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# Note

## AN EXCEPTION TO THE EMPLOYMENT-AT-WILL DOCTRINE FOR NURSES

*Susan R. Gornik*

### INTRODUCTION

**N**URSES WORKING IN employment-at-will positions for large institutions face considerable potential for conflict between following their own judgment and obeying their employers' directives. Under the employment-at-will doctrine, an employer may terminate an employee at any time, for any or no reason.<sup>1</sup> Therefore, a hospital may fire a professional employee for refusing to obey commands, even if the professional's ethical judgment mandated the refusal. Professional nurses employed by hospitals are often faced with this predicament.

Currently, an employed-at-will nurse who refuses to accept her work assignment can be fired from the hospital without legal recourse, even if she<sup>2</sup> believes the work assignment to be beyond her competence. Despite the ethical soundness of her refusal, this nurse has no cause of action against the hospital. This situation allocates all the decision-making power over staffing assignments to the hospital. A nurse, who has been assigned a task that she knows or fears she is not competent to undertake, is faced with a dilemma. She

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1. The employment-at-will doctrine was first pronounced by Wood. See H.G. WOOD, A TREATISE ON THE LAW OF MASTER AND SERVANT, § 133, at 272 (1877). Laissez-faire economic theory of the day held that freedom to contract deserved constitutional protection. See *Coppage v. Kansas*, 236 U.S. 1 (1914)(state law which limited employment-at-will doctrine violated a constitutionally protected property right); *Adair v. United States*, 208 U.S. 161 (1907)(federal legislation which limited the employer's right to dismiss employees violated a liberty and property interest under the Constitution). The doctrine no longer has constitutional protection. See *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1936)(abolishing constitutional right to employment-at-will by protecting unionizing employees from employer retaliation).

2. Although an increasing number of nurses are men, 97% are women. Connie Laueran, *Saturday, Bloody Saturday*, CHI. TRIB., Dec. 10, 1989, § 3 (Sunday Magazine), at C16. This note will use the female pronoun when referring to nurses despite the fact that many nurses are male.

may refuse the assignment at the risk of being fired or accept the assignment at the risk of providing inadequate care to the patient.

This note argues that a nurse who is discharged for refusing to accept an assignment for which she believes she is not qualified should be allowed to bring a wrongful discharge action<sup>3</sup> created by a public policy exception to the employment-at-will doctrine. Recognizing this cause of action for such situations will provide an incentive to hospitals to better allocate decision-making power by including the nurse in hospital staffing decisions. Including the nurse in this decision-making process will yield other positive results that justify the judicial creation of this public policy exception.

## I. THE PROBLEM DEFINED: FACTUAL BACKGROUND

To better appreciate the dilemma faced by nurses it is necessary to understand how hospitals and nurses typically interact.

### A. The Structure of Hospital Employment of Nurses

Hospitals generally employ nurses at three levels, each with a specific function. The first level consists of staff nurses hired to give direct patient care, typically in one particular unit.<sup>4</sup> The second level consists of middle managers and includes both head nurses and nursing supervisors. The head nurse is responsible for hiring and evaluating the nursing staff and for ensuring adequate staffing of her unit on a regular basis.<sup>5</sup> The nursing supervisor's responsibilities include staffing the entire hospital during her shift and supervising the unit head nurses.<sup>6</sup> The third level consists of nurse executives. A nurse executive is responsible for budgeting and acts

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3. For purposes of this note, wrongful discharge also includes constructive discharge. Constructive discharge must be included to prevent the hospital from utilizing other retaliatory techniques, short of actual firing, against the nurse and retaining a voluntary resignation defense. See Jon P. Christiansen, Note, *A Remedy for the Discharge of Professional Employees Who Refuse to Perform Unethical or Illegal Acts: A Proposal in Aid of Professional Ethics*, 28 VAND. L. REV. 805, 830-31 (1975) (arguing that "recovery should be allowed when the employer engages in actions or imposes job requirements that are so unreasonable that they justify the employee's resignation").

4. The term "nurse" used throughout this note refers to a staff nurse. For each shift, a staff nurse acts as "charge nurse" of the unit by being responsible for delegation of work among all health care workers, including nurses and aides. These charge nurses, however, are not considered managers.

5. Mary Wilhite, *Definitions And Descriptions of the Nursing Middle Manager and Nurse Executive*, J. NURSING ADMIN., Oct. 1988, at 6-7. See also Anita L. Beaman, *What Do First-Line Nursing Managers Do?*, J. NURSING ADMIN., May 1986, at 6-8 (study identifying typical head nurse tasks).

6. Wilhite, *supra* note 5, at 6-7.

as a member of the hospital administration.<sup>7</sup>

As mentioned, a staff nurse is typically hired to work in a specific nursing unit within the hospital. Modern nursing units are usually divided according to specialized patient types.<sup>8</sup> Therefore, many nurses practice a very specialized type of nursing. Staffing problems arise when the head nurse of an individual unit is unable to meet shift staffing requirements.<sup>9</sup> These staffing problems are magnified when they develop at the last minute.<sup>10</sup> When a unit needs extra nurses, the head nurse notifies the nursing shift supervisor. The supervisor has two potential responses: (1) send nurses from other areas of the hospital or (2) refuse to send extra help.<sup>11</sup> If nurses are sent from other areas, they are referred to as "floating"; if no help is sent, the unit is designated "understaffed."

Because of nursing shortages,<sup>12</sup> floating and understaffing have become common practices<sup>13</sup> that may be dangerous to patients.<sup>14</sup>

## B. The Problem Created by Current Staffing Methods

Floating and understaffing produce two typical fact patterns that place the nurse in a dilemma between her duty to her employer

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7. *Id.*

8. For example, one unit may contain only pediatric patients, while another may accommodate only open heart surgery patients.

9. Sick calls, chronic shortages of personnel and failure to elicit overtime hours from regular staff nurses are just a few of the several fact patterns that can result in understaffing for a given shift.

10. Edith Kelly Politis, Note, *Nurses' Legal Dilemma: When Hospital Staffing Compromises Professional Standards*, 18 U.S.F. L. REV. 109, 119 (1983).

11. Carol Maier Boston & Sarah Karzel, *Will the Nursing Shortage Lead to Liability Suits?*, HOSPITALS, Nov. 20, 1987, at 64, 65. The hospital may also get outside agency nurses if they have a contract with an agency which has nurses available to work. Although, this contingency is sometimes utilized, hospitals prefer to use only their own staff because it is less expensive. This note examines staffing problems regarding the hospital as a closed system, not inclusive of outside agency nurses. For a discussion of issues regarding the use of agency nurses, see Diana L. Nolte Huff, *Liability Issues Arising From Hospitals' Use of Temporary Supplemental Staff Nurses*, 21 LOY. U. CHI. L.J. 1141 (1990).

12. See *infra* notes 19-25 and accompanying text.

13. Most hospitals outline a floating policy in the hospital handbook. Boston & Karzel, *supra* note 11, at 64.

14. Though not widespread, there have been reports of increased drug errors and patient falls attributed to "unrealistic and inappropriate" nurse workloads. SECRETARY'S COMMISSION ON NURSING, FINAL REPORT, VOL. I 13 (1988)[*hereinafter* COMMISSION ON NURSING]. A nurse sent to a specialty unit who is unfamiliar with the physical layout, procedures performed, or type of patients treated, may be less than satisfactory help and even dangerous to safe patient care. The danger of this unfamiliarity is multiplied if the nurse possesses inadequate knowledge and skill to operate the technical equipment encountered. Dolores M. Garlo, Comment, *Critical Care Nurses: A Case For Legal Recognition of the Growing Responsibilities and Accountability in the Nursing Profession*, 11 J. CONTEMP. L. 239, 274 (1984).

and her duty to her patients. The first fact pattern concerns floating. The nurse may be floated by the nursing supervisor to a specialty unit that requires experience or special training that the nurse feels she lacks. For example, a nurse who usually works in an open heart surgical intensive care unit is unlikely to have experience caring for burn victims; nonetheless, she may be sent to work a shift in the burn unit. The second fact pattern concerns understaffing. Often, due to a lack of staff resources, a nurse may be assigned more patients than for whom she believes she can adequately provide care.<sup>15</sup>

In both situations, the nurse must use her professional judgment to assess her patients' needs, based on their diagnoses and on medical and nursing plans of care, and to determine if she has the ability and time to adequately meet those needs. It is not just a question of what mechanical tasks a nurse must perform in a given period under doctors orders, but includes an assessment of *all* of her patients' needs.<sup>16</sup> An "unsafe assignment" exists when the nurse is unable to meet the patients' needs.<sup>17</sup> A conflict develops when the nurse has assessed an assignment as unsafe but the hospital requires her to take the assignment anyway.<sup>18</sup> This problem impacts not only the nursing profession, but also the quality of patient care.

### C. The Outlook for Staffing Methods

Since these staffing techniques have been necessitated by shortages in the work force, available data suggests that they will be used more frequently in the future. The nursing shortage has worsened in recent years.<sup>19</sup> It is estimated that by the year 2000, the

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15. The assessed resources include available ancillary personnel, not just other nurses.

16. For example, the patient may be on certain medication that requires increased observation which is not reflected in the simple medication order. For a more thorough discussion of the professional expertise required for such decisions, see *infra* notes 78-94 and accompanying text. In fact, the method hospitals use to determine staffing requirements requires a *professional nurse* to fill out a needs assessment on each patient. For a discussion of patient classification systems, see *infra* note 90 and accompanying text.

17. In this note, "unsafe assignments" has a very specific meaning. It does not include situations in which the nurse questions the doctor's orders, or hospital protocols such as for drawing blood. "Unsafe assignments" addresses only situations of inadequate staffing and floating policies.

18. The nursing supervisor, representing the hospital, demonstrates her belief that an assignment is permissible, either by relocating the nurse or refusing to send supplemental staffing to the understaffed unit.

19. There are an estimated 120,000 vacant nursing positions, three times more than just five years ago. Anita Lomurno & Trish Downing-Janos, *Retain Expert Nurses Through Clinical Ladder Alternatives*, 21 J. CONTINUING EDUC. IN NURSING 5 (1990).

United States will have a shortage of 1 million nurses.<sup>20</sup> Several factors contribute to this shortage. First, more nurses are required to take care of the same number of patients. In 1972, 50 nurses were needed to care for 100 patients; in 1986, 91 nurses were required to care for the same number of patients.<sup>21</sup> Second, nursing school enrollment has declined 26% since 1983.<sup>22</sup> This decline in enrollment is a result of a decrease in the college age population as well as expanded career opportunities for women.<sup>23</sup> Third, and perhaps most importantly, hospitals have a high turnover rate with many nurses leaving the profession altogether.<sup>24</sup> Many nurses leave hospital positions due to their lack of control over their workplace.<sup>25</sup>

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20. Glenn Huntley, *Nurse Shortage is Threat for Risk Managers*, BUS. INS., Oct. 31, 1988, at 81.

21. *Id.* Several factors are responsible for this increased nurse requirement. First, the average nursing care needs of today's hospital populations are greater due to the increased number of intensive care beds. Linda H. Aiken, *The Hospital Nursing Shortage: A Paradox of Increasing Supply and Increasing Vacancy*, WEST MED. J., July 1989, at 87, 88. Second, today's hospital patients are sicker than they were in the past. *Id.* Because hospitals are prospectively reimbursed for patient care, patients are discharged from hospitals much sooner than in the past, leaving only the really sick patients. Eliot Freidson, *The Centrality of Professionalism to Health Care*, 30 JURIMETRICS J. 431, 432 (1990). In fact, some experts suggest that patients are sicker once they arrive at the hospital because they put off seeking treatment due to worries about high health care costs. Jack Searles, *Shortage of Nurses Being Felt in County*, L.A. TIMES, July 2, 1990, at B1. Third, increasingly sophisticated medical equipment is being used requiring more nurses as monitors. Milt Freudenheim, *Business and Health; Nursing Shortage Is Costing Billions*, N.Y. TIMES, May 31, 1988, at D2. Finally, "both the elderly and persons with AIDS require above average amounts of nursing care." COMMISSION ON NURSING, *supra* note 14, at 7.

22. Aiken, *supra* note 21, at 87. Data for the past 25 years demonstrate that nursing enrollments have risen when nursing salaries have been increased; for this reason enrollment increased slightly in 1988 for the first time in five years. This data suggests that increased wages have an effect on enrollments, yet this assumption is premature. *Id.* at 89.

There are some indications that the decline in nursing school enrollment is ending. However, it is too early to predicate whether this represents a long term correction. *Nursing Graduations Turn Upward, Ending A Long Decline*, WALL ST. J., May 19, 1992, at A1 (number of bachelor's degree graduates rose 6.2% in 1991 after sharp drops in previous years).

23. COMMISSION ON NURSING, *supra* note 14, at 10. In 1987, more female college freshman were planning on medical school than nursing school. *Id.* In addition, federal funding of nursing education was terminated in 1983, removing a strong financial incentive for women to choose nursing as a career. *Id.* at 11.

24. In 1988, one study found a twenty percent turnover rate for hospital nurses. *I Love My Work. I Hate My Job. The Nursing Crisis in America*, WYATT SURVEY, at 4 (1988) [hereinafter WYATT SURVEY]. The Wyatt study identified failure to retain current nurses as a major cause of the present shortage. *Id.* Another study found that 20% of nurses planned to leave the profession entirely within the next three years. Lomurno & Downing-Janos, *supra* note 19, at 5.

25. Nurses "want less central[ized] decision making, self-contained clinical units where a cohesive professional staff can be developed without constant reassignments to cover

This shortage is costly to our health care system.<sup>26</sup> Hospitals spend large amounts of money to recruit and train nurses.<sup>27</sup> Salaries of temporary nurses also increase hospital costs.<sup>28</sup> If hospitals are unable to provide a sufficient nursing staff, they must turn patients away and postpone surgeries.<sup>29</sup> Obviously, hospitals have a large interest in maintaining questionable staffing patterns that permit them to continue admitting patients and maintaining revenues. As scarce staffing resources become more limited, hospitals' revenue retaining abilities will be even further inhibited. As a result, hospitals' economic incentives to float nurses and run units understaffed will increase. However, as the next section demonstrates, hospitals do not have a countervailing incentive to accommodate the professional nurse's judgment because hospitals fear no liability to the professional.<sup>30</sup>

## II. CURRENT STATUS OF THE EMPLOYMENT-AT-WILL DOCTRINE

### A. Summary of Doctrine and Exceptions

Developed in the nineteenth century, the employment-at-will doctrine states that an employer may fire any employee for any reason or for no reason at all.<sup>31</sup> This doctrine has been frequently criticized as society becomes less willing to grant employers such absolute power.<sup>32</sup> This criticism has intensified as society realizes

shortages in other parts of the hospital, a greater flexibility in working hours, and greater autonomy in the practice of their profession." Aiken, *supra* note 21, at 90.

26. In 1988, nursing turnovers cost the average hospital \$900,000, approximately \$10,000 per each nurse turnover. Cheryl Bland Jones, *Staff Nurse Turnover Costs: Part II, Measurements and Results*, J. NURSING ADMIN., May 1990, at 27, 31.

27. It has been estimated that hospitals spent 3.1 billion dollars in 1988 to recruit and train new nurses. Freudenheim, *supra* note 21, at D2.

28. In parts of California, hospitals paid \$85,000 a year for temporary nurses. *Id.* See also *Agencies Engaging Hospitals in Salary Wars, Bidding Up Per-Diem Rates in Shortage Areas*, 87 AM. J. NURSING 369 (1987)(discussing the expense of temporary agency nurses).

29. Boston & Karzel, *supra* note 11, at 67. A study by the American Hospital Association found that 10 to 32% of the nations hospitals had to limit elective admissions due to inadequate nursing staff. COMMISSION ON NURSING, *supra* note 14, at 14.

30. The hospital does have some other incentives to include the professional in staffing decision-making. See *infra* notes 114-116 and accompanying text. But, there is no fear of liability for wrongful discharge suits leaving a whole area of incentive untapped.

31. See *Payne v. Western & A.R.R.*, 81 Tenn. 507, 519-20 (1884), *rev'd on other grounds sub nom.* *Hutton v. Watters*, 179 S.W. 134, 138 (Tenn. 1915) (stating general rule that employers may discharge employees freely).

32. For criticism of the employment-at-will doctrine, see generally Lawrence E. Blades, *Employment At Will vs. Individual Freedom: On Limiting The Abusive Exercise of Employer Power*, 67 COLUM. L. REV 1404 (1967); John H. Conway, Comment, *Protecting The Private Sector At Will Employee Who "Blows the Whistle": A Cause of Action Based Upon Determi-*

that "[t]his traditional rule, which forces the non-union employee to rely on the whim of his employer for preservation of his livelihood, is what most tends to make him a docile follower of his employer's every wish."<sup>33</sup> Legislation has altered the doctrine to address areas of special concern.<sup>34</sup> However, because these statutes have not sufficiently protected employees,<sup>35</sup> the courts have expanded the exceptions to the doctrine.<sup>36</sup>

Contract theory has been applied in two ways to create exceptions to the employment-at-will doctrine. First, courts have crafted remedies for employees who have demonstrated the existence of an implied promise of a term of employment, and their detrimental reliance on that promise.<sup>37</sup> Second, courts have recognized a good faith contractual obligation in the discharge of employees.<sup>38</sup>

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*nants of Public Policy*, 1977 WIS. L. REV. 777 (1977); Note, *Employer Opportunism and the Need for a Just Cause Standard*, 103 HARV. L. REV. 510 (1989)[hereinafter Note, *Just Cause*]; Note, *Protecting At Will Employees Against Wrongful Discharge: A Duty to Terminate Only in Good Faith*, 93 HARV. L. REV. 1816 (1980)[hereinafter Note, *Good Faith*].

33. Blades, *supra* note 32, at 1405.

34. Statutes have been aimed at five major goals: (1) promoting unionization, (2) setting a minimum allowable wage, (3) preventing discrimination, (4) protecting employees health and safety, and (5) providing retirement plans. Note, *Good Faith*, *supra* note 32, at 1827.

35. Since statutes are very specific and often limit private action, many employees are left without remedies. Conway, Comment, *supra* note 32, at 785.

36. Some commentators argue that it is appropriate for courts to alter the doctrine because they created it. Note, *Good Faith*, *supra* note 32, at 1838. *But see* Robert Brand Gidding, Note, *Pierce v. Ortho Pharmaceutical Corp.: Is the Public Policy Exception to the At Will Doctrine a Bad Omen for the Employment Relationship?*, 33 RUTGERS L. REV. 1187, 1198 (1981)(arguing that courts should show deference to legislatures because they are the policy makers).

37. *See* O'Neill v. A.R.A. Servs., Inc., 457 F. Supp. 182 (E.D. Pa. 1978) (plaintiff left previous job in reliance on promised promotion which implied a term); *Sides v. Duke Hosp.*, 328 S.E.2d 818, 828 (N.C. Ct. App.), *cert. denied*, 335 S.E.2d 13 (N.C. 1985) (plaintiff's move from Michigan to North Carolina deemed detrimental reliance on an implied promise of a term).

Employee handbooks have also provided the basis for an implied promise. *See* *Greene v. Howard Univ.*, 412 F.2d 1128, 1133 (D.C. Cir. 1969) (faculty handbook created contract obligation of a term); *Toussaint v. Blue Cross & Blue Shield of Michigan*, 292 N.W.2d 880 (Mich. 1980) (employee handbook implied promise of term). *See also* Note, *Just Cause*, *supra* note 32, at 513 (discussing the implied contract theory); Note, *Good Faith*, *supra* note 32, at 1820-21 (discussing the courts use of implied-in-fact promises).

38. *See* *Foley v. Interactive Data Corp.*, 765 P.2d 373 (Cal. 1988) (holding all contracts have a good faith requirement including employment contracts); *Fortune v. National Cash Register Co.*, 364 N.E.2d 1251 (Mass. 1977) (firing salesman to avoid paying commission was a violation of good faith); *Monge v. Beebe Rubber Co.*, 316 A.2d 549 (N.H. 1974) (good faith requirement breached by firing woman for refusing to date superior); *O'Sullivan v. Mallon*, 390 A.2d 149 (N.J. Super. Ct. Law Div. 1978) (contract breach occurred when x-ray technician was fired in bad faith for refusing to perform procedures which licensing rules required a nurse or doctor to perform). *See also*, Note, *Just Cause*, *supra* note 32, at 513 (discussing good faith and fair dealing requirement in employment contracts); Note, *Good Faith*, *supra*



Under tort theory, courts have recognized two bases for judicially created exceptions to the employment-at-will doctrine. Courts have allowed a cause of action for intentional infliction of emotional distress when employer behavior in discharging the employee has been shocking and outrageous.<sup>39</sup> Even more far-reaching, however, has been the judicial creation of public policy exceptions. The acceptance and exact meaning of such exceptions vary among jurisdictions. Some courts resist public policy exceptions due to the belief that the laissez-faire policy behind the employment-at-will doctrine is the more important public policy.<sup>40</sup> Other courts, however, have been willing to subordinate employer freedom to clearly identified public policies.<sup>41</sup> Those courts that have been responsive to public policy exceptions have required more than a private or personal stake.<sup>42</sup> Thus, whenever relief is provided to individual employees, the courts were attempting to rectify or address some larger societal problem.<sup>43</sup>

### B. Public Policy Exceptions and the Nurse

As a result of these described changes in the law, nurses have challenged discharges believed to be unjustly based upon a refusal to follow hospital orders that conflicted with the nurses' ethical responsibilities. Most nurse-plaintiffs have invoked a public policy ex-

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note 32, at 1821 (discussing courts' applications of good faith obligation to employment contracts).

39. See, e.g., *Agis v. Howard Johnson Co.*, 355 N.E.2d 315 (Mass. 1976) (manager fired employers in alphabetical order attempting to extract information about food theft). This standard only serves to protect employees from the most egregious forms of abusive discharge and would not be usefully applied to subtle questions concerning professional judgment.

40. See *Hinrichs v. Tranquilaire Hosp.*, 352 So. 2d 1130 (Ala. 1977) (employee fired for refusing to falsify medical records denied relief); *Maus v. National Living Ctrs., Inc.*, 633 S.W.2d 674 (Tex. Ct. App. 1982) (employee fired for complaining about poor quality of patient care was denied relief under public policy exception).

41. See *Petermann v. Teamsters Local 396*, 344 P.2d 25 (Cal. Ct. App. 1959) (leading case which identified public policy exception for employees fired for refusing to commit perjury). See also *Kelsay v. Motorola, Inc.*, 384 N.E.2d 353 (Ill. 1978) (firing employee for filing workman's compensation claim violated public policy); *Nees v. Hocks*, 536 P.2d 512 (Or. 1975) (firing employee for taking time off for jury duty violated public policy). For an in-depth examination of general public policy exceptions, see Conway, Comment, *supra* note 32, at 786-99; Susan Sauter, Comment, *The Employee Health and Safety Whistleblower Protection Act and the Conscientious Employee: The Potential for Federal Statutory Enforcement of the Public Policy Exception to Employment At Will*, 59 U. CIN. L. REV. 513, 517-22 (1990).

42. Sauter, Comment, *supra* note 41, at 519-20. See also Bruce G. Davis, *Defining the Employment Rights of Medical Personnel Within the Parameters of Personal Conscience*, 3 DET. C.L. REV. 847, 855 (1986) (distinguishing public and private harms).

43. Conway, Comment, *supra* note 32, at 793.

ception,<sup>44</sup> although some have also used one of the two contract theories.<sup>45</sup> Courts demand a clear expression of policy from the legislature before recognizing a public policy exception.<sup>46</sup> This requirement assures the court that it is not usurping the legislature's function and that it is upholding policies which the public supposedly desires.<sup>47</sup> While some nurse-plaintiffs have been successful in identifying a clearly mandated public policy in wrongful discharge actions, the allegations against the employer in these cases were not related to the nurses' use of their professional judgment.<sup>48</sup> Statutes and professional codes of ethics are two major sources of public policy exceptions that have been advanced by professionals in wrongful discharge actions. However, as the following examination reveals, nurses' actions generally fail because the plaintiffs are unable to identify a clear source of public policy for the courts.<sup>49</sup>

## 1. Statutes

A Colorado case demonstrates how the demand for a clear statutory mandate can affect the outcome of a nurse's wrongful discharge suit. In *Lampe v. Presbyterian Medical Center*, a head nurse was fired for refusing to decrease staff overtime because she felt it would jeopardize patient care.<sup>50</sup> The nurse-plaintiff alleged that she was fired for complying with the Nurse Practice Act, which prohibits a nurse from acting "in a manner inconsistent with the health or safety of persons under [her] care."<sup>51</sup> The court refused to hold that the legislature intended this provision to alter the hospital and nurse's contractual relationship and denied the plaintiff wrongful

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44. Karen Markus, Note, *The Nurse as Patient Advocate: Is There A Conflict of Interest?*, 29 SANTA CLARA L. REV. 391, 399-400 (1989).

45. See, e.g., *O'Sullivan v. Mallon*, 390 A.2d 149 (N.J. Super. Ct. Law Div. 1978) (duty of good faith); *Francis v. Memorial Gen. Hosp.*, 726 P.2d 852 (N.M. 1986) (declining to find an implied promise of a term in employee manual); *Sides v. Duke Hosp.*, 328 S.E.2d 819 (N.C. Ct. App.), cert. denied, 335 S.E.2d 13 (N.C. 1985) (implied promise of a term).

46. Susan K. Datesman, Note, *Sides v. Duke Hospital: A Public Policy Exception to the Employment-At-Will Rule*, 64 N.C. L. REV. 840, 850 (1986).

47. In addition, a clear standard is easy for the courts to administrate. *Id.* at 851.

48. See *Watassek v. Michigan Dept. of Mental Health*, 372 N.W.2d 617 (Mich. Ct. App. 1985) (nurse allowed cause of action for wrongful discharge because protected under Whistleblower's Protection Act when he reported patient abuse to a supervisor); *Williams v. Hillhaven Corp.*, 370 S.E.2d 423 (N.C. Ct. App. 1988) (nurse allowed cause of action after being fired for testifying for an ex-employee at an unemployment hearing); *Sides v. Duke Hosp.*, 328 S.E. 2d 818 (N.C. Ct. App. 1985) (court identified public policy exception for nurse who was fired for refusing to falsely testify at a medical malpractice trial).

49. Markus, Note, *supra* note 44, at 400.

50. 590 P.2d 513, 514 (Colo. Ct. App. 1978).

51. *Id.* at 515.

discharge relief.<sup>52</sup>

In a similar case, *Free v. Holy Cross Hospital*, a nursing supervisor was fired for insubordination when she refused the hospital vice president's directive to forcibly discharge a bed-ridden emergency room patient.<sup>53</sup> The Illinois Right of Conscience Act states that it is the public policy of Illinois "to respect and protect the right of conscience of all persons. . . who are engaged in, the delivery of medical services and medical care whether acting individually, corporately, or in association with other persons. . . ." <sup>54</sup> The court dismissed the claim holding that the act applied only to moral or religious decisions concerning patient care, not ethical or professional decisions.<sup>55</sup>

There is only one reported case involving a nurse who was fired for refusing to "float." In *Francis v. Memorial General Hospital*, the court held that the nurse did not have a wrongful discharge action.<sup>56</sup> Francis, an intensive care unit nurse, refused to be reassigned to an orthopedic unit because he did not feel that he had the requisite skills. After an initial two day suspension, Francis informed the hospital that he would not float in the future because he felt incompetent. He renewed his refusal even after the hospital offered to orient him to all other units. The hospital then suspended him indefinitely.<sup>57</sup> After hospital grievance proceedings failed to bring any resolution, the hospital offered to reinstate Francis if he would agree in writing that he would comply with the hospital floating policy. Instead, Francis voluntarily terminated his employment and filed a wrongful discharge suit.<sup>58</sup>

Francis claimed that the Nursing Practice Act demanded his refusal, since ethical concerns dictated that he not jeopardize patients with his incompetency. The court dismissed his claim without discussing the Nurse Practice Act. Instead, the court focused on the hospital's floating policy, stating that the policy "is [not] necessarily something that 'public policy would condemn'. . . in fact, [the floating policy] implements another important public policy, that of maintaining an adequate staff on all patient floors in a cost-

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52. *Id.* at 515-16.

53. 505 N.E.2d 1188, 1189 (Ill. App. Ct. 1987).

54. *Id.* at 1189-90.

55. *Id.* at 1190.

56. 726 P.2d 852, 855 (N.M. 1986). The hospital floating policy had been promulgated by the nursing administration under authority granted by the hospital board. *Id.*

57. *Id.* at 853.

58. *Id.*

effective manner."<sup>59</sup> The court stressed that since the hospital had offered to orient Francis in "deference to his . . . scruples, . . . he cannot complain now that he was fired for following them."<sup>60</sup>

These cases are troublesome. The *Lampe* and *Free* courts were unwilling to allow fairly clear statutory mandates regarding safe patient care to interfere with the employment relationship. The *Francis* court did not even examine the Nursing Practice Act even though the plaintiff invoked it as a public policy source. All three courts seemed to want to ensure that the decision-making power remained in the hands of the hospital. Since the courts have not allowed a cause of action based on existing statutes that promote safe patient care, a specific statute allowing such actions for nurses who refuse unsafe assignments is necessary.<sup>61</sup>

## 2. Code of Ethics

One of the first cases to address the role of a professional code of ethics in a wrongful discharge suit was *Pierce v. Ortho Pharmaceutical Corporation*.<sup>62</sup> Dr. Pierce disagreed with her supervisor's decision to continue research with a particular drug that contained saccharin and expressed concern that her continued work would violate her Hippocratic Oath.<sup>63</sup> After being reassigned to a different project which she considered a demotion, Dr. Pierce resigned and filed a wrongful discharge suit.<sup>64</sup>

The court stated that an employer could not fire an employee for refusing to do something which violated a clear public policy mandate and that in *some* instances a professional code of ethics could adequately express that public policy.<sup>65</sup> However, the court held that the portion of the Hippocratic Oath<sup>66</sup> invoked by Dr. Pierce did not provide a public policy exception. The court pointed out that human research was not involved and that even Dr. Pierce admitted saccharine was merely a controversial drug, not a defini-

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59. *Id.* at 855.

60. *Id.*

61. See *infra* notes 130-39 and accompanying text for a discussion concerning the likelihood of such a statute being passed by state legislatures.

62. 417 A.2d 505 (N.J. 1980).

63. *Id.* at 507. The Hippocratic Oath is taken by all physicians when they enter practice. Unlike the conduct code which attorneys have, the Hippocratic Oath is not as detailed. For an examination of the Hippocratic Oath, see WILLIAM S. JONES, *THE DOCTOR'S OATH: AN ESSAY IN THE HISTORY OF MEDICINE* (1924).

64. *Pierce*, 417 A.2d at 507-08.

65. *Id.* at 512.

66. "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." *Id.* at 513.

tively harmful one. While recognizing that a professional employee's code of ethics may require her to refuse to comply with her employer's request, the court also stated that "an employee should not have the right to prevent his or her employer from pursuing its business because the employee perceives that a particular business decision violates the employee's personal morals, as distinguished from the recognized code of ethics of the employee's profession."<sup>67</sup> The dissent in *Pierce* agreed with the majority's view that ethical codes can provide the basis of a public policy exception, but advocated remand to allow Dr. Pierce an opportunity to prove her case with more specific ethical code sections.<sup>68</sup>

In *Kalman v. Grand Union Company*, a lower court applied *Pierce* and upheld a wrongful discharge claim.<sup>69</sup> The plaintiff, a pharmacist, alleged that he had been fired because he demanded that his employer keep a pharmacist on duty when the entire store was open. He cited two sources of public policy: (1) a statute that required a pharmacist always be on duty when a pharmacy was open and (2) the pharmacist's code of ethics which stated that pharmacists "should not engage in any activity that will bring discredit to the profession and should expose, without fear or favor, illegal or unethical conduct in the profession."<sup>70</sup> The *Kalman* court stated that because the code of ethics coincided with public policy as evidenced by the statute, the plaintiff's discharge was invalid.<sup>71</sup> It is not clear whether the code alone constituted a sufficient source of public policy.

Three years later, the same court had another opportunity to apply the *Pierce* holding. In *Warthen v. Toms River Community Memorial Hospital*, a nurse was fired for refusing to continue to perform lifesaving dialysis on a patient.<sup>72</sup> In her wrongful discharge suit, the nurse argued that the provision of the American Nurses Association Code for Nurses, requiring nurses to uphold human dignity, provided a source of public policy.<sup>73</sup> The court found that the nurse "was motivated by her own personal morals, precluding application of the 'public policy' exception to the 'at-will employ-

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67. *Id.* at 512.

68. *Id.* at 514-15. The dissent mentioned both the American Medical Association and Nuremburg Codes as potential sources of support. *Id.* at 516.

69. 443 A.2d 728 (N.J. Super. Ct. App. Div. 1982).

70. *Id.* at 730.

71. *Id.*

72. 488 A.2d 229 (N.J. Super. Ct. App. Div. 1985).

73. *Id.* at 233 (citing CODE FOR NURSES WITH INTERPRETATIVE STATEMENTS § 1.4 at 5 (Am. Nurses' Ass'n. 1985)).

ment' doctrine."<sup>74</sup> Like other courts, the *Warthen* court wanted to ensure that a larger public good would be served and that employers would not be subjected to the individual whims of employees.

As these New Jersey cases demonstrate, the one jurisdiction that has been responsive to professional codes of ethics as supplying the basis for a public policy exception to the employment-at-will doctrine has not been progressive enough to allow a plaintiff to prevail on the basis of a code provision. Although several positive general modifications of the employment-at-will doctrine have been made, for nurses who are discharged for refusing assignments they considered unsafe, the doctrine has remained essentially unchanged. The following section examines rationales for effecting a more viable change in the law on these nurses' behalf.

### III. BENEFITS OF CHANGING THE LAW

#### A. Use of Professional Expertise

Since the beginning of western civilization, society has distinguished "professions" from other occupations.<sup>75</sup> Professionals possess a special authority by virtue of their expertise in a defined body of knowledge which they utilize for the public good.<sup>76</sup> Nurses, long recognized for their concern for the public welfare, should share in

74. *Warthen*, 488 A.2d at 234.

75. Plato recognized that the law might have to treat physicians differently because of their special expertise and their enjoyment of an unusual level of public trust. Jay Alexander Gold, *Wiser Than the Laws?: The Legal Accountability of The Medical Profession*, 7 AM. J. L. & MED. 145, 156-57 (1981). Initially, professional apprentices were exempt from the employment-at-will doctrine. Richard A. Epstein, *In Defense of the Contract at Will*, 51 U. CHI. L. REV. 947, 979 (1984). Today, the National Labor Relations Act defines professionals differently than other employees.

The term "professional employee" means—(a) any employee engaged in work (i) predominately intellectual and varied in character as opposed to routine mental, manual, mechanical or physical work; (ii) involving the consistent exercise of discretion and judgment in its performance; (iii) of such character that the output produced or the result accomplished cannot be standardized in relation to a given period of time; (iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction or study in an institution of higher learning or a hospital, as distinguished from a general academic education or from an apprenticeship or from training in the performance of routine, mental, manual or physical processes.

29 U.S.C. § 152(12) (1982).

76. One noted scholar identified five factors to identify a "profession": (1) knowledge that takes a long time to acquire, (2) expertise in an specific area, (3) a monopoly on certain services that is approved by society, (4) a code of ethics which promotes public welfare, and (5) strong professional culture, replete with organization, dues, special dress and folklore. See Pat E. Crisci et al., *Nursing Faculty Attitudes Toward Collective Bargaining for Nursing Faculty and for Nurses in the Service Setting*, 19 J. COLLECTIVE NEGOTIATIONS 29, 30-31 (1990) (citing Greenwood).

the special authority conferred upon the professions.<sup>77</sup> Nurses desire to utilize their expertise in assessing patient assignments and to receive *some* discretionary power from the hospital.<sup>78</sup>

However, hospital management is concerned more with loyalty to the hospital than nurse autonomy.<sup>79</sup> Management achieves its goals by utilizing bureaucratic decision-making models that "undermine the flexible discretionary judgment that is necessary to adapt services to individual needs."<sup>80</sup> Hospitals typically exclude nurses from the policy making process and then use established policies to limit the nurse's professional discretion.<sup>81</sup> By refusing to heed a nurse's assessment that she has been given an unsafe assignment, hospitals allow neither themselves nor their patients to benefit from the nurse's professional expertise. Conversely, allowing the staff nurse input into patient assignments would increase the utilization of her professional expertise.<sup>82</sup>

Arguably, since some hospital decision-makers are nurses with professional expertise, nothing will be gained by allowing the staff nurse to have input into staffing decisions. There is data, however, that suggests the staff nurse's judgment is valuable. At times, the staff nurse may be the best professional to make decisions regarding safe patient care.<sup>83</sup>

77. For a discussion of nursing's evolution into a profession, see, LINDA ANNE BERNHARD & MICHELLE WALSH, *LEADERSHIP: THE KEY TO THE PROFESSIONALIZATION OF NURSING* 2-13 (2d ed. 1990).

78. Professionals "expect to be autonomous and self-directing, subject only to the constraints of competent knowledge and skill related to their task." ELIOT FREIDSON, *PROFESSIONAL POWERS: A STUDY OF THE INSTITUTIONALIZATION OF FORMAL KNOWLEDGE* 159 (1986). In contrast, managers demand loyalty and obedience regardless of competency levels. *Id.*

79. "Most managers feel that (1) management alone should decide who is competent for a job, and (2) how it will be done, and that (3) an individual's loyalty should be to his own company, and (4) management alone should be responsible for discipline." George Strauss, *Professionalism and Occupational Associations*, *INDUS. REL.*, May 1963, at 7, 9.

80. Freidson, *supra* note 21, at 441.

81. See COMMISSION ON NURSING, *supra* note 14, at 33 (describing the exclusion of nurses from policy making). Hospitals are typical of all large organizations in that their attempts to simplify procedures, end up reducing "the exercise of discretion by subordinates." MAGALIS LARSON, *THE RISE OF PROFESSIONALISM: A SOCIOLOGICAL ANALYSIS* 197 (1977) (citing REINHARD BENDIX, *WORK AND AUTHORITY IN INDUSTRY* 336 (1956)).

82. "Nursing's involvement in decision-making at all levels of the health care organization is essential because nurses provide a substantial portion of the services delivered to the organization's clients, [and] have a unique knowledge of these clients . . ." COMMISSION ON NURSING, *supra* note 14, at 33.

83. Just as the trial court is considered the expert on fact finding and the appellate court the expert on questions of law, the staff nurse may be considered the expert on patient care needs while reserving higher personnel as the experts on overall staffing patterns.

As discussed previously,<sup>84</sup> there are two levels of nursing management within the hospital's organizational structure: nurse executives and nurse supervisors or middle managers.<sup>85</sup> Typically, the nurse executive is responsible for budgeting the number of staff nurse positions for the entire hospital.<sup>86</sup> The nursing supervisor on duty is responsible for making sure all units are adequately staffed for that shift, a responsibility that entails supplementing and relocating staff as necessary.<sup>87</sup> These job descriptions of management nurses alone suggest that they are not experts on specific patient care needs, an inference strengthened by other facts.

Although nursing supervisors usually have more years of work experience than staff nurses, many have been away from bedside patient care for so long that they are not the expert professionals one might logically expect.<sup>88</sup> In fact, nurse managers do not perceive basic nursing skills as an important requirement of their jobs.<sup>89</sup> Staff nurses often perceive that their supervisors have less knowledge about what is actually required for a truly safe patient care assignment than staff nurses.<sup>90</sup> Moreover, nurse supervisors generally base their staffing judgments on patient classification systems prepared by staff nurses.<sup>91</sup> As a result, nurse supervisors may

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84. See *supra* note 5 and accompanying text.

85. While there are two distinct levels of managers, a great deal of confusion surrounds the various roles as the hierarchies, duties and titles of nurse managers vary from institution to institution. Wilhite, *supra* note 5, at 6.

86. *Id.* at 7.

87. *Id.*

88. Harriet Chaney, *Dear Nurse Executive . . .*, J. NURSING ADMIN., Feb. 1990, at 7. In fact, one article concluded that an operating room nurse manager did not really even need past experience as an operating room nurse as long as she was a "seasoned manager." Marguerites Dieffenbach & Kim Kelly-Studnick, *Is Clinical Experience for OR Nursing Managers Necessary?*, 49 ASSOC. OPERATING ROOM NURSES J. 886, 886 (1989).

89. Judith M. Patz et al., *Middle Nurse Manager Effectiveness*, J. NURSING ADMIN., Jan. 1991, at 15, 17. On a scale of one to five, (five being most important), nurse managers gave general nursing skills a rating of 1.27, while human management skills received a rating of 4.33. *Id.* at 17. Educators of nurse managers agree "that advanced clinical knowledge [is] not necessary for either entry level management or the executive level." Carolyn L. Brown, *Aesthetics of Nursing Administration: The Art of Nursing in Organizations*, NURSING ADMIN. Q., Fall 1991, at 61, 66.

90. Patient classification systems ("PCS") were designed as a method of quantifying each nurse's workload per shift to predict how many nurses are needed per unit per shift. They are required by the Joint Committee for the Accreditation of Health Care Organizations. Boston & Karzel, *supra* note 11, at 65. Quantification is accomplished by grouping patients based on their care needs; however, it provides only an average. See RUSSELL C. SWANBURG, *MANAGEMENT AND LEADERSHIP FOR NURSE MANAGERS* 78 (1990) (providing general description of various PCSs). It is a major problem to ensure the PCS's reliability and validity. *Id.* at 84.

91. "What every staff nurse suspects or knows is that nursing administrators rarely have



base staffing decisions on erroneous instrumentations instead of on the individual nurse's input.

Even if the nursing supervisor trusts the staff nurse's judgment that an assignment is unsafe, the supervisor may have few options to rectify the situation. As middle managers, nurse supervisors rarely have the power to make the decisions which reduce staffing problems. Nurse executives, however, could have an effective voice in patient care assignment policies as well as other decisions that effect staffing patterns such as budgeting, closing beds, and canceling surgeries.<sup>92</sup> Further removed than supervisors from direct patient care, the nurse executive's knowledge of patient care requirements is even more limited.<sup>93</sup> As a result, nurse executives may not utilize their influence to change policies to prevent staffing problems since they are unaware of the extent of the problem.

This examination of the nursing hierarchy suggests that the nurse manager's expertise is management and the staff nurse's expertise is patient care. Therefore, although some nurse managers are involved in decision-making, the inclusion of staff nurses, with their unique expertise, in staffing decisions should result in better care for patients.

## B. Promotion of Ethical Decision-Making

Creating liability for hospitals that fire nurses who refuse unsafe assignments will promote ethical decision-making in two ways. First, if the nurse perceives that legal protection is available to support her decision to refuse an assignment, she is more likely to make the choice that promotes the patient's best interest—the correct,

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working knowledge of what the staff nurse role has become because nurse executives are rarely there to make even the most cursory observations or to offer minimal assistance." Chaney, *supra* note 88, at 8. The staff nurse's position is similar to that of an associate in a law firm, who may know as much or more about a specific issue as the partner who is in charge. Indeed, one author concludes that "[i]n such cases, deference by the associate to the questionable ethical decisions of a partner is unwarranted." Leonard Gross, *Ethical Problems of Law Firm Associates*, 26 WM. & MARY L. REV. 259, 300 (1985).

92. Wilhite, *supra* note 5, at 7. A significant number of the members of the Council for Graduate Education for Administration in Nursing ("CGEAN") surveyed believed that nurse executives could function effectively as patient care policymakers. *Id.* In some hospitals, even nurse executives are not included in several aspects of hospital policy making which limits their ability to participate in decisions that may effect staffing ratios. Aiken, *supra* note 21, at 91.

93. Chaney, *supra* note 88, at 8. The fact that most nurse executives hold a Masters Degree in business, not nursing, suggests that hospitals hire nurse administrators for their business skills rather than their nursing skills. See Therese Droste, *Nurse Administrator Positions Are Tough to Fill*, HOSPITALS, Oct. 5, 1989, at 83 (discussing the typical educational backgrounds of nurse executives).

ethical choice.<sup>94</sup> Professionals, trusted to act in the best interest of society, are typically given broad leeway in making decisions.<sup>95</sup> However, hospitals often limit nurses' discretion, thereby creating potential conflicts. If a nurse knows there is no legal remedy when she is fired for refusing hospital orders, she has a strong economic incentive to ignore her ethical duty. Most nurses are not in a position to sacrifice their jobs to assuage their consciences.

Second, a hospital that knows it may be held liable by the wrongfully discharged nurse has an incentive to respect the nurse's judgment and increase her involvement in the policy making process. This incentive is important since the hospital, as an institution, may not feel the ethical mandate of safe patient care as acutely as the professional.<sup>96</sup> Therefore, increased participation by the staff nurse should result in an ethical decision.

### C. Improving Public Perception/Confidence

Professions that are not perceived well by the public have trouble attracting new members.<sup>97</sup> Recruitment is crucial for nursing and for ensuring health care delivery in the future.<sup>98</sup> "The negative public image of nursing has long been a professional liability and is both a contributing factor to and a consequence of the current shortage."<sup>99</sup> This negative image has resulted in a disinterest in nursing as a career.<sup>100</sup> As more career opportunities become available, many women are rejecting nursing.<sup>101</sup> Public awareness

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94. "Enlightened public policy should foster ethical activity by such employee-professionals and must, therefore, refuse to tolerate discharges motivated by employee resistance to orders of superiors that are at variance with public responsibilities." Seymour Moskowitz, *Employment-At-Will & Codes of Ethics: The Professional's Dilemma*, 23 VAL. U. L. REV. 33, 59 (1988).

95. A professional has an obligation "to regard duty to clients and to society as paramount to his own or his employer's economic self interest." Moskowitz, *supra*, note 94 at 57.

96. The hospital as a business entity is not subject to ethics codes. This is not to suggest that the hospital would not be concerned about liability to patients or complying with statutory or licensing mandates. See *infra* notes 114-116 and accompanying text. However, when making ethical choices, the hospital has a competing economic interest in keeping hospital beds open to increase revenues. Nurses have no such competing interest.

97. The medical profession is an excellent example. One doctor stated, "[b]right young students, especially the children of physicians, are entering other fields, such as business, science or law, where they can work unhampered and unthreatened." Joseph D. Wassersug, *Consumerism Soon Will Consume Medical Practice*, AM. MED. NEWS, July 22, 1988, at 23.

98. The Federal Government has been involved conducting studies and making recommendations. COMMISSION ON NURSING, *supra* note 14, at iii-ix. Several books on nursing recruitment techniques have also appeared.

99. *Id.* at 13.

100. *Id.* at 45.

101. See *supra* note 23 and accompanying text.

that nurses are generally excluded from decisions which shape their practice has decreased the number of young students attracted to nursing.<sup>102</sup> By increasing nurse participation in staffing decisions, the public perception of nursing autonomy could be enhanced, resulting in more successful recruitment efforts.

Nursing has been affected by decreased public confidence as well. Public confidence in the health care industry as a whole has been deteriorating. Patients complain that hospitals are depersonalizing<sup>103</sup> and that doctors are interested only in making money.<sup>104</sup> The bureaucratic manner in which hospitals are run seems to contribute to the patient's feelings of dehumanization and general lack of confidence in the health care system.<sup>105</sup> Long ago Aristotle observed that if the public believed a physician was not acting in good faith based on expert knowledge, then society would prefer to heal itself and be unwilling to rely on the professional's decision.<sup>106</sup> Likewise, if the public perceives that institutions are making patient care decisions based on financial concerns, rather than the patient's interests, the public will not engender much faith in health care institutions. But, if the public knows that the nurse is involved in making patient assignment decisions based on the patient's best interests, confidence in the entire health care system may be enhanced due to the public's recognition of the nurse as its advocate.

#### D. Improving Efficiency in the Health Care System by Increasing Nurses' Job Satisfaction

Increasing the nurse's input into staffing decisions will result in

102. "Nursing is generally perceived as a profession having little autonomy." *COMMISSION ON NURSING*, *supra* note 14, at 13. Various newspaper articles that detail nurses complaints keep the public apprised of this fact.

103. See *FREIDSON*, *supra* note 78, at 177-78 (describing the impersonal treatment of clients in the health care system).

104. See Flora Johnson Skelly, *MDs and Patients: Where is the Trust?*, *AM. MED. NEWS*, Jan. 5, 1990, at 28 (patients cite doctor's avarice as the leading cause of public distrust of the medical profession).

105. To evaluate this bureaucratic solution, we must note that health services are addressed to the central core of human existence - physical and mental well-being and the conditions of survival as a human being. The way one conceives of health care tasks and outcomes reflects the way one conceives of the people being treated. Standardizing the conception of tasks and outcomes for the purpose of measuring and controlling them also standardizes the conception of people and their difficulties. In essence, people are reduced to formally defined categories. They become objects produced by reliable methods at a predictable cost.

*Freidson*, *supra* note 21, at 440-41.

106. See *Gold*, *supra* note 75, at 156 (citing Aristotle, *The Politics* III vi. 5-6). For a general discussion of authority and the health professions see *PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

increased job satisfaction among nurses.<sup>107</sup> First, nurses will have an increased influence over their practice. Second, they will arguably face fewer ethical dilemmas because they have a greater voice in their assignments and in patient staffing policies.<sup>108</sup> Increased job satisfaction should decrease job turnover as well as the number of nurses leaving the profession completely.<sup>109</sup> Not only will staff retention save the hospital recruitment and orientation costs, but it will retain for the hospital the benefit of the training and expertise of experienced nurses and the nurses' assistance in training medical students and residents.<sup>110</sup> By expanding nurse input in staffing decisions, the waste that results from high turnover rates will be reduced and the overall efficiency of the health care system will improve.<sup>111</sup>

#### E. Improving Quality of Patient Care

Staff nurses are frequently the professionals in the best position to evaluate patient care needs.<sup>112</sup> Allowing nurses more input into decision-making about patient care assignments will improve quality of care. Nurses are under statutory and ethical mandates to ensure safe patient care.<sup>113</sup> If they have protection from being fired

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107. Many nurses cite exclusion from decision-making as a primary reason for job dissatisfaction. WYATT SURVEY, *supra* note 24, at 6. But when nurses are "on decision-making bodies pertaining to nursing and patient care policy, it has been reported that the work satisfaction of nurses is reportedly higher and the organizations' nurse turnover rate is lower." COMMISSION ON NURSING, *supra* note 14, at 33. In addition, a survey of nurses leaving an Atlanta hospital revealed that many nurses left specifically because of floating policies. WALT BOGODANICH, *THE GREAT WHITE LIE* 62 (1991).

108. Nurses will not have the threat of being fired for adhering to their ethical mandates which should alleviate the internal conflict these dilemmas produce. This lack of internal conflict should result in increased job satisfaction.

109. COMMISSION ON NURSING, *supra* note 14, at 33. Furthermore, a hospital with a reputation in the professional community for involving nurses in staffing decisions should attract new workers who will stay longer. Thus, hospitals will have motivation to involve nurses in order to compete with each other.

110. See Denise Webster, *Medical Students and Nurses*, 36 *NURSING OUTLOOK* 130, 132 (1988) (describing the experienced nurses' roles in training medical students in teaching hospitals).

111. "It is inefficient to discharge employees for reasons unrelated to performance, and such arbitrary dismissals may have a demoralizing effect on the work force." Datesman, Note, *supra* note 46, at 851. Dismissing a nurse for following ethical mandates is not truly related to her "performance" if performance is defined by evaluating her nursing skills not her obedience.

112. Following a quality assurance study, one hospital group concluded that no one was "better prepared to monitor the safety and the quality of the care patients receive than the staff nurses who deliver it." Maryann F. Fralic et al., *The Staff Nurse As Quality Monitor*, *AM. J. NURSING*, Apr. 1991, at 41. See *supra* notes 83-93 and accompanying text.

113. Each state has nurse practice acts for licensing and most mention some command of

for following these mandates, then the economic incentive reinforces the ethical imperative to provide the best patient care possible.

Hospitals also have an incentive to provide quality care to minimize their liability, based upon theories of respondeat superior<sup>114</sup> or corporate liability.<sup>115</sup> Statutory and accreditation requirements provide further incentives to maintain quality care.<sup>116</sup> However, hospitals have a competing economic incentive to serve as many patients as possible and to increase revenues, regardless of the level of patient care provided.<sup>117</sup> Hospital management, using simple

safe patient care. See, e.g., CAL. BUS. & PROF. CODE § 2725(a) (West 1954) (the practice of nursing includes "direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients . . ."). The American Nurses Association has promulgated a Code for Nurses with ethical commands. See *infra* notes 144-48 and accompanying text.

114. Respondeat superior holds the employer liable for negligent acts of its employees. See *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957) (leading case in which the hospital was held liable for the negligent acts of its nurse employees).

115. Under corporate liability doctrine, the hospital is held liable for its own negligence in hiring or supervising employees. See *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966) (leading case establishing corporate liability for hospitals). See also, *HCA Health Servs. of Midwest, Inc. v. National Bank of Commerce*, 745 S.W.2d 120 (Ark. 1988) (hospital liable for inadequate number of staff, but charge nurse not liable as she reasonably assigned what staff she had); *Northern Trust Co. v. Weiss Memorial Hosp.*, 493 N.E.2d 6 (Ill. App. Ct. 1986) (hospital held liable for not providing a qualified nurse); *Leavitt v. St. Tammany Parish Hosp.*, 396 So. 2d 406 (La. 1981) (hospital liable when patient injured trying to get to bathroom by herself since not enough staff was available to answer call bell).

116. For hospitals to receive Medicare reimbursement, they must comply with certain standards of care. 42 U.S.C. § 1395b(a)(1)(2) (1982 & Supp. II 1984). Hospitals also must comply with the Joint Commission on Accreditation of Health Care Organizations ("JCAHO") guidelines to receive accreditation. Though voluntary, almost all hospitals participate in the process. Timothy Stoltzfus Jost, *Joint Commission on Accreditation of Hospitals: Private regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 840-45 (1983). The following is an example of one requirement the hospital must meet to receive accreditation from JCAHO. N.R. 4.3.4 requires that "[t]he patient care assignment is commensurate with the qualifications of each nursing staff member, the identified nursing needs of the patient, and the prescribed medical regimen." JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS 1990, 129 (1990).

However, the strength of this incentive is questionable given deficiencies in the JCAHO accreditation process. JCAHO requires only substantial compliance with its regulations, provides the hospital with "ample warning" of pending inspections, and, in some cases, relies on self survey to determine compliance. Jost, *supra*, at 876-77. "Research has found low correlations between JCAH accreditation and other measures of hospital quality and wide variations in quality between JCAH accredited hospitals." *Id.* at 878. See also Martin Gottlieb, *Questions At The Top On Hospital Policy*, N.Y. TIMES, May 17, 1992 at 18E (critics suggest that JCAHO is a mere trade organization).

117. Hospitals are reimbursed for patient care based on the patient's diagnosis under the Diagnosis Related Group prospective payment system. Freidson, *supra* note 21, at 432. Hos-

cost benefit analysis, could determine that the risk of liability to patients harmed through unsafe staffing assignments is worth the potential gain in revenue.<sup>118</sup> Likewise, a hospital could intentionally decide to assume the risk of paying the cost of any statutory violations.

An exception to the employment-at-will doctrine may not change the hospital's staffing decisions. Arguably, a hospital could decide not to change staffing patterns or involve nurses in the decision-making process and simply accept the risk that liability suits may be brought by fired nurses. However, an employment-at-will exception would add more risk of liability to the equation. The added risk may be enough to persuade hospitals to maintain safer assignment policies, policies that nurses would be involved in establishing.

Not only would liability to fired nurses increase the hospitals' overall liability potential, but it may increase the probability of suits against the hospital as well. Patients often do not realize they have been the victim of negligence. Even if they know negligence has occurred, they may be unwilling or unable to file suit. Moreover, the agencies that investigate statutory violations are often underfunded and the risk of hospitals being cited is more remote.<sup>119</sup> By contrast, a nurse would be readily able to identify situations in which her rights had been violated.<sup>120</sup> Hence, hospital liability could increase both in frequency and intensity.

Furthermore, a hidden aspect of patient care would improve if nurses had a greater voice in staffing assignments. There is a sub-standard, non-negligent level of care which can be just as harmful to patients but harder to detect. A nurse faced with time limitations must ignore non-essential tasks to provide essential care, such as medication administration, treatment delivery, lifesaving therapies,

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pitals receive a flat fee regardless of how many days or how many services the patient requires. *Id.* If a patient requires less than the average then the hospital profits, however, if the patient requires more than the average, then the hospital loses. *Id.* As a result, the hospital has a very real economic incentive to underserve the patient to increase its profit. *Id.*

118. One study concluded that "at most 1 in 10 incidents of malpractice resulted in a claim . . . and at most 1 in 25 received compensation." PATRICIA M. DANZON, *MEDICAL MALPRACTICE THEORY, EVIDENCE, AND PUBLIC POLICY* 18-29 (1985). Based on statistics like these, it would not be unreasonable for the hospital to take its chances with liability to patients.

119. Jack R. Bierig & Robert M. Portman, *The Health Care Quality Improvement Act of 1986*, 32 ST. LOUIS U. L.J. 977, 980 (1988).

120. Granted not all nurses will be willing or able to bring suit, but some nurses have already brought suit when the law was squarely against them.

and direct physician orders.<sup>121</sup> Turning patients prevents bed sores,<sup>122</sup> rigorous pulmonary toileting prevents pneumonia,<sup>123</sup> and getting patients out of bed prevents a multitude of complications.<sup>124</sup> Yet these tasks will often go undone during a shift if the nurse is too busy.<sup>125</sup> When this occurs the patient has received substandard care. However, a patient cannot attribute a future complication to one nurse's shift or one missed intervention.<sup>126</sup>

Consequently, liability to patients only gives hospitals an incentive to prevent clearly negligent care that results in injury. This type of care occurs far less frequently than subtle, substandard care. The patient who receives an injury from substandard care will have problems proving causation, a requisite element of the prima facie case of negligence.<sup>127</sup> This fact provides an economic incentive for hospitals to provide substandard, non-negligent care.<sup>128</sup> Nurses, freed from fear of reprisal type firing, could advocate decisions that might eliminate substandard care resulting from inadequate staffing. Including nurses in the decision-making process would serve to balance the hospital's economic interest, resulting in a net increase in the quality of care.

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121. See Gerry Hendrickson & Theresa M. Doddato, *Setting Priorities During The Shortage*, 37 NURSING OUTLOOK 280,281 (1989) (study examining which tasks nurses forego when their time is limited).

122. JOAN LUCKMANN & KAREN CREASON SORENSEN, *MEDICAL SURGICAL NURSING: A PSYCHOPHYSIOLOGIC APPROACH* 423 (2d ed. 1980)

123. *Id.* at 418.

124. *Id.* at 418-20.

125. Hendrickson & Doddato, *supra* note 121, at 282. The fact that today's average bed sores are larger may be attributed to lack of adequate patient turning due to nurses time constraints. Chaney, *supra* note 88, at 7.

126. One plaintiff alleged that a nursing home had given her substandard care that resulted in malnutrition and bed sores so severe that she required skin grafts. *Koppang v. St. Paul's Church Home*, Ramsey County District Court, MN, #439914, Nov. 19, 1980. The case was settled out of court, perhaps due to the plaintiff's causation proof problems. *Cited in*, Maureen Cushing, *Short Staffing on Trial*, AM. J. NURSING Feb. 1988, at 161.

127. For example, the patient may have a hard time proving that his injury resulted from inadequate staffing which rendered substandard care, rather than that his injury resulted from his own poor health status or medical mismanagement.

128. In the vast majority of cases, a patient would never know that he had been given substandard care. Since hospitals receive prospective reimbursement by Medicare and many private insurers, the institution has a large incentive to underserve the patient in any way possible, including poor care due to labor insufficiencies. Clearly, saving money on labor costs will help to maintain hospital profitability.

#### IV. ESTABLISHING A PUBLIC POLICY SOURCE AND STANDARD FOR AN EXCEPTION TO THE EMPLOYMENT-AT-WILL DOCTRINE FOR NURSES

As previously discussed, there are two potential sources of public policy that could provide an exception to the employment-at-will doctrine: statutes and codes of ethics. The cases suggest that a very specific statute would be required to allow a nurse to pursue a wrongful discharge action when she is fired for refusing to accept an unsafe assignment.<sup>129</sup> Despite the benefits of such a statute, it is unlikely that it would pass in most legislatures. Historically, employees in general are not known to possess political strength.<sup>130</sup> Nurses, in particular, have been very weak politically.<sup>131</sup> Hospitals, on the other hand, have a powerful, well connected lobby in the American Hospital Association ("AHA").<sup>132</sup> The AHA would certainly oppose a bill likely to limit hospitals' power.<sup>133</sup>

Resistance can also be expected from unions.<sup>134</sup> "[O]rganized labor . . . knows that statutory expansion of employee rights may dilute incentives for employees to organize."<sup>135</sup> Approximately 333,600 nurses are currently unionized and the unions are actively pursuing more nurse-members.<sup>136</sup> Unions would oppose legislation that would deprive them of their role as the collective bargaining agent for nurses.<sup>137</sup> Moreover, the American Nurses Association,

129. See *supra* note 61 and accompanying text.

130. Note, *Good Faith*, *supra* note 32, at 1837.

131. Gerald R. Winslow, *From Loyalty to Advocacy: A New Metaphor for Nursing*, HASTINGS CENTER REP., June 1984, at 32, 38.

132. C. Nick Wilson et al., *Union Dynamics in Nursing*, J. NURSING ADMIN., Feb. 1990, at 35, 37. This fact is not surprising. Typically "[e]mployers are well organized politically and influential in legislative assemblies." Henry H. Perritt, *Wrongful Dismissal Legislation*, 35 UCLA L. REV. 65, 69 (1987).

133. Currently, the AHA opposes rules that increase unionization of hospitals because they decrease flexibility and increase labor costs. Wilson, *supra* note 132, at 37.

134. Epstein, *supra* note 75, at 978 n.49.

135. Perritt, *supra* note 132, at 69.

136. *Labor Unions Ready Big Push to Organize Nurses, Counting on Courts to Uphold New Bargaining Rule*, AM. J. NURSING, May 1990, at 134, 135 [hereinafter *Labor Unions*]. Unions exist primarily to protect employees from arbitrary or unjust discharge. Note, *Good Faith*, *supra* note 32, at 1838.

137. Unions often bargain on issues of staffing ratios and nurse participation in decision making. Allen M. Ponak, *Unionized Professionals and the Scope of Bargaining: A Study of Nurses*, 34 INDUS. & LAB. RELATIONS REV. 396, 399-401 (1981). Specifically, "[n]urses have raised collective bargaining issues concerning floating shifts, [and] understaffed shifts . . ." Michael H. LeRoy et al., *The Law and Economics of Collective Bargaining for Hospitals: An Empirical Public Policy Analysis of Bargaining Unit Determination*, 9 YALE J. ON REG. 1 (1992).



the major professional organization for nurses, is also a nurses' union and bargains for the greatest number of nurses—approximately 139,000.<sup>138</sup> Hence, the professional organization that might be expected to rally and lobby for such legislation actually has a disincentive because any change in the law could decrease its union activity and power. With two strong sources of opposition, hospitals and unions, it seems unlikely that a statute which clearly mandated a public policy exception to the employment-at-will doctrine would ever be passed.<sup>139</sup>

The poor prognosis for legislative action leaves the question of reform to the courts.<sup>140</sup> Judicial intervention in the context of the employment-at-will doctrine is not as troubling as it may be in other cases. Since the doctrine was judicially created, it is appropriate that it be judicially modified as well.<sup>141</sup> Moreover, legislatures *have* passed laws that promote ethical decision-making by health professionals to ensure safe patient care.<sup>142</sup> It can be inferred that those same legislatures would also approve of an exception for nurses that promotes the same goal.

Without a statute, however, the courts need a source of public policy from which to draw the exception.<sup>143</sup> The Code for Nurses is a logical choice. The purpose of an ethical code is to outline the professional's responsibilities to the public.<sup>144</sup> Ethical codes also

138. *Labor Unions*, *supra* note 136, at 134.

139. Interestingly, legal scholars have advocated legislative action to protect professionals in employment-at-will situations for some time. *See, e.g.*, Perritt, *supra* note 132; Clyde W. Summers, *Time for a Statute*, 62 VA. L. REV. 481 (1976). No such statutes have been passed. If lawyers have been unable to effect legislation to protect themselves, it seems unrealistic to expect nurses to accomplish the same goal. This fact does not mean, however, that such legislation would not be beneficial to the public, nor does it mean that the public does not desire that protection.

140. "Therefore, it appears that protection of all employees from the abusive exercise of employer power will have to originate, if it is to be established at all, in the courts." Blades, *supra* note 32, at 1434.

141. Note, *Good Faith*, *supra* note 32, at 1816.

142. For example, in 1974, Congress amended the National Labor Relations Act to allow hospital employees the ability to organize. Wilson, *supra* note 132, at 36. This change in the law demonstrated Congress' intent to provide nurses protection in the employment setting. Part of that protection includes the ability to make ethical decisions without fear of reprisal firing. This protection has become a reality for some unionized nurses. *See* *Misericordia Hosp. Medical Center v. N.L.R.B.*, 623 F.2d 808 (2d Cir. 1980) (hospital penalized for firing nurse who reported understaffed conditions to JCAHO). Another example is the Health Quality Care Improvement Act. Congress passed this act to encourage health professionals to report their incompetent peers. Bierig & Portman, *supra* note 119, at 978.

143. Alternatively, the courts could interpret statutes mentioned in the *Lampe* and *Free* decisions to allow a cause of action. Based on past cases, however, the courts seem to have rejected this route.

144. Moskowitz, *supra* note 94, at 59.

provide minimum practice standards that serve as a basis for sanctioning professionals.<sup>145</sup> Nonetheless, such codes do allow for individual discretion.<sup>146</sup> Thus, ethical codes are useful to the judiciary in establishing a standard, while also allowing for the exercise of individual judgment. In addition, an ethical code's value has already been recognized by one court which has expressed a willingness to utilize it as a source of a public policy exception.<sup>147</sup>

Three sections of the Code for Nurses are applicable to the nurse who is assigned an unsafe assignment.

The nurse acts to safeguard the client and the public when health care and safety are effected by the incompetent, unethical, or illegal practice of any person.

The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.<sup>148</sup>

These sections clearly require a nurse to refuse an assignment which she believes is unsafe. Though these provisions could provide source material for a public policy exception, the courts still need to articulate a legal standard.

The standard set by the courts should be as clear as possible to protect both the nurse and the hospital. The following standard should accomplish these purposes: A nurse may succeed in a wrongful discharge action upon showing that her discharge resulted from a good faith refusal of an assignment she reasonably believed to be unsafe.<sup>149</sup>

## V. ADDRESSING HOSPITAL CONCERNS

Hospitals' concerns about courts recognizing a public policy exception for nurses are understandable. Realistically, hospitals can-

145. *Id.* at 58-59.

146. *Id.*

147. *See supra* notes 62-74 and accompanying text.

148. CODE FOR NURSES WITH INTERPRETIVE STATEMENTS §§ 3, 6 & 9 (Am. Nurses' Ass'n. 1985).

149. Moskowitz suggested a similar standard requiring "the claim . . . [to be] made in good faith and . . . reasonable as measured by an ordinary professional situated in a similar situation." Moskowitz, *supra* note 94, at 65-66. The *Pierce* dissent used the following phrasing: "the drug company shall not fire the doctor for the good faith exercise of her informed judgment on matters of professional ethics." *Pierce v. Ortho Pharmaceutical Corp.*, 417 A.2d 505, 520 (N.J. 1980).

not allow each nurse to subjectively decide what constitutes a safe assignment without chaotic results.<sup>150</sup> Hospital apprehension over being subjected to an individual nurse's whim really encompasses several valid concerns. However, the foregoing standard does much to reduce hospital concerns.

The hospital's primary concern is that nurses will frequently refuse assignments that they truly can handle, and subsequently bring suits against the hospital if they are fired. This is a serious concern, but facts suggest that disaster will not result.

As professionals, nurses have a duty to care for patients and cannot ethically refuse an assignment that is truly within their capabilities, especially if their refusal puts the patient in jeopardy.<sup>151</sup> Typically, nurses do not refuse orders from doctors or hospitals.<sup>152</sup> Nurses have been trained to follow orders and often have been unwilling to disrupt the system.<sup>153</sup> Moreover, the articulated standard also requires that the nurse's refusal be made in good faith, otherwise she will be denied relief.<sup>154</sup> This requirement would deter nurses from refusing assignments within their competency level.

The hospital is also concerned that frequent and frivolous suits may result, as they commonly do following the announcement of a new rule of liability. However, frequent litigation is unlikely because most nurses do not want the trauma and expense of being fired and bringing suit.<sup>155</sup> Frivolous suits can be reduced by utiliz-

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150. The *Warthen* court stated "it would be a virtual impossibility to administer a hospital if each nurse or member of the administration staff refused to carry out his or her duties based upon a personal private belief concerning the right to die." *Warthen v. Toms River Community Memorial Hosp.*, 488 A.2d 229, 234 (N.J. Super Ct. App. Div. 1985).

151. Professionals are distinguished by the fact that "when a difficult decision is to be made you can depend on the one who is in a true profession to efface his own self interest." Moskowitz, *supra* note 94, at 58.

152. Nurses did not even begin to question orders until 1929 when an nurse was held liable for negligence because she did not question a doctors order. Winslow, *supra* note 131, at 35. In the late 1960's and early 1970's, with the growth of the women's movement, nurses began to be more assertive in the health care system. *Id.* at 36. However, it was not until 1973 that the Code for Nurses was changed to mandate nurses' loyalty to the patient not the doctor. *Id.*

153. Markus, Note, *supra* note 44, at 398. Nurses' reluctance to be perceived as trouble-makers by their peers is indicated by the fact that few nurses are willing to report doctors or testify in malpractice trials. Arguably, if their own rights are in jeopardy, nurses may be more likely to speak out.

154. A review of the nurse's past work evaluations which reveals attitude or disciplinary problems would strengthen an accusation of bad faith.

155. "[F]ew nurses possess the means or desire to engage in protracted litigation to protect their rights as patient advocates." Markus, Note, *supra* note 44, at 412. In fact, considering the market, the nurse who continually received unsafe assignments would most likely voluntarily find new employment. This option is not ideal as it results in waste in the system

ing relevant decisions made by the National Labor Relations Board to provide guidelines for determining liability.<sup>156</sup> The standard itself should also prevent frivolous suits. The nurse cannot succeed if she did not act reasonably. This means that a prudent nurse in similar circumstances would have made the same decision.<sup>157</sup> Moreover, as discussed, if the nurse did not act in good faith, she cannot prevail.<sup>158</sup> If the nurse cannot prove these two elements, reasonableness and good faith, attorneys should refuse to pursue the case to avoid a Rule 11 sanction.<sup>159</sup>

There are additional procedural tools which would protect the hospital. First, the nurse would have the burden of showing that the hospital's primary reason for firing her was her reasonable, good faith refusal to take an unsafe assignment.<sup>160</sup> Second, hospitals usually have some sort of grievance procedure which courts could require be exhausted before judicial remedies were permitted.<sup>161</sup>

Uncertainty about liability also leads to concerns over the hospital's ability to retain hiring and firing flexibility. One critic stated that allowing codes of ethics to establish a public policy exception would "allow the courts to become arbiters of employment relations and to diminish employer discretion to direct the workplace."<sup>162</sup>

and does not result in protection for patients or the achievement of the other benefits discussed earlier.

156. See *supra* note 142 and accompanying text.

157. This is not a new standard; it is the one applied for negligence. "Competent nursing care. . . is defined as being that which a reasonably prudent nurse would provide under the same or similar circumstances." Sheryl A. Feutz, *Nursing Work Assignments: Rights and Responsibilities*, J. NURSING ADMIN., Apr. 1988, at 9. One author has articulated the standard in these words: "if the 'average prudent nurse' would not have accepted a particular assignment, the nurse who does decide to accept it will be judged by that professional standard." Politis, Note, *supra* note 10, at 123.

158. See *supra* notes 151-54 and accompanying text.

159. The Federal Rules of Civil Procedure prohibit the pursuit of groundless claims, stating:

The signature of an attorney or party constitutes a certificate by the signer that the signer has read the pleading, motion, or other paper; that to the best of the signer's knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

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160. The employee has to prove that "his resistance was the 'primary' motive for the discharge." Christiansen, Note, *supra* note 3, at 833.

161. One author suggests that as long as an organization's internal procedures are effective, they should be followed prior to any court intervention. Moskowitz, *supra* note 94, at 69-70.

162. Gidding, *supra* note 36, at 1195. However, another author argues that "[s]uch protection would provide the individual employee with a greater sense of security, without bur-

The primary concern is the increased cost of freely discharging employees. Cost will increase not only from the hospital being held liable, but also from the increased documentation needed to defend these suits.<sup>163</sup> However, hospitals already have extensive documentation systems which document the evidence such defenses would require.<sup>164</sup> Therefore, it is questionable whether hospitals would incur any increased documentation costs.

Hospitals also have an interest in retaining flexibility in their staffing patterns. The *Francis* court stated that "floating in fact implements another important public policy, that of maintaining an adequate staff on all patient floors in a cost effective manner."<sup>165</sup> However, the court did not address the problem of defining the term "adequate staff." Under the court's language, untrained and unprepared staff may be considered adequate because the person giving care has a nursing license.<sup>166</sup> However, adequate staff should not be defined by the courts to include nurses accepting unsafe assignments.

Perhaps the best answer to the hospital's worry regarding individual whims is to change its policies with nurse involvement.<sup>167</sup> Currently, instead of changing policies to address the underlying problem, "hospitals often resort to crisis staffing with a 'rob Peter to pay Paul' approach at the beginning of each shift."<sup>168</sup> Providing orientations to new units before floating and setting minimum staff-patient ratios would eliminate conflict while still allowing flexibility.<sup>169</sup> Nurses should be involved in developing these policies. It is unlikely nurses will refuse assignments that are within the parameters of policies they helped establish.

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dening the employer with unwarranted obstacles to efficient personnel management." Moskowitz, *supra* note 94, at 66.

163. Gidding, *supra* note 36, at 1196. The increased cost is particularly worrisome for small businesses. *Id.* Hospitals, however, are generally large institutions which would not be broken by the increased cost.

164. Hospitals keep a record of the patient assignments and patient needs per shift with the patient classification systems discussed earlier. In addition, each nurse is evaluated at least annually and disciplinary records are kept.

165. *Francis v. Memorial Gen. Hosp.*, 726 P.2d 852, 855 (N.M. 1986).

166. Recall *Francis'* whole argument was that he was not an adequate staff nurse for an orthopedic unit because he lacked the requisite experience and orientation. *Id.* at 853.

167. The whole purpose of expanding hospital liability is to provide an incentive for hospitals to change policies that cause unsafe assignments.

168. Politis, Note, *supra* note 10, at 119.

169. A non-unionized Maryland hospital in cooperation with its nurses set a policy which limited the number of patients a nurse could be assigned tying the number to a patient classification system. For a further description of a successful collaboration, see *Maryland RNs Win Big in a Pact That Sets Patient-Load Limits*, AM. J. NURSING, Apr. 1990, at 127.

## CONCLUSION

Hospitals clearly have an interest in maintaining control over the workplace. However, the public has an interest in making sure it is receiving safe and efficient health care. By expanding hospital liability, an incentive is created for hospitals to change policies that cause unsafe assignments. The goal of that incentive is for hospitals to more efficiently utilize professional nurses' problem solving skills by including them in staffing decisions. The proposed public policy exception attempts to meet this goal while preserving as much flexibility as possible for hospitals in directing their affairs.

The public as well as nurses would benefit from judicial recognition of an exception based on the nurse's professional code of ethics. "The integrity of [the] codes of professional conduct . . . deserves judicial protection from undue economic pressure."<sup>170</sup> The benefits society gains from the exception's promotion of nurse input far outweigh the burdens hospitals bear from the risk of expanded liability.

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170. *Pierce v. Ortho Pharmaceutical Corp.*, 417 A.2d 505, 515 (N.J. 1980).

