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Hospital Nurses and Tort Liability

Gabrielle G. Kinkela and Robert V. Kinkela***

A YOUNG FOOTBALL PLAYER suffers a leg injury. He is brought to a hospital emergency room for treatment. The X-rays indicate a fractured tibia and fibula, a cast is applied and the patient hospitalized. This set of facts should, in due time, lead to the expected conclusion of healing and the resumption of normal activity. However, an amputation must be performed; certainly a drastic measure for a broken leg sustained by an otherwise healthy, eighteen-year old boy. Even someone completely removed from the medical scene might readily suspect improper care; but who is responsible: the doctor, the nurse or the hospital? In 1965, the Illinois courts were faced with precisely these issues in the *Darling v. Charleston Community Memorial Hospital* case.¹

Some of the salient facts disclosed were that: 1) the hospital was fully accredited by the Joint Commission on Hospital Accreditation and was duly licensed under Illinois state law; 2) the attending physician was not an orthopedic surgeon, nor had he kept pace with progress in this particular area; 3) no consultation was requested, nor were other satisfactory measures taken when symptoms, recorded on the nurse's notes and readily observable, clearly indicated that such steps ought to be taken.² The facts seem to illustrate a typical situation found in medical malpractice suits. Negligence and corresponding liability should then, logically, be fixed on the physician. Interject a pre-trial settlement with the physician,³ and the plaintiff's ostensible cause of action appears to have vanished. Not so, said the court, and held the hospital negligent for not insuring adequate medical supervision.⁴ Furthermore, it attributed negligence to the nurses for failure to report their observations to higher medical and administrative authority.⁵ One year later, the United States Supreme Court denied certiorari,⁶ leaving the case open to numerous interpretations.

Rather than being considered a maverick of the judicial process,

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¹ 33 Ill.2d 326, 211 N.E.2d 253, cert. den., 383 U.S. 946 (1966).

² Ibid.

³ Id.

⁴ Id.

⁵ Id.

⁶ *Darling v. Charleston Community Hospital*, 383 U.S. 946 (1966).

the *Darling* case,⁷ reflects some of the emerging concepts of tort liability. The court not only pinpointed the nurse's responsibility, under this set of circumstances,⁸ it also made decisions relevant to the extent of hospital liability and the standard by which such liability is to be judged. There is no doubt that these determinations, which will be considered at length, have significant overtones for the hospital nurse.

What factors have influenced the courts in the development of their current attitude toward hospitals? Are the emerging concepts reasonable, or are they indicia of a pendulum swinging too far in the direction of the patient? What are the consequences for the nurse? These are the questions to which the ensuing treatment of one aspect of tort liability is addressed.

Current Status of Charitable Immunity

The *Darling* case, together with its other far-reaching consequences, also disposes of whatever remnants were left in Illinois of the charitable immunity doctrine.⁹ Appearing first in this country in 1876,¹⁰ it has, for nearly a century, encased voluntary, non-profit hospitals in a protective cloak. Under the doctrine, hospitals may be relieved of liability for the negligent acts of their servants. A variety of theories evolved to support it,¹¹ and it retained considerable vitality until the past decade. Its approaching end was presaged in the landmark *Avellone v. St. John's Hospital*¹² case of 1956. Today, we are witnesses to its near total demise, with less than a handful of states retaining it.¹³ An explanation of its failure to survive is provided by an articulate justice of the

⁷ *Ibid.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *McDonald v. Massachusetts General Hospital*, 120 Mass. 432, 21 Am. Rep. 529 (1876).

¹¹ The trust fund theory is rationalized on the premise that the donor intends his funds to be used for charitable purposes, and using such funds to pay for damages would be a misappropriation. (Inherent in this theory is the belief that donors would be discouraged from contributing to charitable institutions.) The waiver theory holds that a patient, entering a non-profit hospital, impliedly agrees not to sue his benefactors, should an injury be incurred through negligence. The non-applicability of respondeat superior, providing due care is used in the selection and retention of employees. The public policy theory, whose adherents maintain that denial of immunity would be an offense to the public and charity equally. *Rabon v. Towan Memorial Hospital*, 269 N.C. 1, 152 S.E.2d 485 (1967).

¹² 165 Ohio St. 467, 135 N.E.2d 410 (1956).

¹³ Total Immunity:

Harrigan v. Cape Cod Hospital, 349 Mass. 765, 208 N.E.2d 232 (1965).

Decker v. Bishop of Charleston, 247 S.C. 317, 147 S.E.2d 264 (1966).

Koprivica v. Bethesda General Hospital, 410 S.W.2d 84 (Mo. 1966).

Hill v. Eye, Ear, Nose and Throat Hospital, 200 So.2d 34 (La. App. 1967).

Immunity Limited to Charitable Funds:

Hemenway v. Presbyterian Hospital Ass'n. of Colorado, 419 P.2d 312 (Col. S. Ct. 1966).

Rhoda v. Aroostock General Hospital, 226 A.2d 530 (Me. S. Ct. 1967).

Pennsylvania Supreme Court.¹⁴ In the 1956 decision,¹⁵ abrogating the doctrine for that state, Justice Musmanno stated:

Thus, as a matter of integrity in nomenclature it must be stated that although the hospitals here under discussion are known as charitable hospitals, it does not follow that they offer their services through the operation of charity.¹⁶

Consideration of justice,¹⁷ and the doctrine's historical background, prompted the observation that charitable institutions today are housed in mighty edifices, use the latest scientific equipment, and operate on a business-like basis.¹⁸ The conclusion was that whatever justification there may have been for the doctrine's acceptance in the past, has been lost in the realities of the present.¹⁹

It is proposed that this opinion²⁰ can be validly interpreted to mean that: 1) hospitals are big business, which have joined the mainstream of American life; 2) justice, not precedent or hazy considerations of the party defendant, must be the court's prime consideration; and 3) doctrines with no basis in fact do not constitute a tenable defense.

The impact of these developments on hospital nursing is of parallel importance. Prior to the demise of hospital immunity, the nurse could be held solely liable for her negligent acts.²¹ Today, with hospitals generally answering for negligent acts of their servants, under the rule of *respondeat superior*,²² emphasis should be shifting away from the nurse. However, careful analysis produces an almost paradoxical inference. With hospitals now being subject to more frequent litigation,²³ the nurse can expect a concurrent involvement to a comparable degree. Because of her responsibilities for direct patient care, and her com-

¹⁴ "A person may recover damages if he is injured as a result of negligence in a hotel, theater, street car, skating rink, natatorium, bowling alley, train or ship, yet he cannot recover if he is hurt in the place where accidents are considered most unlikely to occur—in a hospital where one goes to be cured of an already existing infirmity and not to be saddled with additional woe and torment. This is indeed the paradox of paradoxes. It has no logic, reason and least of all logic to support it. And still more paradoxical is the argument that by refusing recovery to the victim of a hospital's own negligence, one somehow is serving charity." *Flagiello v. Pennsylvania*, 417 Pa. 486, 208 A.2d 193, 197 (1965).

¹⁵ *Flagiello v. Pennsylvania*, *supra* note 14.

¹⁶ *Id.* at 196.

¹⁷ "But charity will never be true charity unless it takes justice into account." Pope Pius XI Encyclical Letter, "Divini Redemptoris." Paulist Press Ed. at 22; *supra* note 14, footnote at 196.

¹⁸ See text, *supra* note 14.

¹⁹ *Ibid.* See, Oleck, Non-Profit Corps., Orgns. & Assns., §§ 56, 57 (2d ed. 1965).

²⁰ *Id.*

²¹ *Purowski v. Bridgeport Hospital*, 144 Conn. 531, 134 A.2d 834 (1957).

²² *Parmenter v. Osteopathic General Hospital*, 196 So.2d 505 (Fla. App. 1967); *Moore v. Jefferson Hospital, Inc.*, 208 Va. 352, 158 S.E.2d 124 (1967).

²³ 40 Hospitals, 111 (Oct., 1966).

manding role in the hospital's internal structure, the nurse's acts are destined for closer and more exacting scrutiny by the courts.

The Hospital Nurse

In the modern hospital, the "master coordinator," if you will, is the professional nurse. She functions within a complex maze of facilities, equipment, departments and divisions of personnel. There is but a single unifying force—the patient. All available resources, human and mechanical, exist for his benefit. If he is to reap maximum benefit, all hospital services, whether they involve direct or indirect patient care, must be carefully and consistently coordinated. The most qualified personnel and most sophisticated devices are of no avail, unless they reach the patient who needs them when he needs them. The singularly unique patient-nurse relationship provides the enabling vehicle for the requisite synchronization of time, people, places and things. The privilege, albeit an onerous one, is incurred by virtue of what we refer to as the "you are there" doctrine. To the department of nursing service is relegated the responsibility of providing patient care on a twenty-four hour a day, seven day a week basis. Other departments and their personnel operate on a normal work day or an on-call basis. The nurse remains as the individual having the closest, most continuous and most comprehensive patient contact. Her role as "master coordinator" is the predictable sequitur. Significant though it may be, it is but one facet of nursing practice.

The Nature of Nursing Practice

In the Model Act,²⁴ drafted by the American Nurses Association,²⁵ nursing practice is defined as follows:

The practice of professional nursing means the performance for compensation of any act in the observation, care and counsel of the ill, injured or infirm, or in the maintenance of health or prevention of illness of others or in the supervision and teaching of other personnel, or in the administration of medications and treatments as prescribed by a licensed physician or dentist; requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures.²⁶

The phrase, "for compensation," is included to indicate inapplicability to family members or friends giving gratuitous care to a sick per-

²⁴ Am. Nurses Ass'n; Model Act—Suggestions for Major Provisions to be Included in a Nursing Act (Rev. 1964).

²⁵ The Am. Nurses Ass'n. is the official organization of the nursing profession.

²⁶ *Supra* note 24, § X at 24.

son.²⁷ Of greatest significance is the portion which reads "performance . . . of any act . . . requiring substantial judgment . . ." ²⁸ This element will be of cardinal importance in evaluating some of the cases selected for detailed discussion.

The basic components of the Model Act²⁹ have been incorporated into the statutes of those states where licensure is mandatory.³⁰ Mandatory licensure bars the performance of professional nursing functions by anyone other than a duly licensed professional nurse.³¹ Presently, more than forty states have adopted mandatory licensure.³²

In the minority states having permissive law, the only prohibition is that unlicensed individuals, performing professional nursing functions, may not use the title of *Registered Nurse*, or use the abbreviation *R.N.*³³ An obvious defect of permissive licensure, *inter alia*, is its imposition of responsibility on the layman, for determining whether persons performing professional nursing functions are, in fact, qualified to do so.³⁴

Inherent in the statutory language of most states is not only what is expected, but indeed required, of the professional nurse practitioner. Guidelines are also available to assist in the implementation of mandatory licensure acts and to help determine standards of practice.³⁵ The latter has been a source of vital concern to the American Nurses Association, which recently appointed representatives from five different clinical areas to set standards for clinical nursing practice.³⁶ The profession thus declares, promulgates, enforces and evaluates standards of practice.³⁷

The functions of the general duty nurse, with whom patients ordinarily have the most contact, have also been specifically identified.³⁸

²⁷ Ibid.

²⁸ Id.

²⁹ Id.

³⁰ Example: "Practice of professional nursing means the performance for compensation of the acts requiring substantial judgment and specialized skills based on knowledge and application of scientific principles learned in an approved school of professional nursing. Acts of medical diagnosis and prescription of medical, therapeutic or corrective medical measures by a nurse are prohibited." Ohio Rev. Code, § 4723.06 (1968).

³¹ Ohio Nurses Ass'n., *Why a Bill for Mandatory Licensure*, 3 (1967).

³² Ibid.

³³ Id.

³⁴ *Mandatory v. Permissive Licensure for Nurses*, 195 Am. Med. Assn. 496-7 (Feb., 1966).

³⁵ Ohio Nurses Ass'n., *Guidelines for the Utilization of Nursing Personnel* (1967).

³⁶ 2 Am. Nurses Assn., *A.N.A. in Action*, No. 2 (March-April 1968).

³⁷ Ibid.

³⁸ Am. Nurses Assn., *Functions, Standards and Qualifications for Practice* (Rev. Feb., 1963).

(For a broad distinction, based on scope of responsibility, between the general duty nurse and other levels of professional nurses as they exist in most hospitals, see footnote 39.) These are summarized below:

The general duty nurse is aware of the total nursing needs of the patient and is responsible for seeing that they are fulfilled. This includes such specifics as:

1. The preparation, administration and supervision of a patient care plan for each patient for whom she is responsible.
2. The application of scientific principles in performing nursing procedures and techniques through constant evaluation in the light of nursing and medical progress.
3. The performance of therapeutic measures prescribed and delegated by medical authority.
4. Continuous evaluation of symptoms, reactions and progress which requires observation, recording and reporting to the appropriate person.
5. Assistance in patient education and rehabilitation.
6. Assistance in providing optimum physical and emotional environment.
7. The teaching and directing of nonprofessional personnel for whom she is responsible.⁴⁰

It is of value to note that most of these areas are independent functions which the nurse has the right to perform. The only area in which the nurse is not permitted to function independently is in the performance of prescribed therapeutic measures. (Number three above). In this instance, she must act under the order and the direction and/or supervision of a duly licensed physician, (she must) comprehend the cause and effect of that order, and the order must be legal.⁴¹

In considering the nursing functions, as set forth herein, the question arises whether the *Darling* decision,⁴² by identifying the nurse, in effect, as a guardian over medical treatment, imposed a new responsibility or elaborated on an existing one. As stated in number four above, the nurse is to continuously evaluate the patient's condition, which requires observation, recording and reporting to the appropriate person. Usually, the appropriate persons, to whom the nurse reports, are the attending physician (or his delegate) and the nursing supervisor. The physician appraises the information and makes his own determina-

³⁹ *Director of Nursing Service*—Responsible for patient care on all units. (Unit, ward and floor are synonymous.)

Supervisor—Responsible for patient care on two or more units.

Head Nurse—Responsible for care of all patients on one unit on a 24 hour basis.

General duty or staff nurse—Responsible for care of those patients assigned to her during the time she is on duty.

⁴⁰ Am. Nurses Assn., *op. cit. supra* note 38 at 12.

⁴¹ Lesnik, M., and Anderson, B., *Nursing Practice and the Law*, 277 (2nd ed. 1962).

⁴² *Darling v. Charleston Community Hospital*, *supra* note 1.

tions. The nursing supervisor reports to her superior when the information indicates that some action should be taken which is beyond her scope of authority. If the problem cannot be handled within the department of nursing service, the director informs the hospital administrator.⁴³ It is within the discretion of the hospital administrator to put whatever machinery is required, for a solution, into motion. This situation⁴⁴ (medical management of the patient) was a problem for the appropriate medical body in that particular hospital.⁴⁵ From the case,⁴⁶ as reported, one concludes that the nurses followed standard procedure. It is difficult, therefore, to comprehend how and where they failed in their duty. The responsibility for evaluating patient progress and reporting through proper channels is one matter. The possible consequences, were a nurse to report directly to higher medical authority (unless specifically authorized to do so) is quite a different theory to contemplate. One flagrant defect might be the inference that nurses who did so were not guarding the patient's care, but rather were attempting to supervise medical management. Another obvious flaw is a consideration of whether or not such a responsibility is a fair one for the nurse to shoulder. It remains a delicate area open to deliberation, both in and out of the court room.

Standard of Care

It is generally accepted that tort liability for negligence rests on three premises: 1) the existence of a foreseeable duty; 2) the breach of such duty; and 3) resulting injury, with the breach being the proximate cause.⁴⁷ That the hospital has a duty to exercise such reasonable care and attention as the patient's physical and mental condition warrants⁴⁸ is also evident. However, the precise duty imposed in a given situation, the identification of a specific breach, and determination of whether or not the alleged breach was the proximate cause of injury, are questions which continue to perplex judge and jury.

The "community" or "locality" standard has been frequently (but not always) resorted to as an aid in making such determinations. The usual phraseology, as well as its general acceptance, is illustrated in a 1952 case:⁴⁹

⁴³ Following proper channels of communications seems cumbersome but it can be accomplished rapidly in a hospital setting, when the need is urgent.

⁴⁴ *Darling v. Charleston Community Hospital*, *supra* note 1.

⁴⁵ *Ibid.*

⁴⁶ *Id.*

⁴⁷ Prosser, *Torts*, 146 (3rd Ed. 1964).

⁴⁸ 26 Am. Jur., *Hospitals and Asylums*, § 18. See also, 41 C.J.S., *Hospitals*, § 8-C (3) at 349-50; *Shover v. Iowa Lutheran Hospital*, 252 Ia. 706, 107 N.W.2d 85 (1961).

⁴⁹ *Garfield Memorial Hospital v. Marshall*, 204 F.2d 721 (Ct. App. D.C. 1952).

This duty (of care) is measured by the degree of care, skill and diligence customarily exercised by hospitals generally in the community.⁵⁰

In another case,⁵¹ the same standard of care when applied to nurses, is described as that generally exercised by reputable nurses in the community.

In the late fifties, there were indications of the court's growing reluctance to rely on the rule as faithfully as they had in the past. The defendants (hospital and nurse) in a California case,⁵² sought to avoid liability by urging adherence to the locality rule. The State Supreme Court held that while proof of practice or custom may assist in determining what constitutes due care, it is not conclusive in establishing the standard of care.⁵³ This might have been a forecast of things to come, but the rule continued to flourish.⁵⁴

By 1965 it was possible to discern a palpable trend away from the locality rule in several significant decisions. In the previously cited *Darling* case,⁵⁵ Justice Schaefer flatly rejected its applicability to a fully accredited hospital. He declared that custom will not prevail where it does not conform to the required standard.⁵⁶ To emphasize the ruling, the court used the words of Judge Learned Hand, pronounced twenty-three years earlier, where it was suggested that a whole calling may have lagged in "the adoption of new and available devices," or universally disregarded "imperative precautions."⁵⁷

That same year,⁵⁸ the West Virginia courts equated acceptable standards with "standards of care in accredited hospitals throughout the United States."⁵⁹

A new dimension was added by Wisconsin's Supreme Court in 1966.⁶⁰ In the opinion, professional standards were viewed in the light of what the public expects.⁶¹ The expectation of high standards of care was given added import, by the court's referral to it as a public right.⁶²

⁵⁰ *Id.* at 239.

⁵¹ *Mundt v. Alta Bates Hospital*, 223 Cal.2d 413, 35 Cal. Rptr. 848 (1962).

⁵² *Leonard v. Watsonville Community Hospital*, 47 Cal.2d 509, 305 P.2d 36 (1956).

⁵³ *Ibid.*

⁵⁴ *Goff v. Doctor's Hospital*, 166 Cal. App. 2d 314, 333 P.2d 29 (1958); *Carrigan v. Roman Catholic Bishop*, 104 N.H. 73, 178 A.2d 502 (1962).

⁵⁵ *Darling v. Charleston Community Hospital*, *supra* note 1.

⁵⁶ *Ibid.*

⁵⁷ *Id.* at 257.

⁵⁸ *Darling v. Charleston Community Hospital*, *supra* note 1.

⁵⁹ *Duling v. Bluefield Sanitarium*, 149 W.Va. 567, 142 S.E.2d 754, 762 (1965).

⁶⁰ *Carson v. City of Beloit*, 32 Wis.2d 282, 145 N.W.2d 112 (1966).

⁶¹ *Ibid.*

⁶² *Id.*

Another 1966 case,⁶³ explicitly and dramatically illustrates the waning influence of the locality rule.

On November 14, 1963, a baby was born prematurely in a naval hospital. The infant was placed in an isolette (an improved incubator) which controls temperature, humidity and oxygen content. It also affords protection from the organisms or germs found in the normal environment. Both the facilities and personnel appeared to be adequate. However, twelve days later, "grossly purulent" material was removed from the infant's hip. The organisms were cultured and identified. An examination, five weeks later, revealed a permanent dislocation of the right hip and deterioration of the left hip. There was reasonable anticipation that this would cause pain as the child grew older. Consequently, the parents brought an action against the hospital for negligence.⁶⁴

At the trial, there was testimony that nose and throat cultures had been obtained from the nursing staff. A positive culture had been found on one of its members, a Corps Wave. Under the hospital's nursing regulations, this category of personnel was prohibited from "handling or ministering to infants of the plaintiff's age and development."⁶⁵

Further testimony revealed that: 1) no physical examination was performed nor were any nose and throat cultures taken, prior to the Wave's being assigned to the nursery; and 2) the Wave did, in the course of her duties, have occasion to minister to the child.⁶⁶ From these facts, the court concluded that: "at some critical time before November 26 (date infection was discovered) the Corps Wave did in fact handle the child."⁶⁷

Expert testimony for determining whether or not the Wave's and infant's culture were the same, was provided by the hospital pathologist and an out-of-state specialist in microbiology. Upon this evidence,⁶⁸ the court concluded that there was no substantial difference between the two cultures.

The vital issue remaining was whether or not failure to take cultures and examine the Wave, before assigning her to nursery duty, constituted negligence.⁶⁹

The community standard rule was urged as a defense,⁷⁰ with the hospital pathologist testifying that the requirement of periodic cultures

⁶³ *Kapuschinsky v. United States*, 248 F.Supp. 732 (D.C. S.C. 1966).

⁶⁴ *Ibid.*

⁶⁵ *Id.* at 737.

⁶⁶ *Kapuschinsky v. United States*, *supra* note 63.

⁶⁷ *Id.* at 738.

⁶⁸ *Kapuschinsky v. United States*, *supra* note 63.

⁶⁹ *Ibid.*

⁷⁰ *Id.*

was impractical and not the usual practice in that area. The testimony of the out-of-state specialist conflicted regarding the desirability of the practice.⁷¹

The court strongly rejected the locality rule and held that the hospital was negligent.⁷² Notwithstanding the general practice in the community, the hospital, by its failure to take a known precaution, had breached its duty to this infant.⁷³

It would seem that the position adopted by the court above,⁷⁴ disposes of the locality rule in its entirety. The Supreme Court of Washington made a further distinction.⁷⁵ It considered the factors involved in hospital accreditation and held that a hospital could not be excused from measuring up to national standards, whether it was "accredited or not."⁷⁶ The rationale of the court defies contradiction. In weighing the merits of the locality rule, the court reflected on its historical background. It agreed to its applicability at a point in time when there was little inter-community travel; when a small town doctor did not have the same opportunity or resources as a colleague practicing in a large city; when keeping abreast of professional advances was extremely difficult.⁷⁷ Today, with modern methods of communication, such as closed circuit television, professional journals, etc., the same elements can no longer be considered as controlling in the determination of standards.⁷⁸

Nursing licensure has been the cause of further erosion. In a recent decision,⁷⁹ the community standard was rejected because it conflicted with the state's licensure statute.

The progression from community to national standards should have a special connotation for the nurse, not only when she is a defendant in the court room but in a preventive manner as well. There are instances when doctors and hospital administrator urge the nurse to adopt a particular procedure on the ground that "all the other hospitals in the area are doing it." Certainly, usage and custom are relevant, but they should not be the controlling elements in altering old or establishing new nursing practices.

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Pederson v. Dumouschel*, 431 P.2d 973 (Wash. S.Ct. 1967).

⁷⁶ *Ibid.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Barber v. Reinking*, 68 Wash.2d 139, 411 P.2d 861 (1966).

The Doctor-Nurse Relationship

The doctor and nurse are committed to a common goal; the best possible patient care. Achieving this mutual objective requires a close working relationship. It is the doctor's responsibility to prescribe therapeutic measures and the nurse's job is to carry out such orders. If she does this efficiently, all is well. Superficial analysis leads to this uncluttered conjecture. The *Darling* decision,⁸⁰ as already described, demanded more and set forth a crystalline illustration of the various subtleties interwoven into the pattern of the doctor-nurse relationship.

It is an accepted tenet that the nurse is required to execute all physician's orders which are legal.⁸¹ Failure to do so is tantamount to negligence.⁸² Conversely, carrying out a physician's order, when the patient's condition contraindicates it, may also be deemed a negligent act.⁸³ The dividing line is in the exercise of the nurse's skilled and independent judgment.

A case in point was recently litigated in Missouri.⁸⁴ The physician wrote a medication order with directions as to when it was to be administered. He requested a nurse to give one ampule of the drug and left the hospital without furnishing further instructions. The nurse asked the intern to inject the medication. He did so and cardiac standstill resulted. The patient's husband brought a wrongful death action,⁸⁵ alleging negligence on the part of the attending physician, the intern and the nurse. The attending physician attempted to shift the liability by filing a cross-complaint asserting: 1) that the intern and two nurses ordered, mixed, prepared and handled the drug; 2) that the intern and two nurses had administered or caused the drug to be administered; 3) if any negligence is found resulting in damage to the plaintiff, then such damage was caused solely by the co-defendants' negligence.⁸⁶

The drug ordered was unusual and potent, requiring the specialized skill and knowledge of an anesthesiologist for its proper administration. The medicine label provided ample warning of these facts. On this evidence, the court found the attending physician negligent in ordering the medication and the intern negligent for administering it.⁸⁷ The nurses, who as hospital employees had the patient under their direction and control, were also found negligent in failing to read the literature which would have warned them of the necessary precau-

⁸⁰ *Darling v. Charleston Community Hospital*, *supra* note 1.

⁸¹ *Lesnik v. Anderson*, *supra* note 41.

⁸² *Adams v. State*, 429 P.2d 109 (Wash. S.Ct. 1967).

⁸³ *Arnold v. Haggin Memorial Hospital*, 415 S.W.2d 884 (Ky. S.Ct. 1967).

⁸⁴ *Campbell v. Preston*, 379 S.W.2d 557 (Mo. S.Ct. 1964).

⁸⁵ *Ibid.*

⁸⁶ *Id.*

⁸⁷ *Id.*

tions.⁸⁸ (Missouri is one of the few remaining charitable immunity states,⁸⁹ which explains why the hospital was not involved in the suit).

Another illustration of the imperative need for the nurse to clearly understand an order before executing it, came before Delaware's Supreme Court in 1961.⁹⁰ The nurse properly questioned the dosage of a medication order. However, when the mode of administration was not specified, she did not check with the physician, but rather used her own discretion, based on past experience. She was in error and the court found her liable for failure to use ordinary care in the execution of her duties.⁹¹

There are many variations on the theme of the physician's order. Thus, a nurse who fails to execute an order,⁹² or who executes an order which is contraindicated by the patient's condition,⁹³ or who, in any way, participates in the improper execution of an order,⁹⁴ may be found negligent.

Failure, by the nurse, to follow accepted procedure or use the proper technique may also result in injury to the patient. Although the nurse under these circumstances in executing a physician's order, it is she who breaches a duty, not the physician. Examples are found in cases where: 1) the patient developed "drop foot" as a result of an improperly administered intramuscular injection;⁹⁵ 2) infection resulted from the use of an unsterile needle;⁹⁶ 3) postoperative infection resulted from failure to observe proper technique.⁹⁷

If one cardinal rule can be extracted from the preceding discussion, it is that the nurse is responsible for her own acts. She is further required to exercise skilled judgment in the performance of such acts; notwithstanding the fact that they are executed pursuant to a doctor's order. A phrase heard by most nurses on more than one occasion is, "Don't worry. I wrote the order, I'll take the responsibility." Well-intentioned though they may be, such words should not lull the nurse into a false sense of security. What is being offered as assurance is clearly not within the physician's province: nor indeed, within the province of anyone other than the nurse herself.

⁸⁸ Id.

⁸⁹ See cases cited *supra* note 13.

⁹⁰ Larrimore v. Homeopathic Hospital, 176 A.2d 362 (Del. S.Ct. 1961).

⁹¹ Ibid.

⁹² Adams v. State, *supra* note 82.

⁹³ Arnold v. Haggin Memorial Hospital, *supra* note 83.

⁹⁴ Campbell v. Preston, *supra* note 84; Larrimore v. Homeopathic Hospital, *supra* note 90.

⁹⁵ Honeywell v. Rogers, 251 F.Supp. 841 (W.D. Pa. 1966).

⁹⁶ Kalmus v. Cedars of Lebanon Hospital, 132 Cal. App.2d 243, 281 P.2d 872 (1955)

⁹⁷ Helman v. Sacred Heart Hospital, 62 Wash.2d 136, 381 P.2d 605 (1963).

The Legal Position of the Nurse

The hospital nurse is, generally, considered to be an employee or agent of the hospital.⁹⁸ Since she is hired, assigned and responsible to the hospital, the rule of *respondeat superior* applies.⁹⁹

In certain situations, the hospital nurse becomes the servant of the doctor.¹⁰⁰ The prime example is the nurse in the operating room. Under the "captain of the ship" doctrine, the operating surgeon is responsible for the acts of the nurses who assist him.¹⁰¹ Even though the nurse is employed by the hospital, she becomes the borrowed servant while the surgical procedure is in progress.¹⁰² The borrowed servant doctrine relates back to the doctrine of *respondeat superior*, being founded primarily on the right to direct and supervise.¹⁰³

The question of whether the operating room nurse is the servant of the doctor or the hospital becomes a pivotal issue in cases where a sponge has been inadvertently left in the patient.¹⁰⁴ In such situations, a distinction is made between medical and ministerial acts of the nurse.¹⁰⁵ Ministerial acts have been defined as those "requiring the exercise of a particular skill acquired or developed by training and do not involve the exercise of any professional judgment."¹⁰⁶ The resolution of this issue (medical or ministerial) fixes liability.¹⁰⁷ Most jurisdictions have held sponge counts to be ministerial acts for which the hospital is liable.¹⁰⁸ Total agreement on this question has not, however, been achieved.¹⁰⁹

A major point of dispute also exists relative to the nurse's status as a professional person. The courts freely refer to the nursing "profession."¹¹⁰ There is, however, a remarkable degree of confusion as

⁹⁸ Gormely v. Montana Deaconess Hospital, 423 P.2d 301 (Wash. S.Ct. 1967).

⁹⁹ Ibid.

¹⁰⁰ Harrison v. Wilkerson, 405 S.W.2d 649 (Tenn. App. 1966).

¹⁰¹ Ibid.

¹⁰² McKinney v. Tromly, 386 S.W.2d 564 (Tex. Civ. App. 1964).

¹⁰³ Danks v. Maher, 177 So.2d 412 (La. App. 1965).

¹⁰⁴ Rural Educational Assn. v. Bush, 41 Tenn. App. 701, 298 S.W.2d 761 (1956); Buzan v. Mercy Hospital, 203 So.2d 11 (Fla. App. 1967).

¹⁰⁵ Ibid.

¹⁰⁶ Danks v. Maher, *supra* note 103 at 417.

¹⁰⁷ Rural Education Ass'n. v. Bush, Buzan v. Mercy Hospital, *supra* note 104. See also, Oleck, Doctor, Lawyer & Hospital Administrator: A New Triangle, 8 Clev-Mar. L. R. 416 (1959).

¹⁰⁸ Ibid.; Danks v. Maher, *supra* note 103.

¹⁰⁹ Klema v. St. Elizabeth Hospital, 170 Ohio St. 519, 166 N.E.2d 765 (1960); see Harrison v. Wilkerson, *supra* note 100.

¹¹⁰ Burrows v. Hawaiian Trust Co., 417 P.2d 816 (Hawaii S.Ct. 1966); Kalmus v. Cedars of Lebanon Hospital, *supra* note 96. Even a veterinarian is viewed as "a professional" in treating a dog. See, Oleck, Veterinarian's Malpractice, The Practicing Veterinarian (6) 164 (Nov.-Dec. 1966).

to the precise meaning of the term. An Ohio case exemplifies this confusion.¹¹¹

An obstetrical patient fell out of bed while in the labor room. Nursing negligence was at issue.¹¹² The jury returned a verdict for the plaintiff.¹¹³ The Court of Appeals reversed the lower court's decision,¹¹⁴ based on the rationale that the standard of care, required of the nurse in that particular set of circumstances, had to be shown by expert testimony. The state Supreme Court reversed the Appellate decision,¹¹⁵ with the pronouncement that six of the jurors had been women who probably know more about childbirth than many experts. In addition to this carrousel of opinions, there was an articulate dissent in the State's high court. The dissenting opinion included these observations: 1) nursing is a recognized profession and a nurse's acts should be evaluated accordingly, *i.e.*, in the light of a malpractice action; 2) although the hospital is liable, it is the servant's acts which are at issue; 3) the standards of care are, therefore, those applicable to a professional nurse; 4) evidence testifying to the duties and discretion of a staff nurse, under this set of circumstances, is required; 5) it is not childbirth which is at issue, but the nurse's conduct, making the fact that some of the jurors were women irrelevant.¹¹⁶ The opinion was concluded with the comment that:

Malpractice has been traditionally distinct from other negligence actions. The distinction lies not just in analytical differences but in recognizing the human factor that patients and jurors tend to expect too much. . . . Failure becomes proof of incompetence. The law of malpractice has partially controlled this by a stricter application of the rules of evidence and by emphasis, in instructions. . . .¹¹⁷

The dissenting opinion¹¹⁸ offers a forthright acceptance of the nurse's professional status while challenging the Court's failure to provide equal treatment for the nurse.

Another Ohio case¹¹⁹ dealt with the same problem, but with a different emphasis. At issue was whether or not the statute of limitations for malpractice was applicable when the alleged tort-feasor was a

¹¹¹ Jones v. Hawkes Hospital of Mt. Carmel, 175 Ohio St. 503, 199 N.E.2d 592 (1964).

¹¹² Ibid.

¹¹³ Id.

¹¹⁴ Id.

¹¹⁵ Id.

¹¹⁶ Id.

¹¹⁷ Id. at 512.

¹¹⁸ Jones v. Hawkes Hospital of Mt. Carmel, *supra* note 111.

¹¹⁹ Richardson v. Doe, 176 Ohio St. 370, 199 N.E.2d 878 (1964).

nurse.¹²⁰ The State Supreme Court held that it did not.¹²¹ In reaching its decision, the court first looked to legislative intent, then added that a nurse could not be placed in the same category as a physician, who exercises his independent judgment in matters of life and death.¹²²

Further clouding the nurse's professional status are decisions preceding¹²³ and succeeding¹²⁴ the above Ohio case¹²⁵, which extend to nurses the same degree of care as that owed by physicians. California courts treat the problem matter-of-factly by simply referring to malpractice as "the neglect of a physician or a nurse. . . ." ¹²⁶

That the professional status of the nurse is not clearly established in the courts is evident. However, dissent and variance in certain situations have been known to be the first indicia of a changing attitude.

Conclusions

The abrogation of charitable immunity, in all but a few jurisdictions,¹²⁷ has been a signal development in the history of voluntary non-profit hospitals. The courts have exposed the doctrine in its true light and have found it to be a creature of fiction.¹²⁸ Whatever propriety it may once have had, it clearly has no bearing on the hospitals of today. Its dissolution is having a material effect on the long prevailing mystique surrounding hospitals. Their doors are now open to critical scrutiny, with ever increasing regularity. The total hospital personality is being analyzed. Sociological, economic and scientific forces are prodding, nudging and driving the courts to this end. Our space age culture, with its rapidly growing social sophistication, was bound to find this kind of expression. With hospitals constituting the third largest industry in the United States,¹²⁹ it would be sheer fantasy to think they could have remained isolated and apart.

In the last few decades, we have seen another evolutionary process. Its beginnings were in a few faint mutterings that custom and usage could not be considered conclusive in determining standards of care.¹³⁰ The locality rule, in its original historical setting,¹³¹ was not a myth. It

¹²⁰ Ibid.

¹²¹ Id.

¹²² Id.

¹²³ Norton v. Argonaut Ins. Co., 144 So.2d 249 (La. App. 1962).

¹²⁴ Powell v. Fidelity and Casualty Co. of N.Y., 185 So.2d 324 (La. App. 1966); Louis Chinese Hospital Assn., 249 Cal. 2774, 57 Cal.Rptr. 906 (1967).

¹²⁵ Richardson v. Doe, *supra* note 119.

¹²⁶ Louis v. Chinese, *supra* note 124 at 915.

¹²⁷ Cases cited *supra* note 13, and see, Oleck, Non-Profit Corps., Orgns. & Assns. §§ 56, 57 (2d ed. 1965).

¹²⁸ Flagiello v. Pennsylvania, *supra* note 14.

¹²⁹ 68 Am. J., Nursing (No. 7) (July, 1968).

¹³⁰ Leonard v. Watsonville Community Hospital, *supra* note 52.

¹³¹ Pederson v. Dumouschel, *supra* note 75.

has merely outlived its usefulness. When it proved inadequate, the courts were compelled to find new yardsticks. These first emerged when it became apparent that the care in hospitals accredited by national associations needed to be measured by national standards.¹³² Soon, even this seemed inadequate to the task. Public interest and public rights assumed a new prominence in judicial reasoning.¹³³ The courts are now saying the public is not concerned with whether a hospital is accredited or not,¹³⁴ nor should it be. Inherent in those declarations is the implication that when an institution holds itself out as a center for the care of the sick, it must be prepared to provide quality care; not just some hospitals, but all hospitals.

When we refer to hospitals, we are really talking about people; people who carry out the hospital's reason for being. The plaintiff in the court room is not merely saying that the hospital failed in its duty to him, he is saying that the hospital failed because certain persons were negligent in caring for him. These persons quite frequently are the nurses. As the people most closely involved with the patient on a continual basis, this is an inevitable result. As the nurse's qualifications, skill and knowledge increase, so will her responsibility for patient care.

The doctor-nurse relationship and the nurse's legal status are so closely interrelated, that one cannot be considered apart from the other. Assessing their over-all import is a difficult process. Within the context of the hospital's internal structure, it becomes a tripartite issue, involving the hospital administrator, the doctor and the nurse. Each of the parties may subscribe to widely divergent philosophies. The consequences of such conflict are self-evident, with the realization of the unique interdependency existing among these three people. There are, on the other side of the spectrum, hospitals where mutual respect and recognition make it possible for problems to be solved wisely and uneventfully. Until this is universally true, the nurse will continue to be exposed to confusing pressures. The "you are there" doctrine, mentioned earlier, probably accounts for a major share of them. There are many things in the usual hospital routine which simply must be done and cannot wait for another day. If other personnel are unavailable, it is, perhaps, only natural that they be delegated to the person who is there twenty-four hours a day. The fact that they are non-nursing functions is frequently ignored. The unavailability of medical house staff (interns and residents) may be one of the more frequent, and more serious, causes for this kind of dilemma. Someone must assume their duties; why not the nurse? When this question arises, the nurse magically inherits qualities hitherto unnoticed. "Any good nurse could do this" or "let's

¹³² *Darling v. Charleston Community Hospital*, *supra* note 1.

¹³³ *Carson v. City of Beloit*, *supra* note 60.

¹³⁴ *Pederson v. Dumouschel*, *supra* note 75.

give the nurse the credit due her" are phrases which flow generously. It is unlikely that they will come from the direction of a knowledgeable nurse. Such a nurse accepts the fact that her role is not a static one and change is inevitable. She is aware that she possesses special skills and is anxious to apply them to their best advantage. She further realizes that non-nurses cannot determine nursing practice. To permit them to do so would be an abdication of professional responsibility. If a new duty can be identified as a proper nursing function, but requires additional preparation to qualify nurses to carry it out properly, it follows that the necessary time must be allocated before putting it into effect. This does not mean the patient will not have the care and treatment he requires. It does not mean the nurse is oblivious to scientific advances, which dictate change. It does mean, however, that the nurse is aware of both her professional responsibilities and legal liabilities. Just as the nurse must solve nursing problems, so must the hospital administrator and doctor find other solutions for those problems which are properly theirs.

With this degree of confusion still existing in hospitals, it was probably not too startling to have seen it reflected in the courts. From the cases, we know that when a nurse's negligence is at issue, the term malpractice does not apply to her because she is not required to use independent judgment on matters which mean the difference between life and death;¹³⁵ nor is expert testimony required to determine the propriety of her allegedly negligent acts.¹³⁶ However, the courts have determined that the nurse is negligent if she: 1) fails to follow the doctor's order because of faulty judgment; ¹³⁷ 2) follows the doctor's order but should have made an independent judgment not to; ¹³⁸ 3) fails to take proper precautions when an improper order has been written; ¹³⁹ or 4) fails to report medical treatment to higher medical and administrative authority, when in the exercise of independent judgment, she knows it to be improper.¹⁴⁰ The contradictions are so blatant as to require no further comment.

The observation has been made¹⁴¹ that the nurse is moving away from her traditional role in the hospital hierarchy and is beginning to take her place as a partner with the physician. The consequences of this irreversible trend are still in the embryonic state. They have, however, assumed a significant identity through those emerging concepts of tort liability which have had a demonstrable impact on the hospital nurse.

¹³⁵ Richardson v. Doe, *supra* note 119.

¹³⁶ Jones v. Hawkes Hospital of Mt. Carmel, *supra* note 111.

¹³⁷ Adams v. State, *supra* note 82.

¹³⁸ Arnold v. Haggin Memorial Hospital, *supra* note 83.

¹³⁹ Campbell v. Preston, *supra* note 84.

¹⁴⁰ Darling v. Charleston Community Hospital, *supra* note 1.

¹⁴¹ 67 Am. J., Nursing 1 (Jan. 1967).