The Scope of a Nurse's Duty of Care in Utah

by Michael A. Worel, Esq.; David G. Wirtes Jr., Esq.; and Michael W. Young, Esq.

Florence Nightingale established nursing principles – including careful observation and sensitivity to the patient's needs – in her best-known work, *Notes on Nursing,* in 1860.[1] Almost 150 years later, these principles still resonate in the nursing profession. According to the American Nurses Association (ANA), "The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient."[2]

But what should happen when a nurse's failure to promote or advocate for his or her patient's health, safety, or rights results in injury? Are nurses expected simply to follow doctors' orders, or are they bound to question those orders when something is amiss?

Consider an example: An elderly woman on Coumadin, an anticoagulant, falls and hits her head. She goes to the emergency room with an obvious head wound, but the emergency room physician elects not to order a CT scan, choosing instead to place the woman in the hospital for observation.

The next day, over the course of five hours, the patient deteriorates neurologically. On four different occasions, the nurse informs the attending physician, who is out of the hospital, of the progressive deterioration, but the doctor elects not to visit the patient and instead enters phone orders for medications. The woman becomes comatose and is transferred to another hospital, where she receives a CT scan, and a subdural hematoma is discovered. The woman dies.

When the woman's family files suit, they learn that the physicians have woefully inadequate insurance coverage. Is there a way to impose liability on the hospital for the acts and omissions of its nurses even though the physicians arguably were principally

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at fault? One area of potential nursing liability that plaintiff lawyers should thoroughly explore is whether the nurse failed to fulfill his or her duty as an advocate for the patient.

It is axiomatic that nurses serve as advocates for their patients. When something goes wrong and a doctor breaches the standard of care, the nurse has a duty to speak up.

The ANA's *Code of Ethics for Nurses* describes this duty:

> As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interest of the patient in jeopardy. To function effectively in this role, nurses must be knowledgeable about the Code of Ethics, standards of practice of the profession, relevant federal, state, and local laws and regulations, and the employing organization's policies and procedures.[3]

In our hypothetical scenario, this duty required the nurse to follow a chain-of-command protocol to seek consultation with another physician to protect the patient from the attending physician's negligence. Hospitals routinely have policies and procedures in place that outline the steps to be followed. The nurse's failure to act as an advocate for the patient was a breach of duty that exposed the hospital to liability for the patient's injuries.

Evolution of the Duty

An early and oft-cited case on the subject of a nurse's duty to question a doctor's orders is the Illinois Supreme Court's 1965 decision in *Darling v. Charleston Community Memorial Hospital*.[4] The plaintiff in that case went to a hospital with a broken leg. After a cast was placed on it, he experienced great pain and his toes became swollen and dark, then cold and insensitive. Ultimately, his leg had to be amputated below the knee.

In his lawsuit against the hospital, the plaintiff claimed that "either the nurses were derelict in failing to report developments in the case to the hospital administrator, he was derelict in bringing them to the attention of the medical staff, or the staff was negligent in failing to take action."[5] The jury found for the plaintiff.

Upholding that verdict, the Illinois high court found that the

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jury could reasonably have concluded that skilled nurses would have recognized the dangerous circulation problems and informed hospital authorities if the attending physician failed to act.[6] Many jurisdictions cite the holding in the Darling case on this point.

In 1968, the Court of Appeals of New York ruled in *Toth v. Community Hospital at Glen Cove* that "the primary duty of a hospital's nursing staff is to follow the physician's orders," but then stated in a footnote that "an exception to the rule would exist where the hospital staff knows that the doctor's orders are so clearly contraindicated by normal practice that ordinary prudent [sic] requires inquiry into the correctness of the orders."[7] Subsequent cases have extended this requirement "to a situation in which hospital personnel *should have known* that the physician's orders were clearly contraindicated."[8]

Despite the clear statements of a nurse's duty to question a physician's orders in both *Darling* and *Toth*, few cases were reported on the subject until a 1977 case triggered the rule's resurrection.

In *Utter v. United Hospital Center, Inc.*, the West Virginia Supreme Court reinstated a verdict against a hospital, holding that credible evidence existed that the hospital's nursing staff negligently provided care for a patient. The court noted that the patient's "deterioration continued even though the nurses called the treating physician and he, on some occasions, visited and treated the patient."[9] The court relied largely on a nursing manual, noting, "When the doctor did nothing further, the nurse did not call the departmental chairman or any other doctor as required by the pertinent provision of the nursing manual."[10] The opinion includes this strong language:

> Nurses are specialists in hospital care who, in the final analysis, hold the well-being, in fact in some instances, the very lives of patients in their hands. In the dim hours of the night, as well as in the light of day, nurses are frequently charged with the duty to observe the condition of the ill and infirm in their care. If that patient, helpless and wholly dependent, shows signs of worsening, the nurse is charged with the obligation of taking some positive action.[11]

The Utah Court of Appeals adopted this very language in examining the standard of care applicable to nurses.[12] In expounding on a nurse's duty, the court in *George v. LDS Hospital*[13] noted that in medical malpractice actions a plaintiff must provide expert testimony establishing: (1) the relevant standard of care; (2) the defendant's failure to comply with that standard; and (3) the defendant's failure to comply with that standard caused plaintiff's injuries.[14] Within this context, the court explained that a jury must be able to consider whether a hospital's failure to notify doctors of a patient's declining status was a breach of the duty owed to the patient.[15] Specifically, because a nurse "hold[s] the well-being, in fact in some instances, the very lives of patients in their hands…a nurse may have a duty to notify her supervisor that a life-threatening situation exists and that failure to perform this duty may be a proximate cause of plaintiff's additional injury."[16] While not specifically on point, the *George* decision lends itself to the argument that the same reasons would apply to hold the nurse liable for failing to notify a supervisor if a doctor had been given the proper information and failed to appropriately respond.

"…a nurse may have a duty to notify her supervisor that a life-threatening situation exists and that failure to perform this duty may be a proximate cause of plaintiff;s additional injury.'"

The implications of a nurse's breach of duty have several layers under Utah law. The Utah Supreme Court, in *Butterfield v. Okubo*, reversed an underlying summary judgment ruling and found that an emergency room nurse's failure to produce records from a patient's prior examination created a sufficient question of fact exposing the hospital to *respondeat superior* liability.[17] The *Butterfield* court's ruling highlights how a nurse's duty of care will be evidenced by various formulations and the context of the breach of duty will inform the theory of liability. In *Butterfield*, the theory of liability was rooted in the standard of care for managers of medical records.[18] However, it is important to remember that nurses often perform various functions within a patient's chain of care and while the duty to advocate for their patients remains consistent, the particulars of that duty might vary from one context to the next.

Nursing Standards

According to the ANA's *Nursing's Social Policy Statement*, "all nurses are responsible for practicing in accordance with recognized standards of professional nursing practice and professional performance."[19] The ANA says that such standards "define the nursing profession's accountability to the public and the outcomes for which registered nurses are responsible."[20] Nurses follow standards issued by several different entities.

States typically have administrative codes called Nurse Practice Acts.[21] Each state's act is different, but most require nurses to be responsible and accountable for the quality of care they give patients. Elements of Utah's Nurse Practice Act are found both in statutory code[22] and administrative rules[23] composed and organized by the Utah Division of Administrative Rules per the Utah Administrative Rulemaking Act.[24]

Notable elements of the Utah Code dealing with a nurse's accountability discuss both unlawful[25] and unprofessional[26] conduct of nursing professionals. Also of interest is the general prohibition against nurses practicing outside the limits of their competency.[27] Utah courts have noted that the public's interest in a certified professional's performance is paramount.[28] Nevertheless, case law critically examining the statutory elements of the Utah Nurse Practice Act is sparse. A survey of the relevant statutory provisions, however, provides ample fodder for a practitioner seeking to establish a nurse's duty of care.

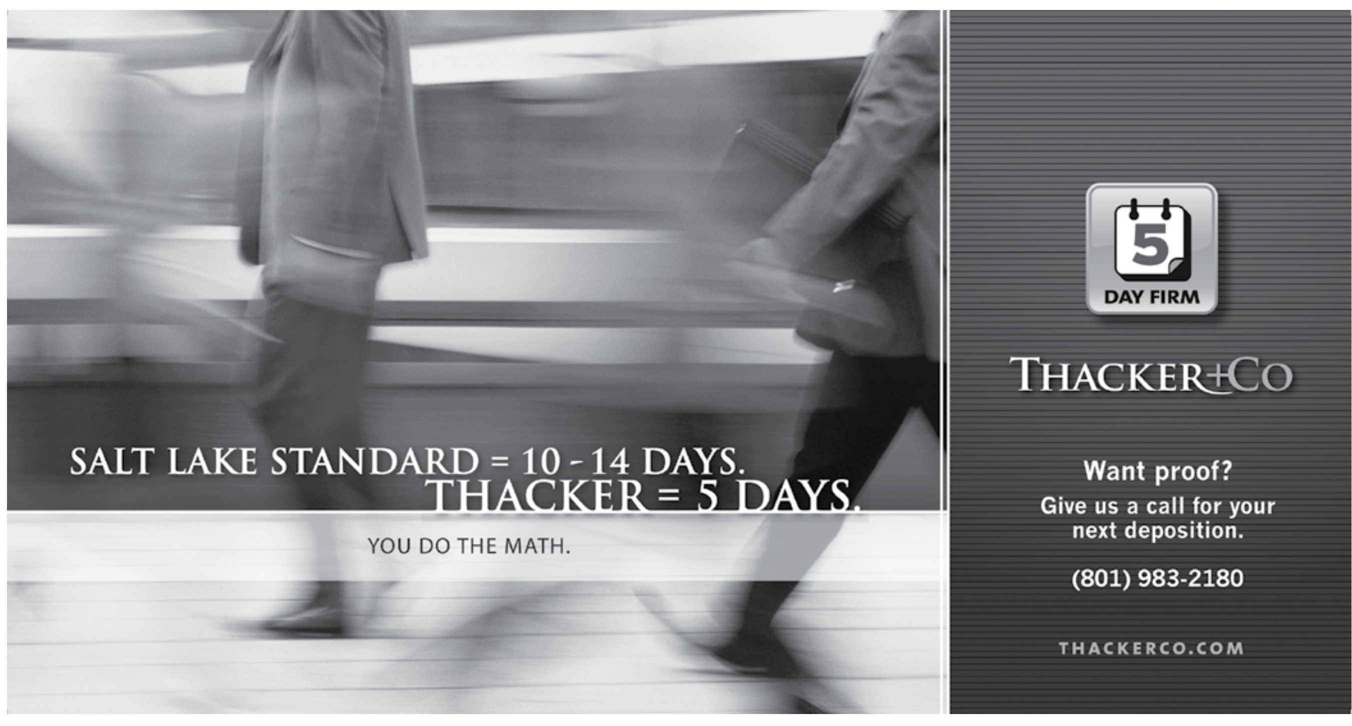
For example, Utah Code Ann. § 58-31b-502 defines "unprofessional conduct" for nurses. Among the myriad of behaviors prohibited by the statute is "the failure to provide nursing service…in a manner that demonstrates respect for the patient's human dignity and unique personal character and needs without regard to the patient's race, religion, ethnic background, socioeconomic status, age, sex, or the nature of the patient's health problem."[29] Equally broad are prohibitions against "unlawful or inappropriate delegation of nursing care" or "failure to exercise appropriate supervision of persons providing patient care."[30]

In addition to the elements of the Nurse Practice Act codified by statute, a practitioner may also look to the Nurse Practice Act Rule in establishing a relevant duty of care. These rules are generally more specific and may be more or less useful depending on the facts at issue in a particular case.

For example, rules R156-31b-702 and 703 establish the scope of practice for a Licensed Practical Nurse and a Registered Nurse respectively.[31] These provisions provide detailed requirements focused on patient care and the obligations of nurses assuming such care. These duties and obligations speak not only to patient care, but also place requirements on nursing professionals related to communication with other nurses and health care professionals.[32]

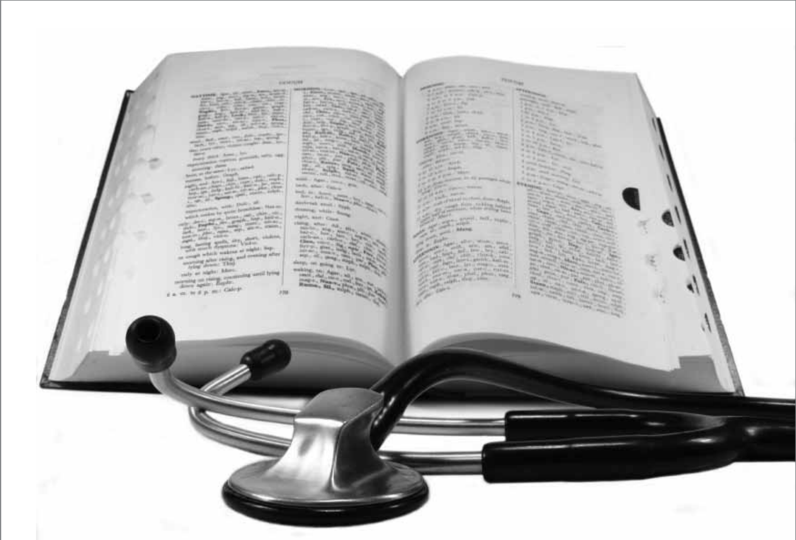
According to the ANA, "Nurse Practice Acts grant nurses the authority to practice and grant society the authority to sanction nurses who violate the norms of the profession or act in a manner that threatens the safety of the public."[33]

As previously noted, case law in Utah examining and applying Nurse Practice Act standards is undeveloped. Notwithstanding this limitation, one can arguably use these state standards to define the standard of care. The Ohio Supreme Court, for example, held that "the statutory standards for licensure are relevant to the standard of conduct required of licensed nurses in Ohio, and may be used to prove that standard."[34]



The Nebraska Supreme Court held that the state department of health standards and regulations may be relevant as evidence of the standard of care.[35] In Illinois, "not only may expert medical testimony establish the applicable standard of care, but regulations, standards, and hospital bylaws are also admissible."[36] In Texas, "it is well-established that state health regulations, national standards, and organizational bylaws are admissible to define the standard of care customarily offered."[37]

Courts in other states have also allowed the use of Nurse Practice Act standards to support an award of punitive damages. In *Convalescent Services, Inc. v. Schultz*, a Texas appeals court held that testimony regarding violations of that state's Nurse Practice Act, coupled with other evidence, would have allowed a fact-finder to "reasonably infer that by knowingly or consistently failing to comply with the proper nursing standards, [the defendant] showed conscious disregard for [the plaintiff's] health and safety."[38] Such evidence also supported the jury's finding of gross negligence and an award of punitive damages.



Nursing Organization Standards

Another approach to establishing the nursing standard of care is to combine the ANA standards and the relevant state Nurse Practice Act standards with those promulgated by professional nursing organizations.

For example, specialty groups such as the Nurses Association of the American College of Obstetricians and Gynecologists and the American Association of Critical-Care Nurses have their own standards. The latter is the largest specialty nursing organization, with more than 68,000 members. Its standards require that critical care nurses "intercede for patients who cannot speak for themselves in situations that require immediate action" and "monitor and safeguard the quality of care the patient receives."[39]

Last year, Okalahoma Supreme Court Justice Marian Opala wrote in a concurring opinion in *Gaines v. Comanche County Medical Hospital*, "While private standards promulgated by standards-making organizations have no official or legal status except to govern the conduct of the profession and industry, courts generally admit them unless a challenge is sustained."[40] Opala also noted that nursing codes of ethics produced by the ANA, other organizations, and individual hospitals provide evidence of standards of care.[41]

Nursing Literature

General nursing textbooks and specialist journals can help establish the standard of care. For instance, many nursing schools use the general textbook *Foundations of Nursing Practice*, which asserts that a nurse must ensure that a physician's orders are clear and will not harm the patient.

This textbook lays out appropriate steps for ensuring clarity of orders, such as contacting the nurse manager or the physician's immediate superior, and it emphasizes caution: "It is clear that although others may be held liable for an incorrect order that results in harm to a client, the nurse surely can be held responsible for carrying out an order that would have been questioned by other reasonably prudent nurses in the same or similar circumstances."[42]

Another well-established nursing textbook, *Illustrated Manual of Nursing Practice*, states, "Nurses are responsible for helping patients receive adequate and safe care. If a nurse fails to identify a situation in which reasonable standards of care have been violated, the nurse and any other participating health care professional may be liable."[43] Another textbook states, "Nurses may share liability for errors made by physicians.…A nurse should not proceed to perform a physician's order if it is foreseeable that harm will come to the client."[44]

Nursing journals may also provide helpful information. For instance, an article in the *Journal of Advanced Nursing* notes that "polices and protocols of critical care activities provided nurses with expected standards of care which they used to legitimize their knowledge and to communicate

with doctors about 'undesirable' medical decisions."[45] An article in the *Journal of Perinatal & Neonatal Nursing* explains that a perinatal nurse's duty "has been affirmed by a growing body of case law" and states that "even in emergency situations, the nurse is expected to exercise professional judgment in evaluating the provider's orders."[46]

Risk Management Publications

You also may find risk management publications, often easily accessible on the Internet, useful in establishing the standard of care. For instance, one article by a legal nurse consultant states:

> As a nurse, you're in a unique position to notice the subtle changes that can mean your patient is improving or losing ground…. It's your responsibility to pass that information along to someone who has the means and authority to interpret and act on it, for the good of your patient. If that person doesn't respond adequately, you must go to the next level of authority in the chain of command.[47]

Hospital Policies and Procedures

Each hospital has its own chain-of-command policy, which you should request early in discovery. A hospital's failure to have such a policy in place or failure to abide by it can form the basis of a cause of action.[48]

Such policies and procedures often set forth clear guidance to nurses but are rarely consulted until after the damage is done and lawyers get involved. But these policies and procedures can be used to define the standards of care and their breach.

For a jury to rule in the plaintiff's favor, in our initial scenario, it would be critically important to establish through the above resources that the physician's negligent act – of either commission or omission – should have been recognized by a reasonably prudent nurse and that the nurse should have recognized that harm to the patient was likely. If, for example, a certain diagnostic test is routinely ordered in a particular setting, but the doctor failed to order one in your case, you should use multiple textbooks, articles, and policies and procedures to establish how routine the test is and how obvious it should have been to the nurse that the failure to perform the test could have grave consequences for the patient.

The resources you use must be so overwhelming that anyone examining the nurse's actions must conclude that the nurse acted not merely negligently, but also illogically, in failing to step forward as an advocate for the patient.

1. Florence Nightingale, Notes on Nursing: What It Is, and What It Is Not (D. Appleton & Co. 1860).
2. Am. Nurses Ass'n, *Code of Ethics for Nurses with Interpretive Statements* § 3, at 12 (Am. Nurses Publ'g 2001).
3. *Id.* § 3.5, at 14.
4. *Darling v. Charleston Cmty. Mem. Hosp.*, 211 N.E.2d 253 (Ill. 1965).
5. *Id.* at 256.
6. *Id.* at 258.
7. *Toth v. Cmty. Hosp. at Glen Cove*, 239 N.E.2d 368, 449 n.3 (N.Y. 1968).
8. *Warney v. Haddad*, 654 N.Y.S.2d 138, 139 (App. Div. 1997) (quoting *Christopher v. St. Vincent's Hosp. & Med. Ctr.*, 504 N.Y.S.2d 102, 105 (App. Div. 1986)) (emphasis added).
9. *Utter v. United Hosp. Ctr.*, 236 S.E.2d 213, 215 (W. Va. 1977).
10. *Id.*
11. *Id.* at 216.
12. In addition to Utah, numerous other state courts have applied a similar duty of care to nurses. In *Bost v. Riley*, the Court of Appeals of North Carolina cited *Darling* and held that a hospital has a duty "to make a reasonable effort to monitor and oversee the treatment which is prescribed and administered by physicians practicing at the facility," and that a nurse "has the duty not to obey instructions of a physician which are obviously negligent or dangerous." *See Bost v. Riley*, 262 S.E.2d 391, 396 (N.C. App. 1980). The Indiana Court of Appeals followed *Darling* and *Toth* in *Poor Sisters of St. Francis Seraph of Perpetual Adoration, Inc. v. Catron.*, 435 N.E.2d 305 (Ind. App. 1982). The court held that hospital employees' failure to recognize and report changes in a patient's condition may constitute a breach of the standard of care. Id. at 308 (citing *Toth*, 239 N.E.2d 368); *see also Vogler v. Dominguez*, 624 N.E.2d 56, 63 (Ind. App. 1993), (stating that "[i]f a nurse or other hospital employee fails to report changes in a patient's condition and/or question a doctor's orders when they are not in accord with standard medical practice and the omission results in injury to the patient, the hospital will be liable for its employee's negligence"). The Kentucky Court of Appeals held in *NKC Hospitals, Inc. v. Anthony* that "the defense that the hospital's nurses were only following a 'chain of command' by doing what Dr. Hawkins ordered is not persuasive. The nurses were not the agents of Dr. Hawkins. All involved had their independent duty to [the patient]." *NKC Hosps., Inc. v. Anthony*, 849 S.W.2d 564, 569 (Ky. App. 1993).
13. *George v. LDS Hosp.*, 797 P.2d 1117 (Utah Ct. App. 1990).
14. *Id.* at 1121.
15. *Id.*
16. *Id.*
17. *Butterfield v. Okubo*, 831 P.2d 97, 104 (Utah 1992).
18. *Id.*
19. Am. Nurses Ass'n, *Nursing's Social Policy Statement* 8 (2d ed., Am. Nurses Publ'g 2003).
20. Am. Nurses Ass'n, *Nursing: Scope and Standards of Practice* 1 (Am. Nurses Publ'g 2004).
21. Frank J. Cavico & Nancy M. Cavico, *The Nursing Profession in the 1990s: Negligence and Malpractice Liability*, 43 Clev. St. L. Rev. 557, 566 (1995) ("[E] very jurisdiction that licenses nurses has a Nurse Practice Act which is designed to protect the public by defining the scope of nursing.").
22. Utah Code Ann. § 58-31b-101 *et seq.* (2010).
23. Utah Admin. Code r. 156-31b-101 *et seq.* (2010).
24. Utah Code Ann. § 63G-3-101 *et seq.* (2010).
25. Utah Code Ann. § 58-31b-501.
26. Utah Code Ann. § 58-31b-502.
27. Utah Code Ann. § 58-31b-801 (2010).
28. *See* note 18, *supra*, at 129.
29. Utah Code Ann. § 58-31b-502(2).
30. Utah Code Ann. § 58-31b-502(9)-(10).
31. Utah Admin. Code r. 156-31b-702-31b-703.
32. *Id.*
33. *See* Cavico & Cavico, *supra* n. 15, at 566-67 & n.
34. *Berdyck v. Shinde*, 613 N.E.2d 1014, 1023 (Ohio 1993).
35. *Foley v. Bishop Clarkson Mem'l Hosp.*, 173 N.W.2d 881, 884 (Neb. 1970).
36. *Taylor v. City of Beardstown*, 491 N.E.2d 803, 811 (Ill. App. 1986) (citing *Darling*, 211 N.E.2d 253).
37. *Hernandez v. Nueces Co. Med. Soc'y Cmty. Blood Bank*, 779 S.W.2d 867, 871 (Tex. App. 1989).
38. *Convalescent Servs., Inc. v. Schultz*, 921 S.W.2d 731, 738 (Tex. App. 1996).
39. Am. Ass'n of Critical-Care Nurses, *AACN Public Policy 12, What Critical Care Nurses Do* (AACN May 2001).
40. *Gaines v. Comanche County Med. Hosp.*, 143 P.3d 203, 213 n.5 (Okla. 2006) (Opala, J., concurring) (citing Marian P. Opala, *The Anatomy of Private Standards-Making Process: The Operating Procedures of the USA Standards Institute*, 22 Okla. L. Rev. 45, 63-66 (1969)).
41. *Gaines*, 143 P.3d at 212 n. 3; *see also Bala v. Powers Ferry Psychol. Assocs.*, 491 S.E.2d 380, 381 (Ga. App. 1997) (citing *Allen v. Lefkoff, Duncan, Grimes & Dermer, P.C.* , 453 S.E.2d 719 (Ga. 1995)).
42. *Foundations of Nursing Practice: A Nursing Process Approach* 70 (Julia M. Leahy & Patricia E. Kizilay eds., 4th ed., W.B. Saunders 1998).
43. *Illustrated Manual of Nursing Practice* 31 (2d ed., Springhouse Corp. 1994).
44. Patricia A. Potter & Anne Griffin Perry, *Fundamentals of Nursing: Concepts, Process, and Practice* 341 (4th ed., Mosby 1997).
45. Elizabeth Manias & Annette Street, *Legitimation of Nurses' Knowledge through Policies and Protocols in Clinical Practice*, 32 J. Adv. Nursing 1467, 1467 (2000).
46. Laura R. Mahlmeister, *The Perinatal Nurse's Role in Obstetric Emergencies: Legal Issues and Practice Issues in the Era of Health Care Redesign*, 10 J. Perinatal & Neonatal Nursing 32, 35 (1996).
47. Diana W. Morgan, *Legally Speaking: Going Up the Chain of Command*, RN 68 (June 2003), http://rnweb.mediwire.com/main/Default.aspx?P=Content&ArticleID=107344.
48. *See* Patricia D. Davis, *The Nurse's Duty to Intervene – Initiating the Chain of Command*, www.thedoctors.com/pdf/riskmanagement/J4242.pdf (2003); Emerg. Care Research Inst., *HRC-Risk Analysis: Risk and Quality Management Strategies 19, Supp. A, Chain of Command* 1 (Sept. 2004) ("Nurses in particular are held professionally accountable for their own actions and have a duty to intervene when medical care does not appear to meet the standard of care.").