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NOTES

Nurse Malpractice in North Carolina: The Standard of Care

Contemporary nurses work in a wide variety of settings and provide many levels of health care. For example, the intensive care nurse, titrating potent vasoactive drugs and measuring intra-arterial pressures, cares for the critically ill patient; the school nurse, screening school children for scoliosis, works toward early detection and treatment. Nurses can be found taking care of patients and teaching people how to maintain and improve their health all along the spectrum of the health care system. Given the diversity of roles that nurses fulfill, how is their performance evaluated in the context of a malpractice trial? This Note examines North Carolina law relating to the standard of care required of a professional nurse. It discusses when and whether expert testimony is necessary to establish the standard as well as who qualifies as an expert. Issues of professional vulnerability are discussed, including the standard of care for nurses in expanded roles and the latitude of nurses to obey or disobey physicians' orders. Finally, the Note addresses the standard's "same or similar" community requirement. The Note concludes that various changes should be made in the way North Carolina courts determine the nursing standard of care. These changes are necessary to ensure that nurses are held accountable for their professional expertise and education, but protected from liability for a standard of care that they have not assumed.

For the purposes of this Note, a professional nurse is a registered nurse who is licensed under state law to practice nursing, including registered nurses practicing in expanded roles.¹ There are presently three routes of educational preparation available for those desiring to become registered nurses: baccalaureate,² diploma,³ and associate degree⁴ programs. The American Nurses' Association⁵ has recommended adoption of the baccalaureate degree as the required educa-

1. Expanded nursing roles refer to positions such as nurse practitioners, nurse anesthetists, and clinical nurse specialists. The hallmark of these positions is increased responsibility and specialization. See A. RHODES & R. MILLER, *NURSING AND THE LAW* 101-02 (4th ed. 1984).

2. In baccalaureate programs student nurses typically study humanities and science courses for two years, followed by two or three years of clinical and theoretical instruction in nursing. COUNCIL OF STATE BDS. OF NURSING, AM. NURSES' ASS'N, *EXAMINING THE VALIDITY OF THE STATE BOARD TEST POOL EXAMINATION FOR REGISTERED NURSE LICENSURE 7* (1979) [hereinafter COUNCIL].

3. Diploma degree programs usually are two or three years long and are conducted by hospitals. *Id.*

4. Associate degree programs usually require two years and are offered by community or junior colleges. *Id.*

5. The American Nurses' Association (ANA), a professional organization for registered nurses, is a federation of constituent state nurses' associations. There are state nurses' associations in all 50 states; any registered nurse may join a state association. The goals of ANA include fostering high standards of nursing care and promoting the professional development of nurses. AM. NURSES' ASS'N, *FACTS ABOUT NURSING* 82-83, at 366 (1983).

tion for registered nurses;⁶ however, at present any of the three programs is sufficient to qualify the nurse to sit for the registered nurse licensing examination.⁷

The more generic term "nurse" refers to a licensed practical nurse or a registered nurse. In older cases, however, the term may refer to any person practicing nursing. Prior to 1903 use of the title "nurse" or "registered nurse" was not regulated in any state.⁸ Licensed practical nurses also are examined and licensed by state boards of nursing;⁹ the usual educational preparation is one year of classroom instruction and clinical training.¹⁰

Certain nursing care tasks may be delegated to unlicensed assistants. These nurses' aides work under a nurse's supervision and perform such functions as bathing, turning, and feeding patients. Although not found in all settings, nurses' aides are prevalent in settings demanding relatively unskilled care, such as nursing homes.

Even though the standard of care for a professional nurse in a malpractice case has its basis in common law, in North Carolina there is also a statute addressing the standard of care for health care providers. As in any negligence case,¹¹ the plaintiff in a medical malpractice case must offer evidence of the standard of care, a breach of that standard, proximate causation, and damages.¹² The North Carolina General Assembly has defined the standard of care required of health care providers in North Carolina General Statutes section 90-21.12, as follows:

In any action for damages for personal injury or death arising out of the furnishing or the failure to furnish professional services in the performance of medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action.¹³

6. AM. NURSES' ASS'N, COMM'N ON NURSING EDUC., A CASE FOR BACCALAUREATE PREPARATION IN NURSING 10 (1979).

7. "Candidates for the [examination] must have graduated from a state-approved school of nursing or, in a few cases, must be nearing graduation and have successfully completed specified nursing courses." COUNCIL, *supra* note 2, at 6.

8. Note, *A Revolution in White—New Approaches in Treating Nurses as Professionals*, 30 VAND. L. REV. 839, 840-42 (1977).

9. See, e.g., N.C. GEN. STAT. §§ 90-171.19 to .23 (1985) (discussing the North Carolina Board of Nursing and its role in licensing practical nurses).

10. Beaver, *Characteristics of an Educational Program in Practical Nursing*, in PRACTICAL NURSING: CURRICULA AND COMPETENCIES 4 (Nat'l League for Nursing 1980).

11. Malpractice is a subset of negligence, not an entirely different tort. "While any person may be negligent, only a professional may be liable for malpractice." Morris, *The Negligent Nurse—The Physician and The Hospital*, 33 BAYLOR L. REV. 109, 110 (1981). Both negligence and malpractice are used to describe causes of action against nurses. See *infra* note 97 and accompanying text (discussing the use of the two terms in the nursing context).

12. *Makas v. Hillhaven, Inc.*, 589 F. Supp. 736, 740 (M.D.N.C. 1984); *Mitchell v. Parker*, 68 N.C. App. 458, 459, 315 S.E.2d 76, 77, *disc. rev. denied*, 311 N.C. 760, 321 S.E.2d 141 (1984).

13. N.C. GEN. STAT. § 90-21.12 (1985).

By definition persons engaged in the practice of nursing are health care providers¹⁴ and, therefore, are held to the statutory standard of care.¹⁵

The courts have not interpreted section 90-21.12 as materially altering the common-law standard of care.¹⁶ Rather, courts and commentators view the general assembly's intent in enacting section 90-21.12 as "merely to conform the statute more closely to the existing case law applying a 'same or similar community' standard of care."¹⁷ Therefore, one must examine the case law as well as section 90-21.12 to understand the standard of care to which nurses are held.

Some appreciation for the historical development of American nursing is necessary to place the case law in proper perspective. That the courts have not always treated nurses as professionals is understandable in view of the profound changes that have occurred in nursing during the last century.¹⁸

Health care during the early to mid-nineteenth century bore little resemblance to that available today. Hospitals at that time were places for the poor who were sick and dying to go, not places to seek cures.¹⁹ Conditions were frequently appalling and in many instances "defied description."²⁰ Surgeons operated without anesthesia and whiskey was the medicine of choice for many illnesses.²¹ Nursing in these "pest houses" fell mainly to untrained women who could find no other work;²² the poor, the illiterate, and the criminal represented the nurses of the time.²³ Religious orders devoted to caring for the sick, however, were an exception to this rule. For example, Elizabeth Seton established the Sisters of Charity as a nursing order in Maryland in 1809.²⁴

News of Florence Nightingale's pioneering work during the Crimean War²⁵

14. *Id.* § 90-21.11. The statutory definition of health care providers includes anyone licensed, registered, or certified to engage in the practice of nursing, "or [who] otherwise performs duties associated with" nursing. *Id.*

15. See *Page v. Wilson Memorial Hosp., Inc.*, 49 N.C. App. 533, 535, 272 S.E.2d 8, 10 (1980).

16. See *Makas v. Hillhaven, Inc.*, 589 F. Supp. 736, 740 (M.D.N.C. 1984); *Wall v. Stout*, 310 N.C. 184, 191-92, 311 S.E.2d 571, 576 (1984).

17. *Wall*, 310 N.C. at 192, 311 S.E.2d at 576; see also Byrd, *The North Carolina Medical Malpractice Statute*, 62 N.C.L. REV. 711, 741 (1984) ("The statute cannot be divorced from the common law it codifies and viewed as an exclusive statement of malpractice liability law."); Comment, *Statutory Standard of Care for North Carolina Health Care Providers*, 1 CAMPBELL L. REV. 111, 113 (1981) (noting the relationship between the statute and prior case law).

18. See Note, *supra* note 8, at 842 (discussing the dramatic changes that took place in the nursing profession from the early 1900s to the mid-1970s).

19. P. KALISCH & B. KALISCH, *THE ADVANCE OF AMERICAN NURSING* 20-24 (1978) [hereinafter KALISCH]; see also Dellinger, *A History of Hospitals in North Carolina*, in *HOSPITAL LAW IN NORTH CAROLINA* (U.N.C. Inst. of Gov't 1985) (detailing the history of hospital development in North Carolina).

20. KALISCH, *supra* note 19, at 24; see also *id.* at 28 (detailing the unsanitary conditions of hospitals in the early 19th century).

21. KALISCH, *supra* note 19, at 24-25. "Physicians were so inadequately trained that they often aggravated rather than alleviated disease. Emetics, purgatives, and bleeding remained the three mainstays among the therapeutic treatments of the typical mid-century practitioner." *Id.* at 25.

22. KALISCH, *supra* note 19, at 28.

23. KALISCH, *supra* note 19, at 28. In New York City women arrested for public drunkenness or disorderly conduct could avoid a sentence in the workhouse if they provided nursing service in local hospital wards. *Id.* at 79.

24. KALISCH, *supra* note 19, at 31.

25. In 1854 Nightingale accompanied 38 women of varied nursing experience to Scutari, Turkey to care for British casualties of the Crimean War. KALISCH, *supra* note 19, at 35-37. Despite

inspired many "respectable" American women to nurse the casualties during the Civil War, particularly in the North.²⁶ Training was not necessary, so long as the nurse was plain in appearance, over thirty years old, and possessed "[g]ood morals and common sense."²⁷ As a result, the American public began to accept nursing as work suitable for respectable women, although education still was not considered necessary to a nurse.²⁸

Even before the Civil War, a movement had begun to establish schools for training nurses.²⁹ After the Civil War, however, the need for trained nurses clearly was recognized.³⁰ The hours were long,³¹ the work menial,³² and the education minimal³³ in these early schools. Student nurses provided cheap labor for hospitals, and a training school came to be considered indispensable to hospitals.³⁴ As the number of training schools multiplied,³⁵ the military and religious origins of nursing influenced the developing profession: "[A]sceticism, duty, and the adherence to authority" were required of trained nurses.³⁶ Societal sexism³⁷ and the paternalism of male physicians³⁸ influenced the developing profes-

the opposition of military physicians, Nightingale reorganized the military hospital and instituted hygienic and nutritional improvements. *Id.* at 40. By the end of the war Nightingale had supervised 125 nurses, the mortality rate at the Barracks Hospital had dropped from 60% to slightly more than 1%, and a new era of nursing had begun. *Id.* at 42.

26. KALISCH, *supra* note 19, at 68. *See generally id.* at 49-68 (discussing the role of female nurses during the Civil War).

27. KALISCH, *supra* note 19, at 51. These were the qualities necessary to join the Union female nursing corps headed by Dorothea Dix. *Id.*

28. KALISCH, *supra* note 19, at 68.

29. KALISCH, *supra* note 19, at 77.

30. Physicians were the first to recognize the need for trained nurses. KALISCH, *supra* note 19, at 81. This recognition was followed by public acceptance of and popular demand for trained nurses. *Id.* at 82-84. *See generally id.* at 71-88 (discussing the development of nurse training programs in the United States during the 1860s and 1870s).

31. Students routinely worked 10-12 hours a day, 7 days a week, in addition to attending lectures and compulsory church services. KALISCH, *supra* note 19, at 156-57.

32. A beginning nursing student dusted, scrubbed, washed dishes, cleaned windows, laundered bandages, and did whatever else needed to be done in the hospital. KALISCH, *supra* note 19, at 154-56.

33. KALISCH, *supra* note 19, at 157. "Despite the ratio of more than 98 percent service to less than 2 percent theory in school of nursing curricula, physicians constantly complained that nurses were being overtrained." *Id.* at 163.

34. J. ASHLEY, HOSPITALS, PATERNALISM, AND THE ROLE OF THE NURSE 11 (1976); KALISCH, *supra* note 19, at 163. "There was . . . no question that hospitals had exploited student nurses in an attempt to avoid the expense required in employing graduate nurses." *Id.* at 350 (discussing the status of nurse education in the late 1920s).

35. KALISCH, *supra* note 19, at 163. Between 1880 and 1900 the number of schools increased from 15 to 432. *Id.* By 1927 there were 2286 schools. *Id.* at 350.

36. KALISCH, *supra* note 19, at 163.

37. One commentator has noted:

Nursing, perhaps more than any other profession, has been influenced by social conceptions regarding the nature of women. Modern nursing originated at a time when Victorian ideals dictated that the role of women was to serve men's needs and convenience. Nursing's development continued to be greatly influenced by the attitudes that women were less independent, less capable of initiative, and less creative than men, and thus needed masculine guidance.

J. ASHLEY, *supra* note 34, at 75-76.

38. The hospital training schools provided physicians with ample opportunity to exercise control over nurses. Physicians favored training over education for nurses and were fond of the maxim "A good nurse is born, not made." J. ASHLEY, *supra* note 34, at 77 (quoting William Alexander

sion tremendously. By the late 1920s training of nurses had evolved into an apprenticeship system, emphasizing training rather than education.³⁹

A case from this general time period illustrates the status of nursing in the early twentieth century. In *Byrd v. Marion General Hospital*⁴⁰ the North Carolina Supreme Court described the duty that a nurse owes to a patient: (1) that the nurse "possess the requisite degree of learning, skill, and ability necessary to the practice of [his or her] profession, and which others similarly situated ordinarily possess"; (2) that the nurse "exercise reasonable and ordinary care and diligence in the use of [his or her] skill and in the application of [his or her] knowledge to the patient's case"; and (3) that the nurse "exert [his or her] best judgment in the treatment and care of the case."⁴¹

This description of the nurse's duty is unobjectionable—indeed it is identical to the duty owed by a physician as described in *Byrd*⁴²—and it represents the starting point for describing the standard of care for nurses under North Carolina case law. The court went on, however, to state that the nurse "must obey and diligently execute" the orders of a physician,⁴³ because "the physician is solely responsible for the diagnosis and treatment of his patient. Nurses are not supposed to be experts in the technique of diagnosis or the mechanics of treatment."⁴⁴ The court, in dictum, did allow that if an order was "so obviously negligent as to lead any reasonable person to anticipate that substantial injury would result," a nurse should disobey the order.⁴⁵ "Certainly, if a physician or surgeon should order a nurse to stick fire to a patient, no nurse would be protected from liability" for carrying out the order.⁴⁶

The *Byrd* decision illustrates two important aspects of early twentieth century nursing. First, the nurse who disobeyed a physician's order was excused only if the order was so negligent that an ordinary person would realize its danger—for example, if the nurse were ordered to "stick fire" to the patient. If, by virtue of knowledge and experience the nurse realized a danger that an ordinary person would not realize, the duty to follow the order would remain. This duty of obedience was consistent with the attitude at the time that education was not necessary and, in fact, could be harmful in a nurse.⁴⁷ Second, the quality of nursing education at that time varied so widely that it was probably in the patient's best interests to restrict the nurse's judgment regarding physicians' or-

Dorland in an address given to the 1908 graduating class of the Philadelphia School of Nursing. "Womanly" qualities on the part of the nurse were valued more than knowledge." *Id.* at 76.

39. KALISCH, *supra* note 19, at 350.

40. 202 N.C. 337, 162 S.E. 738 (1932). Plaintiff in *Byrd* sought to hold a nurse personally liable for the burns suffered by plaintiff during a "sweat cabinet" treatment. *Id.* at 338-40, 162 S.E. at 738-39. A verdict for plaintiff was reversed and defendant's motion for nonsuit granted. *Id.* at 344, 162 S.E. at 741.

41. *Id.* at 341, 162 S.E. at 740 (quoting *Pangle v. Appalachian Hall*, 190 N.C. 833, 835, 131 S.E. 42, 43 (1925)).

42. *Id.*

43. *Id.*

44. *Id.* at 342, 162 S.E. at 740.

45. *Id.* at 341, 162 S.E. at 740.

46. *Id.*

47. J. ASHLEY, *supra* note 34, at 76-77.

ders.⁴⁸ In many instances, despite being a "trained nurse," the individual might actually have received very little education on which to base a judgment of an order;⁴⁹ therefore, a "reasonably prudent person" standard may have been appropriate in the earlier part of the century.

Finally, the *Byrd* decision laid the foundation for nursing negligence or malpractice cases by stating that the nurse owed a duty directly to the patient. That the nurse also owes a duty to the hospital that employs him or her,⁵⁰ and to the physician who he or she assists⁵¹ sometimes puts the nurse in a dilemma; the duties owed to patient, physician, and hospital often conflict.⁵²

Byrd has been described as holding that "between patient and nurse, the nurse who follows the orders of the physician or surgeon in charge is not ordinarily liable if injury results from the treatment as prescribed."⁵³ This is a sound policy, because even by today's standards nurses are not responsible for diagnosis and prescription of medications and certain therapies.⁵⁴ As between physician and nurse, doctors are primarily responsible for diagnosis and prescription and, therefore, should bear legal liability for their orders. As between nurse and layperson, however, the nurse is eminently more qualified to question a physi-

48. If the nurse received his or her training at a hospital, "the training . . . was entirely dependent upon the kind and quality of medical services provided by the individual hospital and the amount of attention its administration gave to its apprentice nurses." J. ASHLEY, *supra* note 34, at 11. By the 1920s it was possible to earn a nursing diploma and a bachelor of science degree in a university program. However, hospitals remained the chief means of training nurses. KALISCH, *supra* note 19, at 337-38. In contrast to the university level of education, many hospitals required neither a high school diploma nor any high school preparation whatsoever. *Id.* at 347.

49. KALISCH, *supra* note 19, at 348-50. Although North Carolina did have a nurse registration act at the time *Byrd* was decided, it is unclear whether defendant nurse in *Byrd* was registered. The early North Carolina statute protected the title of "registered nurse," but did not regulate the scope of nursing practice. See Bullough, *The Current Phase in the Development of Nurse Practice Acts*, 28 ST. LOUIS U.L.J. 365, 369-71 (1984) (discussing the early history of nurse registration acts). "The older nursing laws made it illegal for an unauthorized person to use the title 'registered nurse,' but not illegal for such a person to practice nursing." *Id.* at 372-73.

50. Of course, not all nurses are employed by hospitals. Neither is it reasonable to believe that nurses working outside hospitals never commit negligent acts. However, many nurse malpractice cases do involve hospital nurses, probably because the doctrine of *respondeat superior* allows the plaintiff to recover from the hospital based on the employee nurses' negligence. This provides the plaintiff with a "deep pocket" from which he or she can recover damages. For a discussion of hospital liability for employee nurses' negligence, see 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 16A.02. (1986).

51. Morris, *supra* note 11, at 109.

52. See Comment, *Nurses' Legal Dilemma: When Hospital Staffing Compromises Professional Standards*, 18 U.S.F. L. REV. 109, 121 (1983) ("The unhappy, but inevitable, result of the disaccord between a nurse's professional and legal standards and the realities of an understaffed hospital is increased exposure to liability for the nurse."). In *Fincke v. Peebles*, 476 So. 2d 1319 (Fla. Dist. Ct. App. 1985), testimony that recovery room nursing staff had complained to the head of the anesthesiology department about a physician's tendency to extubate (remove the tube that allows the patient to breathe while unconscious) patients too quickly after surgery was not admissible as evidence of prior circumstances to show defendant nurse's negligence when the patient suffered cardiac arrest following extubation. Such testimony was admissible, however, against the hospital on the issue of punitive damages. *Id.* at 1323-24. This case illustrates the nurses' conflicting duties owed to patient, doctor, and hospital.

53. Jackson v. Joyner, 236 N.C. 259, 262, 72 S.E.2d 589, 592 (1952).

54. See, e.g., N.C. GEN. STAT. § 90-171.20(7)(e) (1985). This provision excludes medical diagnosis and prescription from the definition of nursing practice, subject to *id.* § 90-18.2, which empowers nurse practitioners to prescribe medications and order tests and treatments under the supervision of a physician.

cian's order. To hold a nurse only to *Byrd's* "obvious negligence" standard is to disregard the nurse's superior knowledge; such disregard violates even the reasonably prudent person standard.⁵⁵ The holding in *Byrd* that the nurse has a duty to obey physicians' orders unless those orders pose an obvious danger seems anachronistic.

In the 1985 case of *Paris v. Kreitz*⁵⁶ a North Carolina court again had the opportunity to consider a nurse's duty to obey physicians' orders. Like plaintiff in *Byrd*, plaintiff in *Paris* sought to impose liability on a nurse⁵⁷ who had carried out the orders of a physician or a physician assistant.⁵⁸ Plaintiff in *Paris* arrived at the hospital at 11:40 p.m. complaining of pain in his foot and lower leg. He was seen by a physician assistant at 1:30 a.m., who noted the same physical signs and symptoms as had the nurse. The physician assistant diagnosed the problem as peripheral vascular insufficiency, sent plaintiff home with a pain medication, and instructed him to see the physician in the morning. The pain increased during the night; the next day the physician diagnosed an occlusion. Plaintiff eventually underwent a total of four surgeries, culminating in the loss of his leg. He alleged that the delay in proper diagnosis and treatment was the proximate cause of the amputation. Plaintiff further claimed that the nurse in the emergency room knew he required treatment by a trained physician and was negligent in not obtaining treatment for him.⁵⁹

The *Paris* court considered the question of the nurse's negligence under the *Byrd* "duty to obey" analysis. Relying on *Byrd*, the court stated that "[w]hile a nurse may disobey the instructions of a physician where those instructions are obviously wrong and will result in harm to the patient, . . . the duty to disobey does not extend to situations where there is a difference of medical opinion."⁶⁰ Because the nurse's observations agreed with those of the physician assistant, "[a]ny disagreement or contrary recommendation she may have had as to the treatment prescribed would have necessarily been premised on a separate diagnosis which she was not qualified to render."⁶¹ Although the negligence of the physician assistant and the physician were questions of fact, "it is clear that the

55. PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 185 (W. Keeton, 5th ed. 1984) [hereinafter PROSSER & KEETON] ("if a person . . . has knowledge, skill, or even intelligence superior to that of the ordinary person, the law will demand of that person conduct consistent with it").

56. 75 N.C. App. 365, 331 S.E.2d 234, *disc. rev. denied*, 315 N.C. 185, 337 S.E.2d 858 (1985).

57. Plaintiff in *Paris* sought to hold the hospital liable for its employee nurse's alleged negligence in failing to ensure that plaintiff was seen by a physician. *Id.* at 369-70, 331 S.E.2d at 239.

58. Physician assistants (PAs) are licensed in North Carolina to perform medical acts under the supervision of a physician. See N.C. GEN. STAT. § 90-18.1 (1985). The usual training requires two years of intensive study and clinical rotations. The *Paris* court did not distinguish between a nurse's duty to obey a PA and the duty to obey a physician. However, the statute notes that "[a]ny registered nurse or licensed practical nurse who receives an order from a physician assistant for medications, test, or treatments is authorized to perform that order in the same manner as if it were received from a licensed physician." *Id.* § 90-18.1(f).

59. *Paris*, 75 N.C. App. at 367-70, 331 S.E.2d at 237-40.

60. *Id.* at 380, 331 S.E.2d at 245 (citations omitted). The court did not distinguish between a *right* and a *duty* to disobey orders. In the quotation cited in the text the court first states that a nurse "may" disobey an order in certain circumstances, then in the same sentence equates this with a "duty to disobey." *Id.*

61. *Id.* at 381, 331 S.E.2d at 245.

negligence was not so obvious as to require [defendant nurse] to disobey an instruction or refuse to administer a treatment."⁶²

The *Paris* court relied on *Byrd* to describe the nurse's duty to obey a physician, but failed to specify what standard would apply to a nurse's decision to obey or disobey an order. The quality and uniformity of nursing education has improved considerably since *Byrd* was written;⁶³ nursing practice is defined and regulated by licensure⁶⁴ so that patients and physicians can reasonably expect a professional nurse to use his or her education and experience in judging the soundness of physicians' orders. The broad language in *Paris* regarding the nurse's duty to obey should be restricted to the facts of the case. Those facts did not present the court with a situation in which a nurse made a reasoned judgment to disobey an order based on observations of the patient. The nurse and physician assistant were in agreement over the patient's condition. Thus, *Paris* should not be interpreted as holding that nurses must obey physicians' orders in the absence of obvious negligence, even if the nurse disagrees with the order based on his or her education and experience. The professional nurse has a right and a duty to use his or her judgment in carrying out physicians' orders.⁶⁵

Courts in other jurisdictions have addressed this issue indirectly. At least one court has suggested that the nurse may refuse to follow an order if he or she notifies the physician of the refusal.⁶⁶ In another case in which a nurse did not refuse to carry out an order, but rather exercised judgment in administering a medication ordered on a "P.R.N." or "as needed" basis, the court noted that "[w]hile nurses traditionally have followed the instructions of attendant physicians, doctors realistically have long relied on nurses to exercise independent judgment in many situations."⁶⁷ This recognition contrasts with the *Paris* court's oversimplified view of nursing judgment, that any disagreement with an

62. *Id.*

63. "Despite the background of severe obstacles, nursing as a profession has made considerable progress since mid-century. Nursing has now established standards and national accreditation for all schools of nursing, controlled by the profession." J. ASHLEY, *supra* note 34, at 126-27.

64. See Bullough, *supra* note 49, at 371-76.

65. Courts have long recognized nurses' affirmative duty to question unclear or confusing orders. For example, in *Norton v. Argonaut Ins. Co.*, 144 So. 2d 249 (La. Ct. App. 1962), a nurse was held responsible for an infant's wrongful death due to an overdose of digitalis. The physician neglected to write the route of administration (oral or by injection); the nurse, rather than clarifying the route by talking to the ordering physician, administered the dose by injection. Had the medication been administered orally, as intended, it would have been a normal dosage. *Id.* at 251-58.

66. See *Carlsen v. Javurek*, 526 F.2d 202, 208-09 (8th Cir. 1975). With respect to refusing to obey an order, Rhodes and Miller have noted, "[p]ending review, if the drug or procedure appears dangerous to the patient, the nurse should decline to carry out the order, but should immediately notify the ordering physician." A. RHODES & R. MILLER, *supra* note 1, at 150. They also contend that "[h]ospitals should have established procedures for nurses to follow when they are not satisfied with the appropriateness of an order." *Id.*

67. *Fraijo v. Hartland Hosp.*, 99 Cal. App. 3d 331, 342, 160 Cal. Rptr. 246, 252 (1979). The nurse in *Fraijo* administered Demerol, a pain reliever, to an asthmatic patient complaining of chest pain. *Id.* at 338, 160 Cal. Rptr. at 249. The patient subsequently suffered a cardiac arrest. Although the drug manufacturer's literature warned against giving Demerol during an acute asthmatic attack, *id.* at 337, 160 Cal. Rptr. at 249, there was evidence that it is still used with asthmatics to combat pain, *id.* at 337 n.5, 160 Cal. Rptr. at 249 n.5, and that the drug was not the cause of the cardiac arrest. *Id.* at 339, 160 Cal. Rptr. at 250. The court held that nurses in situations involving the use of independent judgment are entitled to the benefit of specific jury instructions usually reserved for physicians. *Id.* at 343, 160 Cal. Rptr. at 253.

order would be based on a separate diagnosis when a nurse agreed with the physician assistant's observations.⁶⁸ Experience does not support the *Paris* conclusion. Many situations can arise in which a nurse and physician make similar observations, yet the nurse is alerted by his or her experience and education to a problem with the physician's order. This problem arises frequently in interactions between new interns and experienced nurses.⁶⁹

The duty to obey physicians' orders is but one of the many issues that may arise in a nursing malpractice case. How will a defendant nurse's conduct be evaluated in malpractice cases? General negligence principles demand that tortfeasors' behavior be measured against an objective standard of behavior. Generally, this standard is that of the fictitious "reasonably prudent person."⁷⁰ If a person possesses superior knowledge or skill, however, the law demands conduct consistent with that higher level of knowledge.⁷¹ Thus, "[t]he professional standard of care is in effect a statement of the reasonable care standard specifically tailored to the professional."⁷² The court in *Byrd* stated the professional standard expected of a nurse.⁷³

Because most jury members do not have the background necessary to understand the medical and technical aspects of a medical malpractice case, expert testimony usually is required to assist the jury;⁷⁴ the same is true of many nurse malpractice cases. Thus, a case at trial proceeds something like the following example. In *Holbrooks v. Duke University, Inc.*⁷⁵ plaintiff alleged that she had been injured by an injection given to her by a nurse. The nurse had administered a pain medication by intramuscular injection three to four inches above plaintiff's knee.⁷⁶ A nurse expert testified that giving an injection at that location was not in accordance with customary practice among professional nurses in Durham, North Carolina, or similar communities. This testimony, in addition to physician testimony that the injection could have caused plaintiff's injury, was sufficient evidence to submit to the jury the question of the nurse's negligence.⁷⁷

The expert testimony in such cases establishes the customary standard for professional conduct. Although the customary practice standard does allow the professional group in effect to set its own standard of conduct,⁷⁸ it does not

68. *Paris*, 75 N.C. App. at 381, 331 S.E.2d at 245.

69. One example would be if an intern ordered a certain drug to counteract nausea following chemotherapy for treating cancer. The nurse, more experienced in such treatment than the intern, might recognize the drug ordered as effective for post-anesthetic nausea, yet ineffective in combating post-chemotherapy nausea. The nurse in this situation would be observing the same symptoms as the physician, reaching the same conclusion, yet recognizing the ordered treatment as ineffective. Common sense and compassion for the patient dictate that the nurse notify the physician of the availability of a more effective medication and seek a revision of the order.

70. PROSSER & KEETON, *supra* note 55, § 32, at 173-74.

71. PROSSER & KEETON, *supra* note 55, § 32, at 185.

72. *Byrd*, *supra* note 17, at 712-13.

73. See *supra* text accompanying note 41.

74. See *Jackson v. Mountain Sanitarium & Asheville Agric. School*, 234 N.C. 222, 227, 67 S.E.2d 57, 61 (1951) ("both the court and jury must be dependent on expert testimony").

75. 63 N.C. App. 504, 305 S.E.2d 69 (1983).

76. *Id.* at 505, 305 S.E.2d at 67-70.

77. *Id.* at 505-06, 305 S.E.2d at 70.

78. PROSSER & KEETON, *supra* note 55, § 32, at 189.

permit the group to say that no customary practice within a profession can be negligent. Thus, although surgeons universally rely on the operating room nurses' sponge count to ensure that no sponges are left in the patient's body after an operation, they are still liable if a sponge is left in the operative site.⁷⁹

Although the standard of care is defined by section 90-21.12 as "the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action,"⁸⁰ the case law discloses that in certain instances the nurse will be held to a nonprofessional standard. This is true when the alleged act of negligence is one that does not involve professional skill or judgment. In such cases the jury is deemed capable of applying the reasonably prudent person standard and expert testimony is unnecessary.⁸¹

In *Jackson v. Mountain Sanitarium & Asheville Agriculture School*⁸² the North Carolina Supreme Court held that expert testimony is not required in every medical malpractice case.⁸³ The court noted that expert testimony is usually needed to provide opinion evidence for the court and jury; "[o]rdinarily there can be no other guide."⁸⁴ There are instances, however, "where non-expert jurors of ordinary intelligence may draw their own inferences from the facts and circumstances shown in evidence."⁸⁵ One such instance was presented in *Norris v. Rowan Memorial Hospital, Inc.*,⁸⁶ in which a seventy-five-year-old woman fell and fractured her hip while in the hospital. Plaintiff's decedent had been medicated with castor oil and a sleeping pill, and the side rails on her bed were not raised.⁸⁷ Plaintiff introduced a bulletin issued by defendant hospital which stated that bed rails should be raised for elderly and sedated patients; no expert testimony was offered.⁸⁸ The trial court sustained defendant's motion for a directed verdict. Reversing the trial court, the court of appeals held: "Where, as here, the alleged breach of duty did not involve the rendering or failure to render professional nursing or medical services requiring special skills, expert testimony . . . is not necessary to develop a case of negligence for the jury."⁸⁹ The court stated that the nursing staff's failure to raise the bed rails and instruct the patient to call for assistance to get out of bed was the proximate cause of her injury. The combination of the laxative and the sleeping pill given the patient "should have put a reasonably prudent person on notice" that the patient would have to use the bathroom during the night while still under the effects of the

79. See *Truhitte v. French Hosp.*, 128 Cal. App. 3d 332, 349, 180 Cal. Rptr. 152, 161 (1982) (sponge removal is nondelegable duty of surgeon).

80. N.C. GEN. STAT. § 90-21.12 (1985).

81. See *Norris v. Rowan Memorial Hosp., Inc.*, 21 N.C. App. 623, 626, 205 S.E.2d 345, 348 (1974). "The *Norris* case is important because it carefully relates the need for expert testimony to the particular facts and the jury's ability to understand them." Byrd, *supra* note 17, at 719.

82. 234 N.C. 222, 67 S.E.2d 57 (1951).

83. *Id.* at 226-27, 67 S.E.2d at 61-62.

84. *Id.* at 227, 67 S.E.2d at 61.

85. *Id.* at 227, 67 S.E.2d at 61-62.

86. 21 N.C. App. 623, 205 S.E.2d 345 (1974).

87. *Id.* at 623-24, 205 S.E.2d at 346.

88. *Id.* at 625, 205 S.E.2d at 347.

89. *Id.* at 626, 205 S.E.2d at 348.

sleeping pill.⁹⁰ Thus, a jury could reasonably find the hospital liable for the negligence of its nursing staff, even without expert testimony.

Similarly, in *Biggs v. Cumberland County Hospital System, Inc.*⁹¹ defendant hospital's employee, a nurses' aide, was considered negligent in failing to assist plaintiff back to bed following a hot shower. Plaintiff was recovering from back surgery and two hot showers a day were part of her treatment. Plaintiff offered opinion evidence by a certified and experienced nurses' aide regarding the applicable practices and standards of care.⁹² The trial court admitted the testimony over defendant's objections.⁹³ On appeal, the court stated that admission of the testimony was appropriate because the witness "manifestly knew more about the functions and practices of nurse's aides than the jurors did,"⁹⁴ but that the testimony was unnecessary to establish a case for the jury.⁹⁵ Because *Norris* involved a nurse, and *Biggs* involved a nurses' aide, it is clear that it is the alleged act, not the identity of the actor, that determines whether expert testimony is required.

The North Carolina view that expert testimony is unnecessary when the alleged negligent act does not involve special skill or judgment is consistent with the views of other jurisdictions.⁹⁶ Although courts and commentators do not always use the terms consistently, the distinction between "nursing negligence" and "nursing malpractice" rests on the same test used to determine whether expert testimony is necessary: that is, did the act involve professional skill or judgment?⁹⁷

If a nurse's acts are to be judged by a professional standard of care requiring expert testimony at trial, who then is competent to testify? If, "through study or experience, or both, the witness has acquired such skill that he is better qualified than the jury to form an opinion on the particular subject of his testi-

90. *Id.* at 627, 205 S.E.2d at 348.

91. 69 N.C. App. 547, 317 S.E.2d 421 (1984).

92. *Id.* at 547-48, 317 S.E.2d at 422-23.

93. Defendant contended that the witness was not qualified to testify as an expert. *Id.* at 548, 317 S.E.2d at 422.

94. *Id.* at 549, 317 S.E.2d at 423.

95. *Id.* But see *Page v. Wilson Memorial Hosp., Inc.*, 49 N.C. App. 533, 272 S.E.2d 8 (1980) (directed verdict for defendant reversed because expert testimony of registered nurse should have been admitted to establish customary standard in use of bedpan).

96. See, e.g., *Robbins v. Jewish Hosp.*, 663 S.W.2d 341, 346 (Mo. Ct. App. 1983) (expert testimony to show deviation from standard of care unnecessary when nurse left side rail down and patient recovering from drug overdose got out of bed and fell); *Coursen v. New York Hosp.-Cornell Medical Center*, 114 A.D.2d 254, 257, 499 N.Y.S.2d 52, 54 (1986) (expert opinion on standard of care unnecessary when nurses' aide allowed post-operative patient to use bathroom unescorted and patient fainted and fell).

97. *Morris*, *supra* note 11, at 110-11. One court has noted:

[N]egligence rules are applicable in those situations where the issue relating to the exercise of due care may be "easily discernible by a jury on common knowledge." . . . However, where the directions given or treatment received by a patient is in issue, this requires consideration of the professional skill and knowledge of the practitioner or the medical facility and the more specialized theory of medical malpractice applies.

Coursen v. New York Hosp.-Cornell Medical Center, 114 A.D.2d 254, 256, 499 N.Y.S.2d 52, 54 (1986) (quoting *Morwin v. Albany Hosp.*, 7 A.D.2d 582, 585, 185 N.Y.S.2d 85, 88 (1959)).

mony," then the witness is competent.⁹⁸ The expert witness need not be licensed, or employed professionally or commercially in that field of expertise.⁹⁹ Thus, physicians as well as nurses have been held qualified to testify regarding the nursing standard of care.¹⁰⁰ In testifying, however, the physician must restrict his or her opinion to the nursing standard of care, not a physician standard of care.¹⁰¹

Use of physician testimony to establish a nursing standard of care clearly is acceptable in North Carolina, as in other jurisdictions.¹⁰² Whether this is an optimal practice is another question. Physicians and nurses undergo different training and approach problems from different perspectives.¹⁰³ At least one student commentator has found the practice of using physicians rather than nurses to establish a nursing standard of care objectionable:

This [practice] would not be surprising if nurses were still functioning as handmaidens of physicians, following their orders without independent thought. The status of nursing has changed, however, and not only do physicians no longer have the special knowledge required to testify in all cases of nursing malpractice, but their use as experts may create problems that could be avoided by using nurses as experts in most nursing malpractice cases.¹⁰⁴

The inquiry should focus on whether the physician does indeed know the customary practice of nurses regarding the procedure in question. Courts should not assume knowledge, because nursing and medicine are two distinct disciplines, albeit with some overlapping functions.

In addition to expert testimony, written regulations, standards, and hospital by-laws also are admissible as evidence of the accepted standard of care.¹⁰⁵

98. *Maloney v. Wake Hosp. Sys., Inc.*, 45 N.C. App. 172, 177, 262 S.E.2d 680, 683, *disc. rev. denied*, 300 N.C. 375, 267 S.E.2d 676 (1980); *see also* FED. R. EVID. 702 ("If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise."). The corresponding North Carolina rule is identical, except for the omission of the words "or otherwise" found at the end of the federal rule. N.C. R. EVID. 702.

99. *Maloney*, 45 N.C. App. at 178, 262 S.E.2d at 684.

100. *Paris*, 75 N.C. App. at 380, 331 S.E.2d at 245 ("Physicians are clearly acceptable experts with regard to the standard of care for nurses."); *see also* *Haney v. Alexander*, 71 N.C. App. 731, 735, 323 S.E.2d 430, 433 (1984) (within trial court's discretion to allow doctor to testify regarding the duty of a nurse to take patient's vital signs when new or unusual symptoms exhibited), *disc. rev. denied*, 313 N.C. 329, 327 S.E.2d 889 (1985).

101. *Vassey v. Burch*, 45 N.C. App. 222, 226, 262 S.E.2d 865, 867 (physician's affidavit stating that accepted medical practice required checking patient for appendicitis was insufficient to withstand motion for summary judgment because it failed to establish proper standard of care for defendant nurse), *rev'd on other grounds*, 301 N.C. 68, 269 S.E.2d 137 (1980).

102. *See, e.g.,* *Northern Trust Co. v. Skokie Valley Comm. Hosp.*, 81 Ill. App. 3d 1110, 401 N.E.2d 1246 (1980) (accepting such testimony of a physician as an expert on nursing practice); *Sandhofer v. Abbott-Northwestern Hosp.*, 283 N.W.2d 362 (Minn. 1979) (accepting the testimony of a physician as an expert on nursing practice).

103. Comment, *The Use of Nurses as Expert Witnesses*, 19 HOUS. L. REV. 555, 571 n.113 (1982).

104. *Id.* at 571.

105. *See* *Taylor v. City of Beardstown*, 491 N.E.2d 803, 811 (Ill. App. Ct. 1986); *see also* *Makas v. Hillhaven, Inc.*, 589 F. Supp. 736, 742 (M.D.N.C. 1984) (nursing home patients' bill of rights relevant to show patient's expectations for nursing home, but did not allow use of doctrine of negligence per se).

Standards of nursing practice have been established by organizations such as the American Nurses' Association¹⁰⁶ and the Joint Committee on Accreditation of Hospitals.¹⁰⁷ In addition, most hospitals have their own procedure manuals outlining very specific behaviors for nurses. Such documentation of a standard and proof of a breach of that standard is convincing evidence of malpractice.¹⁰⁸

Regulations from a hospital procedural manual presented an evidentiary question for the Nevada Supreme Court in *Wickliffe v. Sunrise Hospital, Inc.*¹⁰⁹ when a patient stopped breathing after surgery, consequently suffering severe brain damage and death. A nurse expert would have testified that the patient's vital signs should have been taken every fifteen minutes for at least the first hour after the patient returned to the surgical ward from the recovery room.¹¹⁰ This practice was consistent with the standards promulgated by the Joint Committee on Accreditation of Hospitals. Because the patient's vital signs were not taken every fifteen minutes, her respiratory depression was not discovered before she quit breathing altogether. The trial court had excluded the nurse expert's testimony entirely. The Nevada Supreme Court reversed and held that her testimony should have been admitted.¹¹¹

Plaintiff in *Wickliffe* sought also to introduce a rolodex that contained portions of the hospital's procedure manual. Part of the rolodex included the policy that vital signs on postoperative patients should be taken every fifteen minutes for an hour after surgery and more often if necessary.¹¹² The trial court limited the testimony of a nursing supervisor, which would have laid the foundation for admission of the rolodex, to matters of rebuttal. On remand, the supreme court directed that the nursing supervisor be allowed to testify during the patient's case-in-chief.¹¹³

The question of what kinds of written regulations rise to the level of establishing a standard in North Carolina was addressed in *Makas v. Hillhaven*,

106. See, e.g., AM. NURSES' ASS'N DIV. ON MEDICAL-SURGICAL NURSING PRACTICE & EMERGENCY DEP'T NURSES' ASSOCIATION, STANDARDS OF EMERGENCY NURSING PRACTICE (1983); AM. NURSES' ASS'N DIV. ON MATERNAL & CHILD NURSING PRACTICE, STANDARDS OF MATERNAL & CHILD HEALTH NURSING PRACTICE (1983). Standards promulgated by specialty nursing associations also are available. See, e.g., NURSES ASS'N OF THE AM. COLLEGE OF OBSTETRICS AND GYNECOLOGY, STANDARDS FOR OBSTETRIC, GYNECOLOGIC, AND NEONATAL NURSING (3d ed. 1986).

107. JOINT COMM'N ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 139-47 (1986).

108. See, e.g., *Norris*, 21 N.C. App. at 627, 205 S.E.2d at 348. The court's opinion in *Norris* illustrates how harmful evidence of such a standard can be: "[T]he jury could legitimately find that [plaintiff's] injury was a reasonably foreseeable consequence of the failure of defendant's employee to observe the very precautions set forth in defendant's own safety bulletin, which were clearly designed to protect against the exact hazard which [plaintiff] encountered." *Id.* The *Norris* case is discussed *supra* text accompanying notes 86-90.

109. 101 Nev. 542, 706 P.2d 1383 (1985).

110. *Id.* at 546, 706 P.2d at 1386.

111. The testimony was excluded on the basis of the witness' unfamiliarity with the local standard of care. The Nevada Supreme Court judicially adopted a national standard for hospital liability. *Id.* at 546-47, 706 P.2d at 1386-87.

112. *Id.* at 549, 706 P.2d at 1388.

113. *Id.* at 550, 706 P.2d at 1388-89.

*Inc.*¹¹⁴ In *Makas* plaintiff alleged that defendant nursing home had acted negligently in caring for plaintiff's decedent. Plaintiff offered no expert witnesses and instead offered the Nursing Home Patients' Bill of Rights¹¹⁵ as the standard of care. Plaintiff contended that "under the doctrine of negligence per se, she needed only to offer evidence of a violation of the statute which proximately caused injury to plaintiff."¹¹⁶ The court held that, as a matter of law, the Patients' Bill of Rights did not establish the standard of care; to hold otherwise would be to disregard section 90-21.12, North Carolina's statutory standard of care for health care providers.¹¹⁷ Although the Patients' Bill of Rights might be relevant in a negligence case to show patients' general expectations of a nursing home, it could not be used to establish negligence per se.¹¹⁸ The case law is uniform in allowing such standards to be admitted as evidence of negligence, but not as establishing negligence per se.

A particular problem in establishing the appropriate standard develops when nurses who practice in expanded roles¹¹⁹ and physicians perform overlapping functions. When a physician testifies in a case involving such a nurse, it often is unclear whether the physician expert witness is describing customary practice for physicians, nurses, or both. When nurses practice in expanded roles, such as nurse anesthetists, nurse midwives, and nurse practitioners,¹²⁰ one would expect the nurse to be held to the standard of a reasonably prudent fellow practitioner. The language of North Carolina's statutory standard, with the phrase "similar training and experience,"¹²¹ points to that result. The standard of care for nurses in specialized roles has not been discussed in the North Carolina cases, although there are several cases in which nurse specialists have been named as defendants.¹²²

114. 589 F. Supp. 736 (M.D.N.C. 1984).

115. N.C. GEN. STAT. § 131E-117 (Supp. 1985) provides a policy statement and imposes requirements for licensed nursing homes regarding the rights of nursing home patients.

116. *Makas*, 589 F. Supp. at 741.

117. *Id.* at 742.

118. *Id.*

119. For a general discussion of role expansion in nursing, see A. RHODES & R. MILLER, *supra* note 1, at 101-02; Bullough, *supra* note 49, at 376-81.

120. For discussions relating to these expanded roles, see Comment, *Nurse Practitioners: Here Today . . . Gone Tomorrow?*, 6 NOVA L.J. 365 (1982); Comment, *The Legal Implications in Utilizing the Nurse Anesthetist in Place of the Anesthesiologist*, 7 WHITTIER L. REV. 855 (1985) [hereinafter Comment, *Legal Implications*]; Note, *Childbearing and Nurse-Midwives: A Woman's Right to Choose*, 58 N.Y.U. L. REV. 661 (1983); Note, *The Role of the Nurse Practitioner: Threatened After Sermchief v. Gonzalez*, 28 ST. LOUIS U.L.J. 493 (1984).

121. See N.C. GEN. STAT. § 90-21.12 (1985). For the full text of this section, see *supra* text accompanying note 13.

122. See, e.g., *Azzolino v. Dingfelder*, 71 N.C. App. 289, 322 S.E.2d 567 (1984) (standard of care for family nurse practitioner not discussed because proximate causation not established), *aff'd in part and rev'd in part*, 315 N.C. 103, 337 S.E.2d 528 (1985); *Parks v. Perry*, 68 N.C. App. 202, 314 S.E.2d 287 (physician used as expert witness, but unclear whether testifying regarding customary practice for anesthesiologist or nurse anesthetist), *disc. rev. denied*, 311 N.C. 761, 321 S.E.2d 142 (1984); *Bentley v. Langley*, 39 N.C. App. 20, 249 S.E.2d 481 (affidavit of anesthesiologist sufficient to oppose summary judgment, but conclusory statements contained therein regarding defendant's negligence failed to specify physician or nurse anesthetist standard of care), *disc. rev. denied*, 296 N.C. 735, 254 S.E.2d 176 (1978); *Starnes v. Charlotte-Mecklenburg Hosp. Auth.*, 28 N.C. App. 418, 221 S.E.2d 733 (1976) (issue was whether nurse anesthetist was responsible for maintaining infant's temperature during surgery, not the appropriate standard of care).

Other jurisdictions have considered the question of the standard of care for nurses in specialized roles. In *Fein v. Permanente Medical Group*¹²³ the California Supreme Court found erroneous a jury instruction that read "the standard of care required of a nurse practitioner is that of a physician and surgeon . . . when the nurse practitioner is examining a patient or making a diagnosis."¹²⁴ The court held that the proper standard was that of a reasonably prudent nurse practitioner.¹²⁵ An Illinois court took a different approach in *Northern Trust Company v. Louis A. Weiss Memorial Hospital*,¹²⁶ holding that whether a nurse working in a hospital nursery was to be held to a standard of care of a competent nurse or to the standard of a nurse specially trained in the care of newborns was a question for the jury.¹²⁷ Thus, when a board of health regulation required a specially trained nurse to supervise the nursery at all times, the jury was justified in finding for defendant nurse by holding her to a competent but not specialized nurse standard, yet finding against defendant hospital by holding the hospital liable for failing to provide a specially trained nurse.¹²⁸

One commentator has criticized determining the standard of care by the identity of the actor in areas of overlapping practice. "The standard of medical care to which patients are entitled should not depend on the health care deliverer. All patients should receive the same high-quality care, regardless of whether the care is rendered by the anesthesiologist or nurse anesthetist."¹²⁹ This view, however, ignores the economic realities of our health care system and is unfair to practitioners. Society has limited resources to expend on health care; use of nurses in expanded roles helps to allocate those resources so that patients in low-risk situations can receive less expensive health care.¹³⁰ Although nurse specialists' and physicians' functions often overlap, their education and approach to problems is not identical. A practitioner, physician or nurse, who is operating within the prerogatives of his or her license and delivering an acceptable level of health care should not be subject to second-guessing by one who does not approach and evaluate problems in the same context.

Nurses who practice outside the limitations of their licenses may be held to the standard of the professional who is expected to perform the prohibited function. Thus, the Washington Supreme Court held a practical nurse to the standard of a registered nurse when she administered a polio booster shot to a child and the needle broke off in the child's buttock.¹³¹ A Washington state statute required that registered nurses administer such injections. The court held that

123. 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (en banc), *appeal dismissed*, 106 S. Ct. 214 (1985).

124. *Id.* at 149-51, 695 P.2d at 673-74, 211 Cal. Rptr. at 376-77.

125. *Id.* at 150, 695 P.2d at 674, 211 Cal. Rptr. at 377.

126. 493 N.E.2d 6 (Ill. App. Ct. 1986).

127. *Id.* at 10.

128. *Id.*

129. Comment, *Legal Implications*, *supra* note 120, at 866.

130. See generally Kissam, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 U. KAN. L. REV. 1 (1975) (discussing the use of "allied" health personnel as a means of expanding the supply of medical care and reducing its cost).

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

"one who undertakes to perform the services of a trained or graduate nurse must have the knowledge and skill possessed by a *licensed registered nurse*."¹³² The court further held that "the failure of [the nurse] to be so licensed raises an inference that she did not possess the required knowledge and skill to administer the inoculation in question."¹³³

North Carolina courts apparently have not yet considered the issue of a nurse practicing outside the scope of the nursing license. The practice of nursing is regulated by mandatory licensure in North Carolina.¹³⁴ Nursing is defined under North Carolina's Nursing Practice Act¹³⁵ as follows:

"Nursing" is a dynamic discipline which includes the caring, counseling, teaching, referring and implementing of prescribed treatment in the prevention and management of illness, injury, disability or the achievement of a dignified death. It is ministering to; assisting; and sustained, vigilant, and continuous care of those acutely or chronically ill; supervising patients during convalescence and rehabilitation; the supportive and restorative care given to maintain the optimum health level of individuals and communities; the supervision, teaching, and evaluation of those who perform or are preparing to perform these functions; and the administration of nursing programs and nursing services.¹³⁶

The North Carolina statutory provisions regarding nurse practitioners¹³⁷ and midwives¹³⁸ are not included under the Nursing Practice Act.

It is evident from examining the statutory definition of nursing that its terms are insufficiently specific to provide guidance on the issue of licensure boundaries. Another statutory definition provides general categories of accepted nursing practice for a registered nurse:

The "practice of nursing by a registered nurse" consists of the following nine components:

- a. Assessing the patient's physical and mental health, including the patient's reaction to illnesses and treatment regimens;
- b. Recording and reporting the results of the nursing assessment;
- c. Planning, initiating, delivering, and evaluating appropriate nursing acts;
- d. Teaching, delegating to or supervising other personnel in implementing the treatment regimen;
- e. Collaborating with other health care providers in determining the appropriate health care for a patient but, subject to the provisions of G.S. 90-18.2, not prescribing a medical treatment regimen or making a medical diagnosis, except under supervision of a licensed physician;

132. *Id.* at 143, 411 P.2d at 863.

133. *Id.*

134. N.C. GEN. STAT. § 90-171.19 (1985). See generally Bullough, *supra* note 49 (discussing the history of American nursing licensure and practice acts).

135. N.C. GEN. STAT. §§ 90-171.19 to .47 (1985).

136. *Id.* § 90-171.20(4).

137. See *id.* § 90-18.2.

138. See *id.* §§ 90-178.1 to .7.

- f. Implementing the treatment and pharmaceutical regimen prescribed by any person authorized by State law to prescribe such a regimen;
- g. Providing teaching and counseling about the patient's health care;
- h. Reporting and recording the plan for care, nursing care given, and the patient's response to that care; and
- i. Supervising, teaching, and evaluating those who perform or are preparing to perform nursing functions and nursing services.¹³⁹

Although the components listed are much more specific than the actions listed in the definition of nursing, questions about the scope of nursing practice under the Act inevitably arise. It would be impossible to define by statute all specific, acceptable nursing functions, especially in light of the rapid advances being made in medical technology. Thus, such questions as whether a registered nurse can administer medication to patients in a venereal disease clinic on the basis of standing orders in the absence of a physician and whether a registered nurse can administer caudal analgesia (via a spinal needle) after placement of the needle by a physician have arisen. In advisory opinions by the state attorney general, both questions have been answered affirmatively,¹⁴⁰ although it would be difficult to predict the answers from the statutory language. Cases such as *Sermchief v. Gonzales*¹⁴¹ illustrate the difficulties and interests at stake in drawing the line between the practices of nursing and medicine. In *Sermchief*, a Missouri case, nurses and physicians working in a nonprofit clinic providing obstetric and gynecologic services to lower-income patients sought a declaratory judgment and injunction. Plaintiffs asked the court to declare that certain practices at the clinic were authorized under the nursing laws of the state and did not constitute the unlicensed practice of medicine.¹⁴² The Missouri Supreme Court, reversing the lower court, held for plaintiffs-appellees.¹⁴³

Jurisdictions differ in holding nurses and physicians to the standard of a professional in the same community, same or similar community, or the nation. North Carolina judicially adopted a "same or similar community" standard in *Wiggins v. Piver*¹⁴⁴ and the general assembly codified this standard in North Carolina General Statutes section 90-21.12.¹⁴⁵ The courts have not suggested specific criteria for qualification as a "similar community"; indeed, research reveals no reported cases in which one North Carolina community has been considered insufficiently similar to another, so that expert testimony has been disqualified. In *Page v. Wilson Memorial Hospital, Inc.*¹⁴⁶ the trial court ex-

139. *Id.* § 90-171.20(7).

140. See 50 Op. N.C. Att'y Gen. 9 (Sept. 12, 1980) (answering the question whether a nurse is authorized to issue medication pursuant to a standing order in a venereal disease clinic); 49 Op. N.C. Att'y Gen. 85 (Dec. 17, 1979) (answering the question whether a registered nurse is authorized to administer caudal analgesia after placement of the needle by a physician).

141. 660 S.W.2d 683 (Mo. 1983) (en banc).

142. *Id.* at 684.

143. *Id.*

144. 276 N.C. 134, 171 S.E.2d 393 (1970).

145. See N.C. GEN. STAT. § 90-21.12 (1985). For the full text of § 90-21.12, see *supra* text accompanying note 13.

146. 49 N.C. App. 533, 272 S.E.2d 8 (1980).

cluded a nurse's expert testimony on the basis that plaintiff had failed to produce evidence that the communities with which the nurse was familiar were similar to the community where the alleged act of negligence occurred.¹⁴⁷ The nurse expert was a registered nurse and had taught nursing students in Rocky Mount, Williamston, Greenville, and Washington, North Carolina. The court of appeals found the expert testimony admissible and granted a new trial, stating "we suggest that nursing practices in connection with patients' use of a bedpan are so routine and uncomplicated that the standard of care should not differ appreciably between . . . Wilson and the neighboring counties of Nash and Pitt, or nearby Martin County."¹⁴⁸

In *Haney v. Alexander*¹⁴⁹ the North Carolina Court of Appeals stated that when the standard of care was the same nationwide, "an expert witness familiar with that standard may testify despite his lack of familiarity with the defendant's community."¹⁵⁰ The witness had stated that the standard for nurses taking vital signs on a deteriorating patient was the same in accredited hospitals nationwide.¹⁵¹ The expert also testified that he was familiar with the standard of care in communities similar to the one in question.¹⁵² Going even further than the North Carolina Court of Appeals in *Haney*, the Nevada Supreme Court in *Wickliffe* rejected the "locality rule" for hospital liability and adopted a national standard. The court discussed the particular advisability of a national standard for nursing practice in light of standardized nursing education and licensing examinations.¹⁵³ Therefore, suits involving routine nursing functions could lead to the routine application of a national standard, although it is unlikely that attorneys will risk using experts unfamiliar with the standard of care in a similar community.

As the nursing profession matures, nurses are moving into positions involving increasing responsibility and accountability. Legal liability inevitably follows. The current status of North Carolina law leaves the nurse vulnerable in several areas, such as the right to use professional judgment in disobeying physicians' orders, the routine and unquestioned use of doctors to establish a nursing standard of care, and the question of what standard will be used to measure the performance of nurses in expanded roles. In fairness to both nurses and their patients, courts should place *Byrd* in its proper historical context and recognize the right and duty of professional nurses to exercise judgment in carrying out physicians' orders. Courts should not automatically accept physicians as experts on customary practice among professional nurses, but should allow them to testify as experts only if they are shown to be well acquainted with the customary standard among nurses. Finally, nurse practitioners should be judged by the

147. *Id.* at 535, 272 S.E.2d at 10.

148. *Id.* at 536, 272 S.E.2d at 10.

149. 71 N.C. App. 731, 323 S.E.2d 430 (1984), *disc. rev. denied*, 313 N.C. 329, 327 S.E.2d 889 (1985).

150. *Id.* at 736, 323 S.E.2d at 434.

151. *Id.*

152. *Id.*

153. *See Wickliffe*, 101 Nev. at 546-47, 706 P.2d at 1386-87.

standard of a reasonably prudent nurse practitioner when practicing within the scope of their licenses. The net result would be accountability of professional nurses for their expertise and education, yet protection from liability for a standard of care they have not assumed.

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