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# Chapter 49
# Nursing and the Law

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**Medical Malpractice**
**Workplace Torts Against Patients Other Than Malpractice**
**Nursing Licensure**

Registered nursing is projected to be one of ten occupations in the United States with the largest growth in employment in the period 2004–2014. According to the federal Bureau of Labor Statistics, the number of RNs is expected to grow from approximately 2.4 million in 2004 to 3.1 million by 2014, an increase of 29%.[1] This growth will likely present significant challenges in nursing workplaces–both professional and personal–as existing staffs assimilate the newcomers and the nursing educations they will bring with them. As in any workplace experiencing an influx of new staff, there will be opportunities to learn but there will also be inefficiencies during the repeated team-building phases as new employees arrive, as well as risks associated with ensuring thorough training of newcomers in the employer's protocols, procedures, and policies. And in an employment climate where nursing graduates will generally be in very high demand, no manager can ignore the imperative to screen applicants carefully—to recognize that just because a person has obtained the necessary qualifications, he or she may *not* be an appropriate hire.

All of these challenges will be heightened by the expectation that the growing number of RNs will not be enough, and that understaffing will have measurably negative effects on patient care.[2] A further complication is that nursing aides, orderlies, and attendants comprise yet another of the ten fastest growing occupations in the country, with an expected growth rate of 22% from 2004 to 2014.[3] The number of home-health aides is expected to grow even faster, at a rate of 56%.[4] These projections portend a very busy decade for directors of nursing and other administrators with responsibility for fostering and managing professional, cohesive, caring, and efficient nursing staffs.

## MEDICAL MALPRACTICE

### Standards of Care in Nursing

#### Sources of Standards

Malpractice is usually defined simply as conduct that fails to meet an appropriate standard of care—the care that a reasonably prudent nurse would provide—and that causes an adverse result. Every adverse result is not the consequence of malpractice. Some adverse results may be unavoidable even with the best possible care. Malpractice occurs only when the adverse result could have been avoided through reasonably prudent care. In *Lenger v. Physician's General Hospital, Inc.*,[5] a patient sued for complications that arose after a nurse breached the standard of care by not following the patient's physician's feeding instructions. But there was no malpractice because there was no evidence that the misfeeding caused the complications. In other words, the adverse result had nothing to do with the misfeeding and could not have been avoided even if the nurse had not erred.

Defining what the nurse should have done—the standard of reasonably prudent care—is often the critical issue in a malpractice case. At the most general level, the nurse's care should be consistent with generally accepted knowledge and practice. For example, in *Hinson v. The Glen Oak Retirement System*,[6] children of a nursing home patient sued the nursing home, alleging (and proving at trial) "that the [defendant home's nursing staff] failed to properly chart, monitor and address [the patient's] condition, and coordinate her care plan. The court further concluded that these omissions led to ineffective communication with [patient's doctor] and resulted in the delayed diagnosis of [patient's] colon cancer."[7] In the course of reversing the judgment, the appeals court made the following observation about the standard of care:

> *It is a nurse's duty to exercise the degree of skill ordinarily employed, under similar circumstances, by the members of the nursing or health care profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his or her best judgment, in the application of his or her skill to the case.*[8]

This general precept (which says, essentially, "always do what *should* be done") is then sharpened, against the facts of any particular case, into an examination of precisely *what* the nurse should have done: what particular standard of care the circumstances demanded. To tell the jury what a reasonably prudent nurse would have done, the parties generally must present evidence from expert witnesses, who should be able to point to authorities that support their versions of the standard of care. These authorities may include current textbooks, treatises, and articles on the particular aspect of nursing at issue in the case; treatment standards issued by the American Nurses Association or any association for the type of nursing at issue in the case; treatment standards issued by the Joint Commission on Accreditation of Healthcare Organizations and by the

hospital or health care provider that employed the nurse;[9] doctors' orders pertaining to the patient;[10] and the expert's own experience in dealing with similar situations and in watching others deal with similar situations. Some combination of these authorities may speak generally or directly to the question of what the defendant nurse should have done. An expert's role is to synthesize these sources and, by drawing on qualifications rooted in "knowledge, skill, experience, training, or education,"[11] to give an opinion about what a reasonably prudent nurse would have done when faced with the same circumstances as the defendant nurse.

### Duty to Follow Physician's Orders

Whatever local or national standard applies, doctor's orders will supplement the standard and, in some cases, override it. If a doctor instructs a nurse to perform a certain action and the nurse fails to do it, resulting damages will be charged to the nurse's negligence.

This obligation is the nurse's shield where the nurse performs as instructed but the result is bad. In *Moore v. Carrington*,[12] an emergency room doctor and nurse failed to resuscitate a child. The hospital could not be held liable for any fault of the doctor because he was an independent contractor, not an employee. Neither the nurse nor her employer, the hospital, could be held liable because she had done as the doctor instructed. Consequently, it was legally possible for only the doctor to be held liable (although the jury, after looking at the facts, decided that the doctor had not committed malpractice.).

## Liability for Breaches of the Standard

Liability for nurse malpractice always falls on the responsible nurse and may also fall on the nurse's employer or supervising physician (or both). Though the employer and the supervising physician may be the same, as in an office-based practice, the employer and the supervising physician are often not the same, as is usually the situation in hospital-based or nursing-home-based malpractice, where the physician is rarely the nurse's employer.

The law assigns shared responsibility for the nurse's malpractice to the employer, the physician, or both based on a test that—like much else in the law—has been much easier to state than to apply with consistency. Where the malpractice arises out of work that the nonemployer physician supervises and controls, then the physician is deemed to have *borrowed* the nurse for purposes of that work and the nurse's actual employer will not be held liable.[13] Where the malpractice arises out of any other work of the nurse, then the nurse's actual employer will be held liable. Both results are rooted in the ancient doctrine of *respondeat superior*, which makes superiors in all lines of work responsible for the negligent (and in some cases, even the intentional) misdeeds of their employees when they act in the course and scope of their employment.

The responsibility is said to be *shared* by the nurse and the other party because the nurse remains liable. Shared liability, also known as solidary liability or joint and several liability, means that both the nurse and the *respondeat superior* co-defendant are each liable for the full judgment against the nurse, giving the plaintiff the option of collecting that judgment from either the nurse (in all probability, the nurse's insurer), the nurse's co-defendant employer (again, probably the insurer), or some portion of it from both.

While a physician or a hospital may have to share a nurse's liability for the nurse's malpractice, a nurse should never have to share a physician's or a hospital's liability for their own malpractice. Legal responsibility runs up the chain of command, not down.

It may seem an obvious point, but one of the first questions to ask in a malpractice case is *who* breached the standard of care (assuming someone did). Unfortunately, every one of the involved parties may have a different answer to that question, for at least two reasons. First, the parties may disagree about the facts—about who did what, when, where, why, etc. Second, they may disagree about the legal effect of the facts, in particular about who—the physician, the nurse, or someone else—had a legal duty of care under one or another version of the facts. In some cases, the law forecloses disagreement over who had the duty of care. In *Ravi v. Williams*,[14] for example, the court held that Alabama law holds surgeons, not nurses, responsible for removing all sponges from the patient before closing an abdominal incision. In *Hinson v. The Glen Oak Retirement System*,[15] the court recognized that "[t]he responsibility for diagnosis, including the decision to further investigate through lab work and other tests, is unmistakably that of the treating physician, not a nursing home or its nursing staff."[16] In thousands of other fact patterns and jurisdictions, the answer may not be so clear-cut.

### A Nurse's Own Liability

A nurse who is found to have committed malpractice is solidarily liable for the damages. The mere fact that the plaintiff may focus collection efforts against a wealthier co-defendant, such as the nurse's employer, does not eliminate the nurse's liability or the various administrative consequences that might follow (such as discipline or termination, or action by a state licensing board) or that *will* likely follow (such as a report being made to the National Practitioner Data Bank[17]). A nurse must be satisfied that he or she has malpractice insurance, either self- or employer-provided. In selecting the amount of coverage, the nurse should be aware of any caps or limits on damages that exist under state law.

### Physician's Liability

A physician may incur *respondeat superior* liability for a nurse's negligence if the physician was either the nurse's actual employer or, during the procedure in question, exercised such supervision and control that the physician is treated as having borrowed the nurse. In *Hunnicut v. Wright*,[18] the plaintiff sued for injuries caused by a screw and washer that fell off a medical instrument and stayed in his body. The evidence showed that a hospital-employed scrub tech failed to tighten the screw after sterilizing it and that if he had done so, the screw and washer would not

have fallen off. The surgeon was not the scrub tech's actual employer, so the plaintiff argued that the surgeon should be *treated as* the actual employer. But the court concluded that the surgeon did not have sufficient supervision or control over the scrub nurse's sterilization and reassembly of the instrument to be treated as the scrub nurse's actual employer and held liable for the scrub nurse's negligence. "The routine acts of treatment which an attending physician may reasonably assume may be performed in his absence by nurses of a modern hospital as part of their usual and customary duties, and execution of which does not require specialized medical knowledge, are merely administrative acts for which negligence in their performance is imputable to the hospital."[19]

On the other hand, the necessary degree of supervision and control were present in *Hudmon v. Martin*[20] for a nurse to be a physician's borrowed servant. In that case, the surgeon and scrub nurse were working together to prepare a patient for surgery and the surgeon directed the scrub nurse to fill a syringe with a certain fluid. The nurse filled it with the wrong fluid, which injured the patient when the surgeon injected it.

### Hospital Liability

A hospital may incur *respondeat superior* liability for an employee nurse's negligence where the nurse is not acting under the supervision and control of a physician, which is equal to saying that the nurse has not been *borrowed* and remains an employee of the hospital (or other nonphysician employer). Most of nursing occurs outside of a physician's direct supervision and control, with the nurse relying upon his or her own education and training or common sense. In these cases, the plaintiff cannot blame the physician for the nurse's negligence.[21] The negligence will remain with the nurse, and the nurse's employer will probably share it.

The hospital may also incur *respondeat superior* liability even if the negligent nurse was acting under a physician's supervision and control, but only where the hospital employs both the nurse and the physician. In that case, the supervising physician cannot borrow the nurse from the hospital because the physician works for the same hospital.[22]

In some instances, a nurse's employer may have been negligent with respect to nursing services regardless of whether any individual nurse employee was negligent. Here, the employer's negligence is not vicarious but its *own* (and the liability is its own). This can happen where, for example, the employer fails to maintain an adequate nursing staff[23]—an allegation that may appear with increasing frequency as the nationwide nursing shortage deepens. In *HCA Health Services v. National Bank*,[24] a day-old infant suffered cardiac and respiratory arrest in a hospital nursery. The nurses were partly negligent for not keeping a better eye on the infant, but the hospital was negligent on its own account for not having sufficient nurses on duty: "the hospital administration had been told of an ongoing need for more nurses in the nursery and . . . the number of staff on duty . . . [on the night in question] was below the hospital's own standards. . . ."[25]

Likewise, in *Landry v. Clement*,[26] the hospital was partly liable for violating its own policy against assigning nurses to work in its obstetric department without having first trained the nurses in the use of a fetal heart monitor.[27] In *Perez v. Mercy Hosp. of Laredo*,[28] the co-defendant hospital settled for $15 million on allegations that an overworked nurse mistakenly injected an ICU patient with paralysis-inducing Norcuron, which stopped him from breathing and caused brain damage. The evidence showed that the nurse had been working 72-hour weeks in the ICU and was finishing an 18-hour shift when the alleged mistake occurred. The evidence also showed that the nurse had failed a placement agency test that covered administration of medication and that the hospital fired the nurse 2 days after the patient's brain damage was discovered. In addition to the money payment, the hospital also agreed to institute a policy limiting ICU nurses to only 60 hours a week. Because the case was settled before trial, there was no final determination that the nurse, the hospital, both, or neither were negligent. But the allegation was that the hospital failed to exercise reasonable care in scheduling such long shifts for the ICU nurses and that this failure contributed to the medication error.

## General Areas in Which Nurses May be Found in Breach of a Standard

*How* a nurse may breach the appropriate standard of care is a question with innumerable answers. Injury-causing errors can occur in countless ways and this chapter will not attempt to catalog them. The result would quickly become outdated because new technologies and treatments constantly offer new pitfalls for malpractice. Also, the new (and the old) pitfalls are often practice-specific—some types of errors that can occur in a gerontology practice are not likely to occur in a neonatal practice, for example. Here, we will briefly consider the commonest types.

### Patient Monitoring and Communication

A nurse's key role is to monitor patients and to convey patient information, mainly through chart notes and but also through direct (and urgent, when circumstances dictate) communication with physicians and other nurses. As one court has emphatically noted (with reference to nursing home patients, but the principle clearly applies across the board), "it is the duty of the nurses involved in the daily care of nursing home residents to communicate details of the residents' conditions to their doctors, which is primarily done through entries and documentation in the residents' charts."[29] Thus, in *Louie v. Chinese Hospital Association*,[30] a nurse was held liable for neglecting to tell a physician that a patient had become restless and confused. Some time later, the patient fell while trying to get out of bed. The doctor testified that he might have changed the patient's medicine if he had been told about the patient's mental state. Similarly, the court in *Merritt v. Karcioglu*[31] affirmed a nurse's share of liability for failing to report the confused condition of a patient who later fell while trying to crawl out of bed (when found at the foot of the bed, she said she was trying to get

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to her kitchen to make dessert for her family).[32] In *Berdyck v. Shinde*,[33] the nurse's failure to report the maternity patient's persistent high blood pressure and other symptoms indicative of preeclampsia (due in part to a lack of knowledge of preeclampsia that was unacceptable in an obstetrics nurse) contributed to the occurrence of an eclamptic seizure that left the patient partially paralyzed.

An employer who has noted a nurse's failure to communicate would be wise to terminate the employment *before* an adverse result. In *Robinson v. Rockford Memorial Hospital*,[34] the hospital employer was found to have legitimately fired the plaintiff nurse for repeatedly noted failures to communicate patient information to other caregivers (among other reasons).

One area of practice where monitoring and communication pose a special challenge is home-health nursing. The possibility of failed communication is much greater where the nurse divides time among many patients in different locations and, because of this dispersal, is not in regular face-to-face contact with the patients' physicians.

In some cases, nurses have failed to communicate but those failures have not been the cause of the patient's injury. In one, an appeals court agreed with the trial court's finding that the patient's nurses "haphazardly charted" the patient's bowel movements, but nonetheless found "no causal connection between the nursing staff's failure to document all of [the patient's] bowel activity and the delayed diagnosis of her colon cancer."[35] Such activity was documented well enough, the court concluded, and in any event it was undisputed that the patient's doctor knew of her chronic constipation.[36] A somewhat similar result occurred in *Miles v. Box Butte County*,[37] where parents on behalf of their minor son sued a nurse for contributing to injuries resulting from hypoxia during labor and delivery. Two of their claims were that the nurse's chart notes reflected an incorrect interpretation of the tracings from the fetal heart monitor (the fetus's condition was much more endangered than the nurse realized) and that the physician had only the chart notes to rely upon because the nurse did not show the tracings to the physician. With respect to showing the tracings, the court agreed that "a hospital [through its staff] has a duty to notify a physician of significant changes in a patient's medical status."[38] But the nurse had not failed there:

> *[W]hen 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.*[39]

Consequently, the nurse in *Miles* was not negligent in not setting the tracings before the physician—the physician knew the tracings existed (the charts notes referenced them) and he could have asked to see them. But, *adverse to the nurse*, the court also held that the nurse was negligent in misinterpreting the tracings, which led to the physician's decision not to ask for the tracings. The liability resulted from the nurse's faulty monitoring of the patient's condition as reflected in her charts notes on the tracings, not the failure to provide the tracings themselves.[40]

## Patient Advocacy

Where a nurse suspects or knows that a patient's physician has failed to treat the patient adequately, the nurse must take appropriate steps to remedy the problem. This cannot include the nurse undertaking on his or her own to treat the patient—that would violate important restrictions on the practice of medicine by nonphysicians—but must include bringing the facts to an appropriate person. In *Tovar v. Methodist Healthcare System of San Antonio, Ltd., L.L.P.*,[41] the appellate court reversed dismissal of the plaintiff's claim and remanded for trial; key to this action was an expert witness's report stating that the hospital's nursing staff failed to advocate on behalf of the patient. The patient presented in the early afternoon at the hospital with a headache and right-arm numbness, was admitted to a neurological care unit, and was first treated around 9 P.M. that night with medication for high blood pressure and nausea. Early the next morning, she suffered a stroke and died soon after. The expert witness asserted that "[d]espite the patient's obvious deterioration [from 5 P.M. to 9 P.M.]..., they [the nursing staff] *meekly accepted* inadequate responses [from two physicians]... with no further calls to physicians until 12:30 A.M. when the patient was in extremis."[42] As another court has explained,

> *the nurse is not prohibited from calling on or consulting with nurse supervisors or with other physicians on the hospital staff concerning those matters, and when the patient's condition reasonably requires it the nurse has a duty to do those tasks when they are within the ordinary care and skill required by the relevant standard of conduct.*[43]

The policies of hospitals and other nurses employers of must account for nurses' professional obligation to go around nonresponsive physicians when necessary, and must protect nurses when they reasonably do so.

## Patient-Handling Errors

As discussed above, nurses may be negligent for patient falls and other injuries resulting from failure to report confused mental states that a physician might have chosen to treat with medication or restraints. Apart from such failure, a nurse may be negligent for falls and other injuries that might have been avoided if the nurse had been reasonably prudent. For example, a reasonably prudent nurse might see, without the need for doctor's orders, that a particular patient's bed rails should be raised to prevent the patient from trying to get up,[44] or that the patient should not be allowed to use the bathroom alone.[45]

## Medication Errors

Considering nurses' central role in delivering medicine to patients, medication errors make up what is certainly one of the largest areas for negligence claims against nurses. According to the Joint Commission on Accreditation of Healthcare Organizations, they are one of the five commonest types of sentinel events recorded by JCAHO since 1996.[46]

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The negligence may take as many forms as there are facets to this nursing activity. A nurse may, for example, accidentally give the wrong medicine or the wrong dose, or give it to the wrong patient, or administer it incorrectly. The growing use of barcoding and hand scanners, and information technology in general, promises to eliminate some of these occurrences.[47]

A medication error may not cause physical consequences for some time, and other circumstances may make it difficult to discover quickly that a patient received something in error, thus delaying the necessary backtracking to find the error. For that reason, some negligence lawsuits based on medication errors may be resolved by applying the evidentiary principle of *res ipsa loquitur*, which expresses the idea that some results cannot have occurred without negligence. For example, in *Thomas v. New York Univ. Med. Ctr.*,[48] the patient sued for injuries suffered when he fell off the operating table. The court found the hospital liable without any further proof of negligence: "it can hardly be debated that anesthetized patients do not fall from operating tables in the absence of negligence."[49] In some cases, on the other hand, the mistake will become apparent immediately as when, in *Loveland v. Nelson*,[50] a dentist injected a patient's gum with Lysol instead of anesthetic.

### Transfusion Errors

A related mistake is giving a patient the wrong type of blood. A nurse may mix up two patients' different blood types,[51] type the blood incorrectly,[52] retrieve the wrong type of blood from the blood bank,[53] think the doctor ordered one type when in fact ordering another, or make some related mistake.

## Nursing Negligence and the National Practitioner Data Bank

A nurse involved in a case of professional negligence may, in certain circumstances, be reported to the National Practitioner Data Bank (NPDB). Congress created the NPDB in 1986 because of concerns that state oversight of health care providers (including nurses) was fragmented and that information about providers who may have been negligent in one state was not being shared with other states, thus allowing negligent practitioners to remain in practice simply by moving.[54] The NPDB legislation requires, in part, that any entity (including an insurance company) paying a settlement or a judgment on a written medical malpractice claim must report the name of any licensed professional on whose behalf the payment is made, the amount of payment, the name of any hospital with which the person is affiliated, and a description of the acts or omissions and the injuries alleged.[55] The fact that money was paid in settlement (rather than judgment) is not to be construed as presumptive evidence that malpractice occurred.[56] The NPDB legislation allows hospitals to request NPDB reports on applicants for nursing employment.[57] Practitioners may self-query to obtain their own NPDB file.[58]

NPDB entries are permanent, but the subjects of such records are entitled to present their own statement along with the payor's report and/or to dispute the accuracy of information reported on them to the NPDB.[59] In general, the Secretary of the Department of Health and Human Services will mail to the person affected a copy of any NPDB report submitted. The person affected then has 60 days to dispute in writing the accuracy of the report as submitted. The practitioner must try to resolve the dispute with the reporting entity, which is primarily responsible for making a change to a submitted report. If the dispute is not resolved, the practitioner may request review by the Secretary of DHHS, who will determine whether the report as submitted was accurate and whether the report should have been submitted in the first place.

## Criminal Liability for Medical Malpractice

In rare but well-publicized instances, negligence in nursing has been so extreme that criminal charges have resulted. In *State v. Winter*,[60] a registered nurse was convicted of simple manslaughter and sentenced to 5 years in prison after she mistakenly transfused a patient with the wrong blood and then intentionally took several steps to conceal the error, "including failing to inform the patient's doctor of her error, secreting and disposing of the remainder of the blood upon realizing her mistake, and changing notations on... [the patient's] chart to mask the effects of the transfusion reaction."[61]

Even when it ends with acquittal of the defendant nurse, a prosecution may be expensive and devastating to a career. In one case, a Denver area grand jury indicted three nurses on charges of criminally negligent homicide in the death of a day-old baby. The baby's physician wrote a prescription for penicillin to be injected in the baby's hip muscle. A hospital pharmacist misinterpreted the prescription and filled it at 10 times the prescribed dosage but correctly showed that it was to be given in the hip muscle. When one of the three nurses received the medication from the pharmacy, she consulted a neonatal nurse practitioner who told the nurse to give the medicine intravenously instead of in the hip muscle. The homicide charges that followed this mistake carried a maximum jail term of 6 years and a maximum fine of $100,000.

Two of the nurses eventually pled guilty under an arrangement that called, in part, for each to perform 24 hours of public service and to satisfy other conditions set by the Colorado Nursing Board, which suspended each for one year with subsequent two-year probationary periods. The third nurse was acquitted at trial, but the ordeal of defense must have been difficult. The pharmacist who misfilled the prescription received a letter of admonition from the Colorado Board of Pharmacy but was not charged because, according to published reports, prosecutors believed that the much higher dosage would not have killed the baby if it had been administered through the hip muscle as prescribed and as the pharmacist correctly indicated.[62]

In another case, *Caretenders, Inc. v. Kentucky*,[63] the state tried two RNs, one LPN, and their employer (a home-health agency) for knowing and willful neglect of a patient.

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The patient, when admitted to a hospital, was dirty and covered with extensive bedsores. Evidence showed that agency employees did not turn the patient as ordered, did not keep her clean, and kept bad records of their patient care activities, and it also showed that the agency failed to train and supervise its employees properly. Even though the nurses were acquitted (while the agency was convicted and fined $8,333.33), their employment prospects must have suffered.

# WORKPLACE TORTS AGAINST PATIENTS OTHER THAN MALPRACTICE

Nurses and their employers may be held liable for behavior other than substandard patient care constituting professional negligence. Some these torts include the following.

## Patient Battery

Intentional mistreatment of patients may be a basis for liability. For example, an Oklahoma jury awarded $1.25 million in damages against a nursing home because a drunk aide harshly slapped a patient while trying to bathe him.[64] Employers must be careful in screening, retaining, and training employees, especially as they compete with other employers amid the nationwide nursing shortage.

## Breach of Patient Privacy and Confidentiality

Privacy is a broad right that everyone enjoys with respect to personal information, and invasion of privacy is a widely recognized basis for filing a lawsuit. Confidentiality is a somewhat narrower right, as it is rooted specifically in a patient's medical records. Together, the rights of privacy and confidentiality ensure the nondisclosure of patients' medical records as well as other private information regardless of whether it has been documented in a medical record. The advent of HIPAA has added a federal statutory layer to these protections.[65]

While nurses must be careful to preserve the confidentiality of both records and other private information, they should be particularly on guard concerning the second. Nurses' jobs, especially in institutional or home-health settings, often bring them into relatively informal contact with patients' visiting family and friends. These contacts present a dangerous opportunity for a nurse to reveal confidential patient information to a person not entitled to receive it.

Such inadvertent disclosures should ordinarily be considered within the course and scope of the nurse's employment, with the result that the nurse's employer should have to share any civil liability under the principles of *respondeat superior* discussed above. But a nurse may have to bear alone the liability for a purposeful breach. In *Jones v. Baisch*,[66] the nurse's employer was dismissed as a defendant in a case based on a nurse's breach of confidentiality. The nurse had told friends about a specific, named patient who had herpes. The court ruled that the nurse was not acting in the course and scope of employment when she made the disclosure.

# NURSING LICENSURE

States regulate nurses by legislating the requirements for getting and keeping a license to practice.[67] These regulations vary from state to state, so a nurse must be familiar with the requirements in the state(s) where he or she practices. License requirements cannot violate state and federal constitutional requirements. For example, a state probably could not make getting a nursing license significantly harder for out-of-state nurses solely for the purpose of preserving nursing jobs for current state residents. A state also probably could not enact a license revocation procedure that did not provide any procedural standards or any opportunity for appeal.

In the absence of such constitutional problems, federal law has very little to say about nursing licensure. However, federal law may affect a nurse's employability with an employer that receives federal funds. For example, federal law requires that nursing care in a skilled nursing facility "must meet professional standards of quality."[68] In a similar vein, federal law provides that home-health agencies shall employ only those who meet competency standards established by the federal Department of Health and Human Services and who are actually competent to serve patients.[69]

Federal courts provide an unlikely forum for seeking damages where a nurse believes that a state wrongly revoked[70] his or her license. In *O'Neal v. Mississippi Board of Nursing*,[71] two Mississippi nurses unsuccessfully sued state board members under federal law for wrongly revoking their licenses. The board revoked their licenses for false or negligent record-keeping. Mississippi state law allowed the nurses to appeal the board's decision to the state courts. The first-level state court affirmed the board's revocation, but the second-level state court reversed and restored the nurses' licenses.

With their licenses restored, the nurses then sued in federal court, alleging that the board's mistake in revoking their licenses amounted to a violation of constitutional rights. They sued both the board itself and individual board members. The district court dismissed the claims against all defendants and the Fifth Circuit affirmed. It concluded that suing the board itself was equivalent to suing the state in federal court, which the Eleventh Amendment to the Constitution prohibited. It also concluded that board members could not be held liable because of the doctrine of absolute quasi-judicial immunity. This doctrine immunizes public officials when they act in the role of judges or prosecutors, which is how the court held the board members acted when they decided that the evidence warranted revocation of the nurses' licenses (even though the decision was ultimately found to be wrong).[72]

## Endnotes

1. Press Release, U.S. Department of Labor Bureau of Labor Statistics, *BLS Releases 2004–14 Employment Projections* (Dec. 7, 2005) (on file

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with author), available at http://www.bls.gov/news.release/pdf/ecopro.pdf.

2. Already, "[i]n a recent study conducted on behalf of the American Hospital Association, respondents reported that the nursing shortage has caused emergency department overcrowding in their hospitals (38%); diversion of emergency patients (25%); reduced number of staffed beds (23%); discontinuation of programs and services (17%); and cancellation of elective surgeries (10%)." Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis* 8 (2002) (on file with author), available at http://www.jcaho.org/about+us/public+policy+initiatives/health_care_at_the_crossroads.pdf.
3. *Id.*
4. *Id.*
5. 455 S.W. 2d 703 (Tex. 1970).
6. 853 So. 2d 726 (La. App. 2003).
7. *Id.* at 729.
8. *Id.* at 730.
9. "[P]olicy and procedure manuals are hospital-specific and can be viewed as setting the standard of care for that institution." *Mills v. Angel*, 995 S.W. 2d 262, 269 n.25 (Tex. Ct. App. 1999). In *HCA Health Services v. National Bank*, 745 S.W. 2d 120 (Ark. 1988), the Arkansas Supreme Court held that the trial court erred in dismissing negligence claims against two nurses. The evidence showed that the patient, a day-old infant, suffered cardiac and respiratory arrest in a hospital nursery that the nurses had failed to staff according to hospital policy. The policy required at least one nurse in every room of the three-room nursery and could have been complied with if the nurses on duty had moved all the babies into one room. As they did not, the infant was in a room that was not attended.

   "In determining the standard of care, we may also look to the hospital's internal policies and bylaws, as well as the standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO). However, these factors alone do not determine the governing standard of care." *Denton Regional Medical Ctr. v. Lacroix*, 947 S.W. 2d 941, 951 (Tex. Ct. App. 1997) (footnote omitted). *See also Advincula v. United Blood Servs.*, 678 N.E. 2d 1009, 1023 (Ill. 1996) ("[w]hether a hospital is reasonably careful may be shown by a wide variety of evidence, including, but not limited to, expert testimony, hospital bylaws, statutes, accreditation standards, custom and community practice").
10. "[The hospital and its employees have a duty to follow the orders of an attending physician . . . " *Berdyck v. Shinde*, 613 N.E. 2d 1014, 1023 (Ohio 1993).
11. Fed. R. Evid. Ann. 702 (West 2005).
12. 270 S.E. 2d 222 (Ga. 1980).
13. *See, e.g., Dickerson v. American Sugar Refining Co.*, 211 F. 2d 200 (3rd Cir. 1954).
14. 536 So. 2d 1374, 1376 (Ala. 1988).
15. 853 So. 2d 726 (La. App. 2003).
16. *Id.* at 737.
17. *See generally* 45 C.F.R. Pt. 60 (2005) and discussion *infra* under Nursing Negligence.
18. 986 F. 2d 119 (5th Cir. 1993).
19. *Id.* at 123.
20. 315 So. 2d 516 (Fla. Dist. Ct. App. 1975).
21. *Striano v. Deepdale Gen. Hosp.*, 387 N.Y.S. 2d 678 (N.Y. App. Div. 1976).
22. In some cases, even a nonemployee physician (such as a contract doctor in an emergency room) is regarded as a hospital employee. *Ryan v. N.Y.C. Health & Hospitals Corp.*, 633 N.Y.S. 2d 500, 501 (N.Y. App. Div. 1995).
23. *See generally* Thomas M. Fleming, Annotation, *Hospital's Liability for Injury Resulting from Failure to Have Sufficient Number of Nurses on Duty*, 2 A.L.R.5th 286 (1992 & Supp. 2004).
24. 745 S.W. 2d 120 (Ark. 1988).
25. *Id.* at 125. *See also Merritt v. Karcioglu*, 668 So. 2d 469 (La. App. 1996) ("the jury could have concluded that Tulane was negligent in understaffing the ward and in requiring [the nurse]... to be in two places at the same time").
26. 711 So. 2d 820 (La. Ct. App. 1998).
27. *Id.* at 834.
28. No. 98-CVQ-492-D3 (341st JDC, Webb County, Texas), as reported in Rebecca Conklin, *Hospital Changes Work Hours Policy as Part of $15 Million Med Mal Settlement*, Lawyer's Weekly USA, (Nov. 29, 1999), at 1098.
29. *Hinson*, 853 So. 2d at 737–38.
30. 57 Cal. Rptr. 906 (Cal. Dist. Ct. App. 1967).
31. 668 So. 2d 469 (La. Ct. App. 1996).
32. *Id.* at 473, 478.
33. 613 N.E. 2d 1014, 1024 (Ohio 1993).
34. 1986 U.S. Dist. LEXIS 19527, 45 Fair Empl. Prac. Cas. (BNA) 91 (N.D. Ill. 1986).
35. *Hinson*, 853 So. 2d at 738.
36. *Id.*
37. 489 N.W. 2d 829 (Neb. 1992).
38. *Id.* at 839.
39. *Id.*
40. *See also Landry v. Clement*, 711 So. 2d 820 (La. Ct. App. 1998), where the nurses failed to inform the physician of decelerations in the fetal heart rate. The failure to do so effectively misrepresented the patient's condition and possibly contributed to the physician's failure to review the tracings.
41. No. 04-05-00054-CV, 2005 Tex. App. LEXIS 9549 (Tex. Ct. App. Nov. 16, 2005).
42. *Id.* at *6 (emphasis added).
43. *Berdyck v. Shinde,* 613 N.E. 2d 1014, 1024 (Ohio 1993) (emphasis added).
44. *Robbins v. Jewish Hosp. of St. Louis,* 663 S.W. 2d 341, 346 (Mo. Ct. App. 1983) (nurse recognized that patient should not get out of bed without assistance, but failed to implement that insight by raising bed rails).
45. *Cf. Simon v. N.Y. Univ. Med. Ctr.*, 700 N.Y.S. 2d 31 (N.Y. App. Div. 1999) (not seeing any evidence that the patient was fatigued or unsteady, the nurse did not violate any standard of care in leaving him unattended once he was seated on the toilet).
46. Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury* 22 (2005) (on file with author), available at http://www.jcaho.org/about+us/public+policy+initiatives/medical_liability.pdf. JCAHO defines a "sentinel event" as "an unexpected occurrence involving death or permanent loss of function." *Id.* at 28.
47. "Communications between caregivers, availability of patient information, *medication prescribing and use*, and adherence to clinical guidelines can all be improved through reliance on IT capabilities" (emphasis added). *Id.* at 23.
48. 725 N.Y.S. 2d 35 (N.Y. App. Div. 2001).
49. *Id.* at 36.
50. 209 N.W. 835 (Mich. 1926).
51. *Parker v. Port Huron Hosp.,* 105 N.W. 2d 1 (Mich. 1960).
52. *Redding v. United States*, 196 F. Supp. 871 (W.D. Ark. 1961); *Berg v. New York Soc. for Relief of the Ruptured and Crippled*, 136 N.E. 2d 523 (N.Y. 1956) (medical technician's error).

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53. *Parker v. St. Paul fire & Marine Ins. Co.*, 335 So. 2d 725 (La. Ct. App.), *writ denied*, 338 So. 2d 700 (La. 1976); *Kyte v. McMillion*, 259 A. 2d 532 (Md. 1969).
54. 42 U.S.C. §11101 (2003).
55. 42 U.S.C. §11131 (2003).
56. 42 U.S.C. §11137(d) (2003); 45 C.F.R. §60.7(d) (2005).
57. 42 U.S.C. §11137(a) (2003).
58. For information on self-querying, see National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank, Fact Sheet on Self-Querying (undated) (on file with author), available at http://www.npdb-hipdb.com/pubs/fs/Fact_Sheet-Self-Querying.pdf (last visited Dec. 11, 2005).
59. 42 U.S.C. §11136(2) (2005); 45 C.F.R. §60.14 (2005).
60. 477 A. 2d 323 (N.J. 1984).
61. *Id.* at 324.
62. Keith Coffman, *Nurse Acquitted in Death; Improper Injection was Fatal to Newborn*, The Denver Post, (Jan. 31, 1998), at B-2; Kieran Nicholson & Marilyn Robinson, *2 Nurses Plead Guilty in Death of Newborn; Deferred Judgment, Public Service Ordered*, The Denver Post, (Jan. 23, 1998), at C-2; Ann Schrader & Marilyn Robinson, *Baby's Nurses Face Homicide Charges*, The Denver Post, (Apr. 29, 1997), at A1.
63. 821 S.W. 2d 83 (Ky. 1991).
64. *Rodebush v. Oklahoma Nursing Homes, Ltd.*, 867 P. 2d 1241 (Okla. 1993).
65. *See generally* 45 C.F.R. Pt. 165 (2005). At least one person has already been convicted of a HIPAA crime for disclosing individually identifiable health information for personal gain. In a plea agreement in *United States v. Gibson*, No. CR04-0374 RSM (W.D. Wash. Aug. 19, 2004), Richard W. Gibson, an employee of a health care provider, admitted that he used a patient's name, birthdate, and social security number to obtain four credit cards in the patient's name. He then used the cards to obtain cash advances and to purchase various items, including video games, home improvement supplies, apparel, jewelry, porcelain figurines, groceries, and gasoline, all totaling $9,139.42. *Id.* at 9(F). Gibson was sentenced to 16 months in prison, 3 years of supervised release, and more than $9,000 in restitution to the victim. Press Release, United States Attorney's Office, Western District of Washington, *Seattle Area Man Gets Prison Time in First Ever HIPAA Violation Conviction* (Nov. 5, 2004) (on file with author), available at http://www.justice.gov/usao/waw/press_room/2004/nov/gibson.htm.
66. 40 F. 3d 252 (8th Cir. 1994).
67. *Semler v. Oregon State Bd. of Dental Examiners*, 294 U.S. 608, 611 (1935).
68. 42 U.S.C. §1395i-3(b)(4)(A) (2003).
69. 42 U.S.C. §1395bbb(a)(3)(A) (2003).
70. *See generally* Emile F. Short, Annotation, *Revocation of Nurse's License to Practice Profession*, 55 A.L.R.3d 1141 (1974 & Supp. 2004).
71. 113 F. 3d 62 (5th Cir. 1997).
72. Absolute quasi-judicial immunity also protected medical board members in *Watts v. Burkhart*, 978 F. 2d 269 (6th Cir. 1992); *Bettencourt v. Bd. of Registration in Medicine of the Commonwealth of Massachusetts*, 904 F. 2d 772 (1st Cir. 1990); and *Horwitz v. State Bd. of Medical Examiners of the State of Colorado*, 822 F. 2d 1508 (10th Cir.), *cert. denied*, 484 U.S. 964 (1987).