. Thus, "obvious injury" must be defined from the standpoint of a similarly situated nurse rather than the "any reasonable person" standard of *Byrd*.

While a nurse has a positive duty to treat her patients with the reasonable level of skill which a nurse in her situation in her general community would use, this duty can be breached in a variety of ways. While some of the more common examples have been pointed out, this compilation is not all inclusive. As in other areas dealing with complex human behavior, new kinds of breaches arise with expected frequency.⁷³

71. *Id.* In *Norton*, the nurse who administered the fatal dose of lanoxin did inquire of several staff doctors as to the preferred route. Following accepted medical procedure, they told her to consult the doctor who had prescribed the dosage. She failed to do so, however, before administering the medication. 144 So. 2d at 255, 257.

72. See note 69 *supra* and accompanying text.

73. For example, in *Hendrickson v. Hodkin*, 276 N.Y. 252, 11 N.E.2d 899 (1937), a known layman applied an arsenic compound (which was known to be caustic, if not fatal) to a sore on the plaintiff's lip, in the presence of a doctor, a nurse, and the superintendent of the hospital. In reversing a lower court judgment, the court said the basis for the hospital's liability lay in the fact that the superintendent committed a crime by knowingly allowing a layman to treat the plaintiff while a patient in the hospital. The court noted with approval Judge Lazansky's dissenting opinion to the trial court's opinion:

Nurses are not expected to advise the administration if they are of the opinion that a doctor is not using the proper methods, for they are under the supervision of the doctors. But here, they observed that it was not a doctor who was treating the patient This was a concern of administration, and not of medical care.

Hendrickson v. Hodkin, 294 N.Y.S. 982, 985 (1937). The inference can reasonably be drawn that had the nurse, but not the superintendent, been aware that treatment was being rendered by a layman, she could have been held liable.

CAUSATION

Once the plaintiff in a malpractice action against a nurse establishes the duty and standard of care required in the situation and demonstrates the nurse's breach of that duty, he must then prove that the activity complained of was the proximate cause of his injury. Proximate causation is the means by which courts limit liability for the negligent act.⁷⁴ In a nurse's malpractice action, as in situations of general negligence law, if the injury can be said to have been proximately caused by the nurse's negligent actions, then the nurse is liable for the injurious results.

After the plaintiff establishes proximate causation, he still must prove that he has suffered an injury which is compensable in damages; either actual damages (such as additional medical treatment to correct the result of the negligent medical procedure), or special damages (such as pain and suffering). In this area of causation and damages, a nurse's malpractice suit radically departs from common negligence lawsuits and is more analogous to traditional malpractice proceedings against a doctor. The principal distinction between malpractice actions and other liability claims is the need for expert testimony in malpractice cases to establish that the injury was proximately caused by the alleged negligent act.⁷⁵ Generally, expert testimony is needed in malpractice cases because of the difficulties implicit in trying to establish that a particular injury resulted from the alleged negligent act. Ordinarily, in the absence of expert testimony, a layman is unable to understand the connection between the act and the injury, because of the complexities involved in medical treatment and diagnosis.⁷⁶

While expert testimony is generally required to establish the injury and causation, the plaintiff's burden can be eased in some situations

74. W. PROSSER, HANDBOOK OF THE LAW OF TORTS, § 42, 244 (4th ed. 1971) [hereinafter cited as PROSSER].

75. 2 Wash. App. at —, 469 P.2d at 232.

76. "A bad result is not in itself evidence of negligence . . ." *Id.* In most cases, in order to understand the relationship between the "bad result" and the alleged negligent act, the layman will require a non-technical explanation of the causal link. For example, in situations where the nurse has made a blatant error, the average layman would have no difficulty in seeing that the nurse was negligent. See *Emerson v. Chapman*, 138 Okla. 180, 280 P. 820 (1929) (where the nurse used a caustic solution to prepare the patient for an operation); see also *Hallinan v. Prindle*, 220 Cal. 46, 29 P.2d 202 (1934) (where the nurse substituted formalin for novocain). In *Emerson*, the normal juror would expect a caustic solution to burn the patient; therefore, the cause of the burn would be relatively easy to establish. In *Hallinan*, however, the average layman would have no idea whether or not an injection of formalin rather than novocain would cause grievous injury to the patient. This demonstrates the obvious need for expert testimony and the reason why it is usually required in malpractice cases.

through the use of legal presumptions. One readily identifiable act automatically shifts the burden of going forward with the evidence to the defendant hospital: proof that a foreign object was left in the patient following surgery. All the plaintiff must show is that the object was left in him; the burden then shifts to the defendant to show that the negligence caused no damage, or that the inclusion was either intended or a normal practice in that particular type of operation.⁷⁷ This is a typical example of the application of the presumption of negligence doctrine, or negligence per se.⁷⁸

The other major presumption of negligence which can benefit the plaintiff in a medical malpractice action is the doctrine of *res ipsa loquitur*. In order to benefit from this presumption, the plaintiff must show that the injury complained of occurred through someone's negligence, and that the instrumentality of that negligence was under the exclusive control of the defendant.⁷⁹ While this is an obviously useful presumption for the plaintiff, it should be noted that he may still have to establish, through expert testimony, that his injury was not the result of natural forces, but was caused instead by someone's negligence.⁸⁰ Inherent is the need to establish the relative standard of care applicable to his case, whether for the doctor, the hospital, the nurse, or all three. Through application of the doctrine, the plaintiff is relieved of the burden of proving exactly who the negligent party is and the specific act or omission causing the injury.⁸¹

POTENTIAL MALPRACTICE DEFENDANTS

While a negligent nurse is individually liable if the necessary elements of a malpractice action are proved against her, many nurses have insufficient financial resources to compensate an injured plaintiff.⁸² As

77. See *Buzan v. Mercy Hosp., Inc.*, 203 So. 2d 11 (Fla. App. 1967); *Grant v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969); *Martin v. Perth Amboy Gen'l Hosp.*, 104 N.J. Super. 335, 250 A.2d 40 (App. Div. 1969); *Harle v. Krchnak*, 422 S.W.2d 810 (Tex. Civ. App. 1967).

78. PROSSER, *supra* note 74, indicates that the doctrine of negligence per se is utilized when a statute has been violated; however, courts apply the term more loosely in malpractice cases. See cases cited in note 77 *supra*.

79. *Ybarra v. Spangard*, 208 P.2d 445 (Cal. 1949). See generally WILLIG, *THE NURSE'S GUIDE TO THE LAW* 118-20 (1970) [hereinafter cited as WILLIG].

80. *Id.* See also *Stone v. Sisters of Charity of House of Providence*, 2 Wash. App. 607, 469 P.2d 229 (1970); *Horner v. Northern Pac. Beneficial Ass'n Hosp., Inc.*, 62 Wash. 2d 351, 382 P.2d 518 (1963). See generally Annot., 9 A.L.R.3d 1315 (1966); PROSSER, *supra* note 74, at 214.

81. 208 P.2d at 445.

82. In 1973, the median income for physicians was \$49,415, up from \$37,620 in 1968 and \$22,100 in 1959. DEP'T OF HEW, S.S. ADM. OFFICE OF RESEARCH & STATIS-

a result, a plaintiff must carefully analyze the negligent act to determine if, based on the nurse's act causing the injury, others besides the nurse are subject to liability. Determining who, aside from the nurse herself, is liable for the nurse's negligent actions is frequently complicated by the fact that, in the performance of her duties, a nurse may be responsible to the doctor,⁸³ the hospital,⁸⁴ neither or both. This complex relationship is compelled by the very nature of the nursing profession; the task of ministering to the needs of the ill often calls for the simultaneous performance of acts ordered by different supervisors.⁸⁵

Assuming the negligent nurse is employed by a hospital, it is likely that the hospital will be joined as a defendant in any action against her.⁸⁶ Through application of agency principles, an entity employing a nurse is liable for her negligence resulting from activities performed within the scope of her employment.⁸⁷ Thus, a non-negligent supervisor or employer may be liable under the doctrine of respondeat superior.⁸⁸ This rule becomes more complex as it relates to nurses who perform numerous different tasks, because of the concept of the "borrowed employee." This corollary was carefully delineated and its application explained in *Dickerson v. American Sugar Refining Company*.⁸⁹

TICS, MEDICAL CARE—EXPENDITURES, PRICES AND COSTS: BACKGROUND BOOK, DHEW PUB. NO. (SSA) 75-11909, Sept. 1975, at 59. On the other hand, the average starting salary for nurses in 1972 was \$8,200, up from \$6,400 in 1968. AMERICAN NURSES' ASS'N, STATISTICS DEP'T, *Survey of Salary Ranges for R.N. Staff-Level Positions in Non-federal Short-Term General Hospitals*, December 1971-January 1972, at 2. The average individual net worth of nurses interviewed (*see* Interview, *supra* note 31), was \$10,500. This figure does not include assets held solely by their spouses, or accumulated by virtue of their spouses' earnings.

83. When a nurse performs a task under a physician's direct supervision, she is responsible to him.

84. For example, when a nurse performs a strictly administrative task, as part of her employment duties with the hospital, she is directly answerable to the hospital for her actions.

85. A common example is the performance of certain routine procedures by nurses, such as caring for patient hygiene. If requested by a physician to perform such services, the nurse may be considered as performing at his bidding and under his supervision. However, the task could also be considered to be a routine part of patient care and administrative in nature. If so, this puts the hospital, as employer, in the position of supervisor.

86. In some cases, such as with specialized private nurse-practitioners, this is impossible, since the nurse's only employer is the patient. There is, of course, nurses' malpractice insurance to cover this particular professional hazard.

87. *See generally* Annot., 29 A.L.R.3d 1065 (1970).

88. *Stone v. Sisters of Charity of House of Providence*, 2 Wash. App. 607, 469 P.2d 229 (1970). *See also* 368 F. Supp. at 755.

89. 211 F.2d 200 (3rd Cir. 1953).

We begin with the fundamental proposition that one sought to be held is liable only if he is the master of him who was negligent. One who is in the general employ of A may, as to certain work, be transferred to the services of B so that he becomes B's servant while engaged in that work. In order to determine whether a person is the employee of A or B, the test is whether the one or the other had the right to control, not only the work to be done, but also the manner of doing it, and the person is the servant of him who had the right to control the manner of performance of the work, regardless of whether or not he actually exercises that right. Then, of course, there is a middle ground. That is, a person may be the servant of two masters, not joint employers, at the same time as to the same act, provided that service to one does not involve an abandonment of service to the other.⁹⁰

The "borrowed employee" corollary is further complicated by the doctrine of charitable immunity. Simply stated, the doctrine provides that a charitable entity is immune from tort liability through operation of law.⁹¹ If this rule is followed, a plaintiff employing respondeat superior in a suit against a nurse may find the principal is a nonprofit charitable hospital immune from liability for its negligent employees' acts.

In most jurisdictions, the doctrine of charitable immunity is a judicially-created rule, developed on the theory that if a charitable institution is liable for the tortious acts of its agents, the corpus of the trusts set up to finance the institution would be dissipated through damage suits, forcing the institution to close.⁹² This possibility is felt to be cumulatively more harmful to society than any individual hardship suffered by an injured party through denial of damages for his negligence claim. One major exception to the doctrine has, however, accorded plaintiffs some relief; if a charitable institution has liability insurance coverage, the insurance carrier cannot use the defense of charitable immunity to avoid payment on the policy.⁹³ Insurance carriers have somewhat negated this relief by writing policies that specifically exclude coverage for malpractice by the insured institution's employees.⁹⁴

90. *Id.* at 202-03. See generally WILLIG, *supra* note 79, at 39-42, 58.

91. See generally PROSSER, *supra* note 74, at 992-96.

92. *Id.*

93. See *Hemenway v. Presbyterian Hosp. Ass'n*, 161 Colo. 42, 419 P.2d 312 (1966); *O'Connor v. Boulder Colo. Sanitarium Ass'n*, 105 Colo. 259, 96 P.2d 835 (1939); *Brown v. St. Lukes Hosp. Ass'n*, 85 Colo. 167, 274 P. 740 (1929); *St. Mary's Academy of Sisters of Loretto v. Solomon*, 77 Colo. 463, 238 P. 22 (1925); *Grant v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969).

94. See *Grant v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969).

Other exceptions have been carved out of the broad protection of charitable immunity. In *Grant v. Touro Infirmary*,⁹⁵ a Louisiana court upheld the doctrine, but noted with approval two additional exceptions to charitable immunity in negligence actions: first, that the doctrine applies only to beneficiaries of the charity (including paying patients) and, secondly, that it does not apply when direct corporate negligence can be shown (such as where the hospital is negligent in hiring the individual nurse).⁹⁶

A number of illogical legal fictions developed concurrently with the immunity doctrine. For example, the court in *Schloendorff v. Society of New York Hospital*,⁹⁷ stated that nurses treating patients are carrying out the orders of physicians, to whose authority they are subject, and that during such an undertaking they are not servants of the hospital.⁹⁸ This statement was later expanded to the point that the hospital was liable only if the negligent act was administrative or clerical in nature.

By 1939, this immunity was extended to cover all hospitals, whether private or charitable.⁹⁹ At that point, the question to be resolved in malpractice cases was simply whether or not the act by the nurse was "medical" in nature. If so, the hospital, whether charitable or not, was not liable. The extent courts went to in their efforts to distinguish "medical" acts from "administrative" acts is well illustrated in *Bing v. Thunig*,¹⁰⁰ which overruled parts of *Schloendorff*.¹⁰¹

Bing noted that acts such as placing improperly capped hot water bottles on a patient, giving a transfusion to the wrong patient, using an improperly sterilized needle for an injection, and failing to place sideboards on a bed when they were necessary had been held to be administrative acts. On the other hand, keeping a hot water bottle on a patient too long, giving the wrong type of blood to a patient, improperly

95. 254 La. 204, 223 So. 2d 148 (1969).

96. See *Hallinan v. Prindle*, 17 Cal. App. 2d 656, 62 P.2d 1075 (1936); *Shane v. Hospital of the Good Samaritan*, 2 Cal. App. 2d 334, 37 P.2d 1066 (1934); *Henderson v. Twin Falls Co.*, 59 Idaho 97, 80 P.2d 801 (1938); *Ratliffe v. Wesley Hosp. & Nurses' Training School*, 135 Kan. 306, 10 P.2d 859 (1932); *Norton v. Argonaut Ins. Co.*, 144 So. 2d 249 (La. App. 1962); *Miller v. Mohr*, 198 Wash. 619, 89 P.2d 807 (1939); *Bise v. St. Luke's Hosp.*, 181 Wash. 269, 43 P.2d 4 (1935).

97. 211 N.Y. 125, 105 N.E. 92 (1914).

98. *Id.* at —, 105 N.E. at 94.

99. *Steinert v. Brunswick Home*, 172 Misc. 787, 16 N.Y.S.2d 83 (Sup. Ct. 1939), *aff'd*, 20 N.Y.S.2d 459 (App. Div. 1940).

100. 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957).

101. While the court in *Bing* did not claim to overrule *Schloendorff*, it is accurate to say it overruled that portion of the *Schloendorff* holding discussed in this comment.

administering an injection, and failing to decide that sideboards were necessary had been held to be "medical."¹⁰² This illustrates the arbitrary decisions courts were making in applying this doctrine.

Fortunately for the injured plaintiff, the concept of charitable immunity is rapidly disappearing.¹⁰³ In most jurisdictions the courts have struck down the doctrine; however, some states have limited the charitable immunity exemption through legislation.¹⁰⁴ With the doctrine rapidly fading into disuse, the rule of respondeat superior, previously applicable only to private hospitals, will be applied to charitable institutions as well. Therefore, the issue of concern for courts today is who has control over the nurse's acts.¹⁰⁵

The general method for determining if a physician is liable for a nurse's negligence was stated in *Burns v. Owens*.¹⁰⁶ *Burns* notes that generally a doctor is not liable for the negligence of hospital nurses unless they are performing under his direct supervision and control, or unless he is independently negligent for allowing them to attend the patient. A physician may not be charged with liability if he gives a nurse proper instructions which she fails to carry out, resulting in injury to the patient.¹⁰⁷

IMPLICATIONS OF INSURANCE

An additional non-legal factor gaining increasing significance in the area of nurses' malpractice is nurses' malpractice liability insurance. In contrast to insurance rates paid by physicians, malpractice insurance

102. 2 N.Y.2d at 657-58, 163 N.Y.S.2d at 4-5, 143 N.E.2d at 4-5.

103. See *Moore v. Guthrie Hosp., Inc.*, 403 F.2d 366 (4th Cir. 1968); *Bernardi v. Community Hosp. Ass'n*, 166 Colo. 280, 443 P.2d 708 (1968); *Bing v. Thunig*, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957).

104. See, e.g., *Martin v. Perth Amboy Gen'l Hosp.*, 104 N.J. Super. 335, 250 A.2d 40 (App. Div. 1969), where the New Jersey Charitable Immunity statute, N.J. STAT. ANN. § 2A:53A-8, which limits a charitable organization's liability to \$10,000, was applied to set the negligent nurses' liability. Out of a total award to the patient of \$36,000, the jury required the surgeon to pay \$18,000. The court said the hospital's share was its statutory limit, and assessed the nurses the remainder of the judgment.

105. States are split as to the kind of control necessary over a nurse's activities. Some states employ a "Captain of the Ship" philosophy to operations, holding that the surgeon in charge has complete control. See, e.g., *Aderhold v. Bishop*, 94 Okla. 203, 221 P. 752 (1923); *Harle v. Krchnak*, 422 S.W.2d 810 (Tex. Civ. App. 1967); WILLIG, *supra* note 79, at 59. Other states look to the specific activity involved to see who has control. See, e.g., *Buzan v. Mercy Hosp., Inc.*, 203 So. 2d 11 (Fla. App. 1967); *Emerson v. Chapman*, 138 Okla. 180, 280 P. 820 (1929); Annot., 29 A.L.R.3d 1065 (1970); WILLIG, *supra* note 79, at 59.

106. 459 S.W.2d 303 (Mo. 1970).

107. *Id.* at 305.

is readily available to nurses at nominal rates.¹⁰⁸ Traditionally, however, nurses have not been inclined to insure themselves against malpractice exposure.¹⁰⁹ In light of several factors gaining increased importance today, however, nurses' malpractice insurance coverage should show rapid gains in the future.

First of all, professional nurses are beginning to realize that while most plaintiffs join the employer hospital in any negligence action against a nurse, the doctrine of respondeat superior does not cut off the nurse's liability. The negligent nurse not only can be required to compensate the plaintiff for his injuries, but also to indemnify her employer for payments made to the plaintiff because of the negligence.¹¹⁰ Because of the possible conflict of legal interests between them, a nurse sued along with her employer may be forced to hire her own attorney, at her own expense. Secondly, wide coverage by the national press of medical malpractice and the cost of malpractice insurance is making health care professionals keenly aware of the personal financial devastation which can result from an adverse malpractice judgment.¹¹¹ Finally, professional nursing organizations, realizing the need for malpractice insurance, are making determined efforts to encourage their members to purchase this protection.¹¹² As more nurses become aware of the increasing necessity for carrying malpractice insurance and the availability of inexpensive coverage, it is likely they will take advantage of it.

Because of the methods utilized in modern medicine, doctors do not function in a vacuum, but rely heavily on nurses to carry out their

108. According to a 1973 government study, registered nurses and licensed practical nurses could obtain \$200,000/\$600,000 (limit per occurrence/limitation on all occurrences for a calendar year) limit coverage for an annual premium of \$10.95. The same coverage was available to the "high-risk" specialty of Nurse Anesthetists for \$43.80. See A-HEW, *supra* note 1, at 650. The comparable coverage for doctors averaged \$2,307.40, *id.* at 540, with individual costs ranging widely, depending upon locale and specialty. *Id.* at 494-601.

109. One Tulsa hospital has indicated that its malpractice policy covers its nurses; therefore, it advises its employees they do not need separate individual coverage. Interview with Mrs. R. J. Honeyman, Ass't Dir. of Nursing Service, St. Francis Hospital, Tulsa, Oklahoma, October 23, 1975. Another Tulsa hospital has no such coverage, but makes no strong recommendations as to the acquisition of individual coverage. Interview, *supra* note 31.

110. A-HEW, *supra* note 1, at 649.

111. During the period September 1971 to August 1972, more than 1600 news items pertaining directly to malpractice were published in the United States. A-HEW, *supra* note 1, at 654.

112. See, e.g., 75 AMERICAN JOURNAL OF NURSING 1420 (1975). The advertised plan indicates a 1975 increase in the premium for 100/300 coverage to \$15.00 annually. "The policy covers legal defense costs, and nurses receive compensation of \$50.00 a day for time lost from work." *Id.*

orders, observe patients' reactions, and monitor patients' conditions. Widespread malpractice coverage by health care professionals may encourage more malpractice suits against physicians, hospitals and nurses. Coupled with the continuing trend of impersonal medical treatment,¹¹³ not only will there possibly be an increase in the number of malpractice actions brought against nurses, but the size of the average settlement may increase as well.¹¹⁴ While this bodes well for the successful litigant, it means insurance premiums will be increased at all levels.¹¹⁵ This results in higher costs of rendering medical treatment which will be passed on to everyone seeking medical care.¹¹⁶

STATUTORY COMPLICATIONS

Aside from the insurance aspects, the area of nurses' malpractice is further complicated by various statutory provisions. Every state, pursuant to its police power, regulates the nursing profession operating within its borders;¹¹⁷ however, in most states, regulation consists solely of licensing. The usual practice is to establish a board or commission to oversee the practice of nursing,¹¹⁸ including such functions as preparing, administering and grading licensing examinations; promulgating regulations concerning the tasks nurses may perform; supervising license renewals; and conducting investigations and proceedings in connection with disciplining nurses for dereliction of their professional duties.¹¹⁹

The grounds supporting a finding that a nurse's license should be

113. A government survey of consumer attitudes indicates that 36.1% of the consumers surveyed felt doctors were more impersonal than they had been twenty years ago. A-HEW, *supra* note 1, at 668.

114. In the medical malpractice claims closed by insurance companies in 1970, the median payment to a plaintiff was \$2,000. While there is no definite information available, the trend seems to be toward higher settlements. REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, DHEW PUB. No. (OS) 73-88, p.11 (1973) [hereinafter cited as HEW].

115. Because of the complications arising from respondeat superior, the vast majority of malpractice actions brought against nurses also name doctors and hospitals. Thus, it can be presumed that an increase in the number of cases against nurses will also mean an increase in malpractice suits against doctors and hospitals. Increased litigation will lead to an increase in insurance premiums, the cost of which will be passed on to the patient. A-HEW, *supra* note 1, at 552.

116. In 1970, the average physician treated 3,396 patients. Of the 206 million patients treated in the United States in 1970, only 14,500 malpractice claims were filed. HEW, *supra* note 114, at 5-6.

117. See SARNER, *supra* note 62, at 15.

118. See, e.g., OKLA. STAT. tit. 59, § 567.4 (1971).

119. *Id.* at §§ 567.5-567.8.

denied, revoked, or suspended are statutory.¹²⁰ The majority of states permit the board to penalize a nurse if she is "unfit or incompetent by reason of negligent habits."¹²¹ While this seems to imply a further malpractice sanction, most courts construe this type sanction as calling for gross negligence.¹²² In any event, licenses are rarely revoked for this reason.¹²³

In addition to the licensing standards, most states have passed "Good Samaritan" laws, even though few malpractice cases arise from the rendering of emergency treatment by doctors and nurses.¹²⁴ These laws are designed to protect the medical practitioner from liability arising from emergency first aid treatment, except for acts of gross negligence.¹²⁵ In many states, this protection has been extended to nurses.¹²⁶

Some states include nurses under their medical malpractice statutes, passed in the face of the doctors' malpractice crisis.¹²⁷ These statutes range from guaranteeing the availability of malpractice insurance¹²⁸ to the establishment of special boards to hear malpractice cases in the first instance and make findings of fact which may be introduced at a later trial.¹²⁹

There is some question, however, as to whether all such medical malpractice statutes apply to nurses. In the licensing statutes, clear distinctions have been made between registered nurses, licensed practical nurses, and the various types of attendant positions or nurses' aids.¹³⁰ Courts, on the other hand, usually do not bother to make distinctions between RNs, LPNs and other attendants, lumping them together under the broad category of "nurse."¹³¹ The question of statutory applicability to nurses is further complicated by judicial construction of

120. *Id.* at § 567.8.

121. *See, e.g.*, KAN. STAT. § 65-1120(a)(3) (Supp. 1975). *See generally*, Annot., 55 A.L.R.3d 1141 (1974).

122. *See* SARNER, *supra* note 62, at 27. *See generally* Annot., 55 A.L.R.3d 1141 (1974). *See also* OKLA. STAT. tit. 59, § 567.8(a)(3) (1971).

123. SARNER, *supra* note 62, at 27.

124. HEW, *supra* note 114, at 15.

125. *See* Note, *Good Samaritans and Liability for Medical Malpractice*, 64 COLUM. L.R. 1301 (1964); WILLIG, *supra* note 79, at 126-27; SARNER, *supra* note 62, at 86.

126. *See, e.g.*, OKLA. STAT. tit. 59, § 518 (1971).

127. *See, e.g.*, KY. REV. STAT. §§ 304.40-010-330 (Supp. 1976); LA. REV. STAT. ANN. §§ 40:1299.41-.47 (Supp. 1975).

128. *See, e.g.*, IOWA CODE ANN. § 519A.1 (Supp. 1975).

129. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 231, § 60B (Supp. 1976).

130. *See, e.g.*, OKLA. STAT. tit. 59, §§ 567.5-.6 (1971).

131. *See generally* Annot., 51 A.L.R.2d 970 (1957).

special statutes of limitation for "medical malpractice." New York and Ohio have both decided that such statutes do not apply to nurses.¹³² Hawaii and Utah, on the other hand, specifically include nurses in their statutes of limitation for medical malpractice.¹³³

CONCLUSION

Malpractice has become a fact of life for doctors, hospitals and patients alike. On the other hand, while malpractice has always been of concern for nurses in a few isolated instances, the malpractice problem is just looming on the horizon for the nursing profession as a whole. Fear of potential liability will lead to increased insurance coverage which, in turn, will lead to increased malpractice claims against nurses, creating a vicious cycle similar to that which currently embroils doctors in the "malpractice crisis." It is possible, of course, that the process will be slowed, or the chain broken, by legislative action; existing statutes, however, are too new, and nurses' malpractice cases too few, to make any firm predictions.

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132. *Wolff v. Jamaica Hosp.*, 11 App. Div. 2d 801, 205 N.Y.S.2d 152 (1960); *Isenstein v. Malcomson*, 227 App. Div. 66, 236 N.Y.S. 641 (1929); *Richardson v. Doe*, 176 Ohio St. 370, 199 N.E.2d 878 (1964); Annot., 8 A.L.R.3d 1336 (1966).

133. HAWAII REV. STAT. § 657-7.3 (Supp. 1975); UTAH CODE ANN. § 78-12-28 (Supp. 1975).