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THE NURSE PRACTITIONER IN MALPRACTICE ACTIONS: STANDARD OF CARE AND THEORY OF LIABILITY

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INTRODUCTION

AS HEALTH CARE costs continue to escalate, the government and health care providers are constantly searching for less expensive ways to deliver quality health care. One viable method is the use of nurse practitioners (NPs) for the delivery of primary health care.[1] NPs are registered nurses who qualify for advanced nursing practice by receiving postgraduate education.[2] As this new type of health care provider[3] emerges, it is important to develop appropriate professional and legal standards of care and theories of liability. As NPs achieve administrative autonomy and move into independent practice, they will become exposed to increased liability for malpractice actions. It is also important that victims recover for negligent NP care and NPs are provided with clear guidelines of their legal responsibilities. A consistent legal standard of care and theory of liability must be established to ensure proper recovery for injured plaintiffs and to protect the NP from malpractice judgments based on inappropriate standards.

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1. DEPT. HEALTH & HUMAN SERVICES, REPORT OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE 6 (1980) (functions of primary health care include health status assessment, physical examinations, formulation of a care plan, counseling, management, referral and coordination).

2. The NP has been defined as one who assesses the physical and psychosocial status of clients by means of interview, health history, physical examination, and diagnostic tests, . . . interprets the data, develops and implements therapeutic plans, and follows through on the continuum of care of the client . . . [The NP] implements these plans through independent action, appropriate referrals, health counseling, and collaboration with other health-care providers.

AMERICAN NURSES' ASSOCIATION, AMERICAN NURSES' ASSOCIATION CONGRESS FOR NURSING PRACTICE, THE SCOPE OF NURSING PRACTICE: DESCRIPTION OF PRACTICE, NURSE PRACTITIONER, CLINICIAN, CLINICAL NURSE SPECIALIST (1976).

3. Physician assistants (PAs), in contrast to NPs, generally are not licensed nurses but rather have specialized post-baccalaureate training. The tasks performed by the PA and NP are often the same. For a discussion of the PA's role, *see* Elisabeth Rosenthal, *The Person in the White Smock is Not a Doctor*, N.Y. TIMES, Jan. 10, 1991 at B11.

This note will review the NP's scope of practice and the current economic and political trends in health care which limit the NP's practice. Case law will be reviewed for the various theories of liability and standards of care applied in nursing malpractice actions. This note will then identify and explain the appropriate theory of liability: that is, professional malpractice as opposed to ordinary negligence; and recommend that the correct standard of care be that of a "reasonable and prudent nurse practitioner functioning in like or similar circumstances" in all practice settings. Finally, this note will demonstrate that the best expert witness in all malpractice cases against a nurse practitioner is another nurse practitioner.

I. TRANSFORMATION OF AMERICAN MEDICINE

The need for primary health care providers in rural and urban areas which are underserved by physicians[4] has contributed to the evolution of the NP. Toby Turner of the National Rural Health Association recently indicated, "[T]here is a need for nurses who function in expanded roles, such as nurse practitioners and nurse midwives."[5] As NPs increase their independent practice the role of the NP has developed in response to these changes and to the demands of registered nurses who want to practice on a more advanced level and with recognition of their clinical expertise.[6] The NP will be viewed as the primary caregiver and will be at greater risk of being named as the primary defendant in malpractice actions.[7]

NPs practice in various geographical and economic settings. They have traditionally practiced in medically underserved areas.[8]

4. *See* Michael Dolan, *Cardiologist Arrest*, WASH. MONTHLY, Dec. 1992 at 22 (medical schools turn out too many specialists who practice in urban areas and not enough family physicians); Julie Kosterlitz, *Wanted: GPs*, 24 NAT'L. J. 2011 (1992) (shortage of primary care doctors could halt expansion of access to health care to residents of rural and inner-city areas).

5. *See* Emily Friedman, *Nursing: Breaking the Bonds*, 264 JAMA 3117, 3118 (1990) (interview with Toby Turner, RN, senior staff associate at the National Rural Health Association).

6. *See* Walter T. Eccard, Note, *A Revolution in White - New Approaches in Treating Nurses as Professionals*, 30 VAND. L. REV. 839, 849 (1977).

7. *See* Bonnie Bullough, *The Malpractice Insurance Crisis*, 1 J. OF PEDIATRIC HEALTH CARE 2, 5 (1987) (as nurses make more decisions and carry more malpractice insurance, the number of claims against them will increase). *See also* Michael A. Salatka, Note, *Professional Liability in Critical Care Nursing*, 19 OHIO N.U. L. REV. 85 (1992).

8. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, HEALTH TECHNOLOGY CASE STUDY 37, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS 6 (1986) [hereinafter OTA STUDY]. The case studies represent extensive reviews of the literature on the efficacy, safety and costs of the specific technol-

In 1965 Drs. Loretta Ford and Henry Silver founded the first NP program in a university setting at the University of Colorado Medical Center.[9] This pediatric NP program developed in response to a nationwide study which revealed that children were being denied access to primary medical care because of a lack of providers. NPs also practice in urban areas, specifically in inner city emergency rooms.[10]

Official recognition of the advanced level of skill required by the nurse practitioner comes from professional certification and statutory recognition in the State Nurse Practice Acts and corresponding regulations.[11] Today there are approximately 13,834 NPs certified by the ANA.[12] Since many more are certified by their specialty groups there is no accurate overall count.[13] The American Nurses Association (ANA) through its coalition with approximately forty nursing specialty groups represents one million or roughly half of all registered nurses in the United States.[14] The ANA certifies five specialty groups; School Nurses, Geriatric Nurse Practitioners, Adult Nurse Practitioners, Family Nurse Practitioners and Pediatric Nurse Practitioners.[15] Other specialties such as Certified Nurse Midwives and Certified Registered Nurse Anesthetists are certified by their national specialty groups.[16] These groups set the professional standard of care for NPs practicing in those specialty areas

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ogies and are subject to an extensive review process. This study reviewed the literature and existing studies on nurse practitioners, physician assistants, and certified nurse midwives (CNMs) in the U.S. OTA case studies are designed to provide OTA with specific information that can be used in forming general conclusions regarding broader policy issues and to provide useful information on the technologies covered. The OTA Study found that in addition to improving access to care in rural areas, NPs, PAs, and CNMs increase access to primary care in a wide variety of nongeographic settings and for populations not adequately served by physicians such as primary care for underserved children in school settings, and elderly patients in nursing homes and socioeconomically high-risk pregnant women and adolescents.

9. Henry Silver & Loretta Ford, *The Pediatric Nurse Practitioner at Colorado*, 67 AM. J. NURSING 1443, 1444 (1967).

10. Telephone Interview with Sarah Stanley, MS, RN, CNA, CS, Assistant Director of Nursing Practice and Economics, American Nurses Association, March 14, 1991 [hereinafter Stanley Interview].

11. For an extensive discussion of statutory patterns, *see* Bonnie Bullough, *The Current Phase in the Development of Nurse Practice Acts*, 28 ST. LOUIS U. L.J. 365, 382 (1984).

12. Stanley Interview, *supra* note 10. However, others have estimated the number of NPs actually practicing to be much higher. *See* Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, 424 (1992) (approximately 23,000).

13. Stanley Interview, *supra* note 10.

14. *Id.*

15. *Id.*

16. *Id.*

by setting the accrediting requirements.[17]

By authorizing direct third party payment for NP services, the federal government has increased the opportunity for NPs to expand their practice horizons.[18] In October of 1990, Congress passed the Rural Nursing Incentive Act amending the Rural Health Care Act and provided for direct reimbursement by Medicare to NPs employed in rural areas.[19] The federal government also provides direct reimbursement for certified registered nurse anesthetists.[20] Certified registered nurse anesthetists (CRNAs) are a specialty group of NPs who provide anesthesia services in a variety of inpatient and outpatient settings. Direct reimbursement for certified registered nurse anesthetists will circumvent the existing practice of billing through the physician for services which are actually provided by the CRNA.

II. FACTORS ENCOURAGING THE GROWTH OF NURSE PRACTITIONERS

The economic advantages of using NPs has been recognized and increasingly private health care providers have incorporated NPs into their systems. HMOs have been especially successful in their use of NPs, both in terms of quality of care provided and cost effectiveness.[21] In primary care settings the type of services provided by NPs is indistinguishable from that rendered by physicians (MDs).[22]

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17. *Id.* By 1992 all nurse practitioners certified by the ANA must be prepared at the master's level, have graduated from an accepted nurse practitioner program, and have extensive supervised clinical experience. As each nursing specialty group joins the ANA for the accrediting process, they develop and print standards of care specifically for that practice area.

18. Safriet, *supra* note 12, at 468.

19. 42 U.S.C.A. Sec. 1395 u(b)(4) (West Supp. 1991) Omnibus Budget Reconciliation Act of 1990. P.L. 101-508 Sec. 4155, 104 Stat 1388 (1990) (Coverage of Nurse Practitioners in Rural Areas).

20. *Id.*

21. Dana Priest, *How Hawaii Stands Above Health-Care Fray*, WASH. POST., Oct. 18, 1992 at A4 (Kaiser Permanente HMO NPs, who earn one-third of a doctor's salary, effectively handle primary care needs at a lower cost). *See also* Collen & Garfield, NEW MEDICAL CARE DELIVERY SYSTEM (Kaiser Foundation Research Institute and Permanente Medical Group NTIS Mo. PB-253066) (1973) (utilization of NPs increased numbers of new patients seen, saved MD time, decreased costs, and was accepted by patients and staff).

22. AMERICAN NURSES' ASSOCIATION, THE SCOPE OF PRACTICE OF THE PRIMARY HEALTH CARE NURSE PRACTITIONER 3 (1985) (*citing* AMERICAN ACADEMY OF NURSING, PRIMARY CARE BY NURSES: SPHERE OF RESPONSIBILITY AND ACCOUNTABILITY 36 (1977)). Primary health care is a way of delivering health care. It is the care the client receives at the first point of contact with the health care system and leads to a decision of what must be done to help resolve the presenting health problem. It then extends to continuous and comprehensive care, including all the services necessary for health promotion, pre-

Patient satisfaction is rated higher for primary care provided by NPs.[23] In the past, private third party payors have followed the government's example in adopting payment systems for health care services. For example, when the government switched to a prospective payment system of diagnosis-related group (DRG) for Medicare Part A, the private insurers also moved to prospective payment systems.[24] As these third party payors realize the cost savings and consumer satisfaction achieved by using NPs, they will also provide for direct third party reimbursement for NP services.[25] All these factors support the prediction of increased growth in the numbers and utilization of NPs in the health care delivery system.

III. NP ECONOMICS

NPs will play a significant role in containing health care costs because of their lower salaries and educational costs.[26] NPs also have a greater focus on preventative health care. Further savings can be realized through the reduction in hospital days, laboratory fees and emergency room services associated with the use of NPs. The utilization of NPs will also increase access to medical care for populations who might otherwise fail to receive preventative health care[27] (i.e., residents of rural areas and underinsured or uninsured

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vention of disease and disability, health maintenance, and in some cases rehabilitation. Primary health care includes identification, management and referral of health problems, as well as promotion of health-maintaining behavior and prevention of illness.

23. Ada Jacox, *The OTA Report: A Policy Analysis*, 35 NURSING OUTLOOK 263 (1987).

24. The DRG (diagnosis-related group) approach is a method of payment whereby Medicare pays a fixed amount for the operating costs associated with treating patients in each diagnostic category. It is a method of payment applied to Part A Medicare which covers inpatient hospital care and was implemented in 1983. This method of payment is prospective because the amount the hospital receives for the care is predetermined by the DRG which is assigned to the patient. This replaces a fee for service method. AMERICAN MEDICAL ASSOCIATION, A GUIDE FOR PHYSICIANS: DIAGNOSIS-RATED GROUPS AND THE PROSPECTIVE PAYMENT SYSTEM 4 (1984)

25. Susan McGrath, *The Cost Effectiveness of Nurse Practitioners*, NURSE PRACTITIONER July 1990, at 40.

26. OTA STUDY, *supra* note 8 at 44. The average total direct cost of training a NP in 1983 was $16,900, compared with the $86,100 it cost to train a physician. Based on 1983 figures, the average salary of the NP was $25,000 compared with $60,000 to $80,000 as the median salary of a primary care physician. *See also* Jane C. Record et al., *New Health Care Professionals After a Decade and a Half: Delegation, Productivity and Costs in Primary Care*, 5 J. HEALTH POLITICS, POL. & LAW 470, 490 (1980).

27. Constructing an "adequate" package of health benefits, including preventive care, is a difficult task. For a thoughtful discussion of this issue, *see* Paul E. Kalb, *Defining an "Adequate" Package of Health Care Benefits*, 140 U. PA. L. REV. 1987, 1993 (1992). Also, it should be noted that there is a shortage of MDs who specialized in disease prevention and public health. In the past 2 years, 5 of the 45 residency programs at U.S. universities have closed such programs due to funding problems. P. Mona Khanna, *Preventive Care Is Pre-*

individuals). While escaping direct measurement, substantial savings can be realized from increased accessibility resulting in the early detection and prevention of medical problems.[28]

The cost effectiveness of the NP can be explained in terms of microeconomic theory. The quantity demanded of a particular good will increase as its price decreases if all factors other than price are held constant.[29] If the price of a good rises, the quantities demanded of that good and its complements will fall, but the demand for substitute goods will rise.[30] Consumers will turn to less expensive substitutes if they exist.[31]

In the case of U.S. health care the factor which must remain stable is the manner in which health care is delivered. That is, the theory is applicable if the health care system in the United States continues to operate on a fee for service system. Assuming the constant of a fee for service delivery system it can be inferred that the lower relative price charged by NPs will cause the demand for their services to rise.[32] By prohibiting direct third party reimbursement and unnecessarily limiting the scope of practice of the NP, the law prohibits substitution of the NP for the MD in some situations where it would be appropriate to substitute.[33] By artificially limiting the consumer's choice, society pays too high a price for health care services.

Moreover, the higher price does not necessarily signify higher quality: if two inputs (NP primary health care and MD primary health care) are perfect substitutes in the production process the quality of the final product will remain the same regardless of which input is chosen.[34] By beginning to provide direct third party payment, the government is encouraging independent practice by NPs

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scribed to Cut Costs, But Doctor Training Faces the Scalpel, WALL ST. J., Nov. 23, 1992, at B1.

28. OTA STUDY, *supra* note 8, at 40. NP charges are less than those of physicians, thus increasing access.

29. Elizabeth Harrison Hadley, *Nurses and Prescriptive Authority: A Legal and Economic Analysis*, 15 AM. J. OF LAW & MED., 245, 252 (1989) (*citing* Hurdis Griffith, *Nursing Practice: Substitute or Complement According to Economic Theory*, NURSING ECON. (Mar.-Apr. 1984 at 105, 108)).

30. Hadley, *supra* note 29, at 252.

31. *Id.*

32. *Id.*

33. *See* Edward Felsenthal, *Antitrust Suits Are on the Rise In Health Field*, WALL ST. J., Nov. 26, 1992 at B1 (discussion of antitrust litigation between MDs and advanced nursing practitioners).

34. Hadley, *supra* note 29, at 252.

and the consumer is given the choice of a less expensive option.[35]

The OTA Study supports claims of NP cost-effectiveness.[36] The OTA reviewed the quality and cost of the care provided by NPs and Certified Nurse Midwives (CNMs).[37] It found that 50 to 90 percent of the physician delivered primary care could be done by an NP[38] and that 65 percent of obstetrical care could be safely and efficiently delivered by a certified nurse midwife.[39] The OTA study recommended increasing third party direct reimbursement to NPs and CNMs. Some commentators predict that cost-conscious third party payors and managed care systems such as HMOs will increasingly turn to the NP as a source of cost-effective health care providers.[40]

Rural health care could also benefit from the cost effective NP provider system. Rural health care remains inadequate partly because of the low economic incentive for MDs to practice in sparsely populated areas.[41] NPs and MDs, working in collaboration with each other, could provide access to health care for large geographical areas.

Finally, NPs could increase medical care to those who do not have health insurance. Between 34 and 37 million Americans are underinsured or uninsured.[42] These citizens have too high an income to receive federal or state assistance but do not make enough

35. *Hearing before the Physician Payment Review Commission on Payment to Non Physician Providers* (Dec. 5, 1990) (statement of The American Nurses Ass'n.). The ANA's position is that the care provided by NPs and Clinical Nurse Specialists (CNS) is essentially the same at Levels 1,2,3 of the Family Practice Physician and that NPs are able to independently deliver 60 to 80 percent of primary care services traditionally provided by physicians, therefore the relative value assigned to their services should be comparable. However, because of decreased malpractice costs and practice costs, the ANA feels that NPs could be paid less.

36. OTA STUDY, *supra* note 8, at 42-43.

37. *Id.*

38. *Id.* at 39.

39. *Id.* The study also cited a Canadian study of the cost effectiveness of NPs which stated that the substitution of NPs for MDs in primary care areas would save 16-24 percent of the total cost for ambulatory care. *Id.* at 46.

40. Light, *Surplus Versus Cost Containment: the Changing Contexts for Health Providers* in APPLICATIONS OF SOCIAL SCIENCE TO CLINICAL MEDICINE AND HEALTH POLICY (Linda D. Aiken and David Mechanic eds., 1986). Light indicates that HMOs will seek clinicians with the ability to minimize hospitalization, to ration ambulatory care wisely, to teach patients how to manage their problems themselves (thus using fewer services) and who know how to manage a clinical team effectively. This is why HMOs have found the NP to be a cost effective, efficient health care provider.

41. OTA STUDY, *supra* note 8, at 46.

42. *Over 36 Million Individuals Lack Coverage, EBRI Report Finds*, 19 PENS. REP. (BNA) 1963 (Nov. 2, 1992) (the Employee Benefits Research Institute will release a report in Jan., 1993, indicating that 36.3 million non-elderly Americans lack either private or public health insurance); Peter Ries, *Advance Data No. 201: Characteristics of Persons With and Without Health Care Coverage: United States, 1989, Nat'l Center for Health Statistics* (avail-

money to afford traditional primary and preventative care without risking financial hardship. Less expensive visits to an NP would enable a large segment of the uninsured population to benefit from primary and preventative health care.

According to the OTA Study patients expressed a higher degree of satisfaction with the primary care given by the NP with regard to several factors, such as personal interest exhibited and amount of information provided, than with care given by the MD in a comparable setting.[43] If patients are educated to the role of the NP, and are afforded the opportunity to choose, it is likely that they will choose the NP over the MD when the care is more satisfactory and the cost is less.

This opportunity to choose is afforded by the Rural Nurse Incentive Act.[44] The Act allows this choice because it pays for health care provided by practitioners not previously covered. The patient is able to make a choice independent of financial concerns. Independent third party payors have recently expressed an interest in providing direct reimbursement for NP care.[45] Direct reimbursement provides greater financial independence for the NP and will facilitate increased independent clinical practice.

In addition to being cost effective, the NP provides unique services to the health care system.[46] For example, the NP can provide the necessary coordination of social and health services which are integral to providing health care to the geriatric population and the multiproblem poor family. As the elderly population increases, the need for health care services in the area of geriatrics is increasing.[47] NPs can provide care to nursing home patients and to elderly patients in independent living situations. Currently there are only 1,210 ANA certified Geriatric Nurse Practitioners in the U.S.[48] It is estimated that the United States needs 6,000 to 8,000 Geriatric

able from the Dept. of Health and Human Services, Nat'l. Center for Health Statistics, DHHS Publication No. (PHS) 91-1250).

43. OTA STUDY, *supra* note 8, at 19. Patients appear to be more satisfied with the care they receive from NPs than with care from physicians, in regard to several factors: personal interest exhibited, reduction in the professional mystique of health-care delivery, amount of information conveyed, and cost of care.

44. OTA Study, *supra* note 8.

45. *See* Stanley Interview, *supra* note 10. The ANA has been approached by Blue Cross/Blue Shield in an effort to begin preliminary negotiations regarding direct reimbursement to NPs for their services to Blue Cross/Blue Shield subscribers.

46. Emily Friedman, *Nursing: Breaking the Bonds*, 264 JAMA 3117, 3118 (1990).

47. *Id.* at 3118.

48. *See* Stanley Interview, *supra* note 10.

Nurse Practitioners.[49] The OTA study also supported an expanded role for NPs in providing health care and social services for the socioeconomically disadvantaged.[50] The unique services of the NP, their cost effectiveness and the institution of direct reimbursement for services all favor the growth of the NP.

IV. NPs vs. THE MEDICAL ESTABLISHMENT

The biggest impediment to the growth of NPs may be organized medicine. The historical relationship of nursing and medicine has been one of paternalism with the physician in firm control of all patient care decisions. As the emphasis on preventative health care continues to grow and new models for delivery of health care are explored, the scope of NP practice has increased. The AMA has historically been opposed to such growth.[51] "We do not believe in the concept of independent physician extenders. We believe they should be dependent and supervised . . . I believe that you maintain

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49. *Id.*

50. For a discussion of the health care needs of the socioeconomically disadvantaged, *see generally* PATRICIA A. POTTER, BASIC NURSING THEORY AND PRACTICE (2nd ed. 1991). The elderly and multiproblem poor family (families at or below the poverty level with health problems and dysfunctional family units) require many support systems to effectively meet their health care needs. Transportation to clinic appointments, nutritional support systems such as WIC (Women, Infants and Children) and Meals on Wheels and family counseling are all part of the holistic model on which the NP bases the client's plan of care. Coordination of these services to assist the client to reach his optimal level of health are unique aspects of the NP model of care.

51. A report on Independent Nursing Practice Models by the AMA Board of Trustees was adopted by the AMA House of Delegates in 1990. The Board of Trusteees recommended that:

> 1. The AMA continue to monitor federal and state legislation for direct reimbursement of nonphysicians, so that statutory guidelines for physical supervision as a qualification for reimbursement may be maintained.
> 2. The AMA continue to monitor federal state legislation for indepdendent nursing practice models and encourage statutory changes so that physicians may retain their intermediary responsibilities and advocacy for direct, quality patient care.
> . . . .
> 4. The AMA . . . oppose any attempt at empowering nonphysicians to become unsupervised primary medical care providers and be directly reimbursed for care management activities.

AMA, *Proceedings of the House of Delegates*, 139th Annual Meeting (June 24-28, 1990), Board of Trustees, *Independent Nursing Practice Models*, AM. MED. ASS'N PROC. 141-152 (1990). Thus the AMA opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. It should be noted, however, that the outlook of the AMA and the American Hospital Association have undergone dramatic, almost radical, changes in the past three years due to the political momentum for overhauling the nation's health care system, and the AMA may eventually soften its stand on NPs. *See generally* Julie Kosterlitz, *Survival Tactics*, 24 NAT'L. J. 2428, 2431 (1992).

control by maintaining control of the money."[52]

State medical boards have also gone to court to challenge the scope of practice of the NP. In 1984, the Arkansas State Medical Board[53] attempted to revoke a physician's license by positing the idea that he had committed malpractice because he employed more NPs than the Board of Medicine's regulations permitted. The court held that the State Board of Medicine did not have the authority to revoke the physician's license for employing more NPs than the regulations permitted. In 1986, the Louisiana State Board of Medicine challenged the statute which allowed NPs to practice in an expanded role. The Board of Medicine claimed that the statute gave NPs the right to practice medicine.[54] The court refused judicial review because the statute had been on the books since 1981 without challenge from the State Medical Board and therefore reasoned that the time for opposing the statute had lapsed. Suits such as these emphasize that the plaintiff's malpractice bar will not be the only opponent independently practicing NPs will have to face in the court room.

The state nurse practice acts have also affected the growth of the NP. Licensure laws in some states have placed the expanded role of the NP under co-control of the Board of Nursing and the State Medical Board.[55] NPs and state boards of nursing have traditionally opposed this arrangement which allows medicine to control NPs' scope of practice. Impediments to NP practice, however, are not as much related to which body regulates the NPs in each state but rather the degree of autonomy that these regulatory bodies allow.

Another area of contention in the legislature between NPs and physicians has been the use of the word "diagnosis" in nurse practice acts. State medical malpractice acts typically broadly define the practice of medicine and organized medical groups oppose any leg-

52. *Rural Health Clinic Act, 1977: Hearings before the Committee on Health Education and Welfare*, Pub. L 95-210, 95th Cong.(1977) (statement of E. Beddingfield, M.D. spokesperson for the AMA)

53. Arkansas State Nurses Assoc. v Arkansas State Medical Bd., 677 S.W.2d 293 (Ark. 1984).

54. Louisiana State Bd. of Medicine v. Louisiana State Bd. of Nursing, 493 So.2d 581 (La. 1986).

55. Linda J. Pearson, *How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice*, NURSE PRACTITIONER, Jan. 1989, at 27. This is a summary of a comprehensive study of all 50 states and the District of Columbia's Nurse Practice Acts, reviewing each for legal authority, reimbursement and prescriptive authority for advanced nursing practice. It states that 12 of the 50 states require physician or Board of Medicine supervision of advanced nurse practitioners.

islative language which would suggest that diagnosis is not exclusively within the domain of the physician.[56] The irony in the situation is that the word diagnosis in connection with "nursing" has a different definition than that traditionally associated with medical diagnosis.[57] Legislative action as it relates to the scope of practice and standard of care will be discussed in more detail under those sections of this paper.

Despite these impediments to growth, the majority of factors point to the continued growth of the NP. Administrative autonomy achieved through direct third party reimbursement will result in more independent practice patterns for NPs. However, as the NP comes to be viewed as a primary care giver it follows that the NP will be put at greater risk to be named as the primary defendant in malpractice cases.[58]

V. TRENDS IN MALPRACTICE ACTIONS AGAINST NPs

On June 1, 1987 the ANA's insurance administrator, Maginnis and Associates, informed ANA that it would no longer accept new applications for NPs.[59] Maginnis had decided not to accept the risk of insuring NPs in their expanded nursing role. Additionally, Maginnis informed the ANA that nurses currently insured would face an increase in insurance premiums based on their area of employment and experience rating. This action took place at the time physicians were experiencing a "medical malpractice crisis."

The *Nurse Practitioner*, the national journal for nurse practitioners, conducted a practice claims history survey in an effort to ascertain whether Maginnis's action was a knee-jerk reaction to the medical malpractice "crisis" occurring at that time or if the insurance company really was at serious risk because of malpractice

56. *See* Eccard, *supra* note 6, at 841.

57. POTTER, *supra* note 50, at 111-112. A nursing diagnosis is the identification of an actual or potential response to an illness or medical treatment the nurse is educated and licensed to treat independently or in collaboration with other health care providers. Thus the focus of the nursing diagnosis is helping the client to reach a maximum level of function and wellness. Medical and nursing diagnoses are derived from physiological, psychological, sociocultural, developmental, and spiritual dimensions of the data base. Medical and nursing diagnoses compliment each other because they identify the disease and the client's response to it and its treatment. Nursing diagnoses are standardized and are promulgated by the North American Nursing Diagnosis Association. This is a body of professionals who meet every two years to add new nursing diagnoses and to refine taxonomy.

58. Bullough, *supra* note 7, at 5.

59. Linda J. Pearson, *The Liability Insurance Crisis: Address it Now or Pay Later*, NURSE PRACTITIONER, June 1987, at 6.

claims against NPs.[60] Of the 3,542 respondents, 48 or 1.4 percent reported a professional liability claim filed against them as a nurse practitioner.[61] Statistics also showed that the specialty group with the largest number of malpractice claims were the groups involved with obstetric responsibilities.[62]

As NPs are viewed as the primary care giver, the patient will look to the NP to bear responsibility for his or her actions and will name the NP as the first defendant. In a malpractice claim the court in *Beiler v. Bodnar* summarized the trend when it stated:

> The role of the registered nurse has changed, in the last few decades, from that of a passive, servile employee to that of an assertive, decisive health care provider. Today, the professional nurse monitors complex physiological data, operates sophisticated life-saving equipment, and coordinates the delivery of a myriad of patient services. As a result, the reasonably prudent nurse no longer waits for and blindly follows physician's orders.[63]

Every professional has an obligation to carry sufficient malpractice coverage to ensure that a patient injured by malpractice will be justly compensated.[64] Even if the NP must incur extra expense to carry a larger malpractice insurance policy the salaries of NPs are still so far below those of physicians that the NPs services will continue to be affordable.

Because of the unique factors which contributed to the medical "malpractice crisis" of the 1980s, it is unlikely that in the near future there will be a comparable nursing "malpractice crisis" in the 1990s.[65] Up to this point NPs have avoided high exposure through

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60. Linda J. Pearson, *Comprehensive Actuarial Data on Nurse Practitioners . . . At Long Last*, NURSE PRACTITIONER, Dec. 1987, at 6.

61. *Id.*

62. Bullough, *supra* note 7, at 5. This corresponds with a 1980 study by B.C. Campazzi, which revealed that NPs practicing in areas such as anesthesia had a higher number of claims against them. B.C. Campazzi, *Nurses, Nursing and Malpractice, Litigation 1967-1977*, NURSING ADMIN. Q. 1-18 (Fall 1980). A study of all cases involving nurses that had reached appellate level in the decade between 1967-77, 1,696 total cases; Campazzi found that NPs with proportionately more claims against them practiced in specialty areas with the greatest increase in medical malpractice suits. He predicted a rise in the number of suits in "high risk" malpractice areas. The study also noted a growing trend to name registered nurses as the first defendants in malpractice suits.

63. Beiler v. Bodnar, 489 NYS.2d 885, 889 (1985).

64. Bonnie Bullough, *Nurse Practitioners: The New Victims of the Malpractice Crisis*, 1 J. OF PEDIATRIC HEALTH CARE 231 (1987).

65. David J. Nye, et al., *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L. REV. 1495, 1561 (1988). In this comprehensive study of malpractice claims in Florida, the authors suggest that the medical malpractice "crisis" was caused by a unique combination of unusually high awards for malpractice actions, the cyclic nature of the insurance industry which previously charged inade-

their well documented attention to a positive patient relationship.[66] However, if communication between NPs and patients decreases, because of busier practice schedules, patient satisfaction will decrease and there may be an increase in malpractice claims.

Professionals attempt to guard against malpractice in the profession through various means of self regulatory mechanisms. Regulation and discipline of the NP is accomplished through the State Boards of Nursing. Regulations promulgated by the state boards of nursing are directed at minimum educational levels required for licensure and are not written to establish practice standards. These regulations vary greatly among the states. Some states, such as Ohio, do not even address the regulation of the NP. This means that the scope of practice and standard of care are not statutorily defined.

Insurance companies and NPs are not required to report to the State Board of Nursing when they have been involved in a malpractice action. NPs in most states are only required to report any felony conviction or drug related arrest which results in conviction. The emphasis on drug and alcohol abuse and felony convictions and the lack of reporting mechanisms for malpractice actions, means that incompetence, negligence and other types of substandard care go unpunished by the state agency responsible for regulating NPs.[67] If patients become discontented with care provided by the NP and are unable to address that complaint to the State Board of Nursing, there could be an increase in the number of malpractice actions naming nurses as first defendants.[68]

Should the number of malpractice claims increase, the premiums charged for coverage will increase.[69] This will erase some of the economic benefits of the NP. However, NPs' salaries are so much lower than physicians that even with an increase in fees to cover the increase in malpractice costs, the NP will still be a good economic investment.

In light of the malpractice insurance concerns and the lack of statutory guidelines clearly defining standards of practice for the

quate premiums, and unprofitable investments made by the insurance companies which resulted in inadequate reserves. Since that time there has been a movement towards tort reform, with several states enacting caps on medical malpractice awards. Insurance companies have readjusted their malpractice premiums to realistically reflect the risk associated with insuring medical care providers.

66. Pearson, *supra* note 59, at 8.

67. *See* Bullough, *supra* note 64.

68. *Id.*

69. *See* Bullough, *supra* note 64.

NP, it will become important to define the scope of practice of the NP. There is disparity in the statutes defining the scope of practice and standard of care attributable to the NP. Because of the lack of uniformity the NP may be held to a lesser or greater standard of care than his or her education and expertise would demand. This disparity may result in malpractice awards which are inappropriate.

VI. SCOPE OF PRACTICE

Fundamental to the identification of an appropriate theory of liability and standard of care is the delineation of the scope of practice of the NP. Without delineation it is difficult for courts to say if the NP was acting within the scope of practice of an NP or breached the standard of care of an NP. Failure to delineate the scope of practice causes hesitancy among NPs to expand their role for fear of malpractice actions or actions from the medical community charging them with practicing medicine.

Scope of practice legally refers to permissible boundaries of practice for the health professional. The scope of practice is defined by statute, rule, and educational requirements.[70] From a legal perspective scope of practice issues usually arise in one of two instances: (1) some negligent act was committed and it is necessary to decide if this act was within the scope of the professional's practice or (2) the practitioner was clearly acting within the scope of the professions' practice and because of this, owed the patient some higher standard of care.[71]

Licensure is a way to define the scope of practice. Licensure statutorily defines the scope of practice of the NP in some states. All states require practicing nurses to be licensed according to their legislative nurse practice acts. These nurse practice acts create the authority for the State Boards of Nursing which were discussed previously. The primary purpose of these nurse practice acts is to protect the public from persons who fraudulently hold themselves out as nurses.[72] In the early 1970s many state nurse practice acts were amended to include the words "nursing diagnosis," and a "turf" battle over the scope of practice of the NP began between physicians and NPs.

Many states have promulgated regulations which specifically de-

70. GINNY W. GUIDO, LEGAL ISSUES IN NURSING: A SOURCEBOOK FOR PRACTICE 133 (1988).

71. *Id.*

72. Robin S. Phillips, *Nurse Practitioners, Their Scope of Practice and Theories of Liability*, 6 J. LEGAL MEDICINE 391, 408 (1985).

lineate the scope of practice of the NP. The creation of these regulations caused physicians to fear that a new health care professional was being created that would be able to practice independently within the scope of medical practice without being under the direct control of the physician.

The American Nurses Association (ANA) has taken the stance that the state nursing practice acts should provide for the legal regulation of nursing without reference to a specialized area of practice.[73] The ANA believes that the professional association should establish the scope and desirable qualifications required for each area of practice and certify competent individuals.[74] Its position is that since the NP's scope of practice is constantly evolving and the NP's role is a relatively new concept, specific delineation of the NP's scope of practice could result in unnecessary restriction on the evolution of the NP.[75]

Failure to define the boundaries of practice may restrict instead of expand the scope of practice by causing hesitancy among NPs to expand their role for fear of malpractice actions or actions from the physician community charging them with practicing medicine.[76]

At least two such suits charging NPs with practicing medicine have been filed, one in Texas [77] and one in Louisiana.[78] In those states the State Boards of Nursing promulgated rules defining the scope of practice of a NP. Both suits asked for a declaratory injunction to invalidate the regulations governing NPs. In each case the court held that the Nurse Practice Act did provide the authority for the State Boards of Nursing to promulgate such regulations and

73. AMERICAN NURSES' ASSOC., THE NURSING PRACTICE ACT: SUGGESTED STATE LEGISLATION (1981).

74. *Id.*

75. The ANA has encouraged broad language in establishing a statutory scope of practice definition. *See, e.g.*, N.Y. EDUC. LAW sec. 6902 (McKinney Supp. 1977).

> The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential health problems through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well being, and executing medical regimes prescribed by a licensed or otherwise legally authorized physician or dentist. A nursing regimen shall be consistent with and shall not vary any existing medical regimen. *Id.*

76. Karla Kelly, *Nurse Practitioner Challenges to the Orthodox Structure of Health Care Delivery: Regulation and Restraints on Trade*, 11 AM. J. LAW AND MED. 195, 211 (1986).

77. Bellegie v. Texas Bd. of Nurse Examiners, 685 S.W. 2d 431 (Tex. Ct. App. 1985) (suit for declaratory judgment denied and the court held that the defendant had not enlarged the practice of professional nursing beyond the statute).

78. Louisiana State Medical Society v. Louisiana State Bd. of Nursing, 493 So. 2d 581 (La. 1986) (suit for declaratory injunctive relief seeking to invalidate R. 3.041 governing nurse practitioners was denied, no irreparable harm could be shown).

that it was not an attempt to allow a person to practice medicine without a license.

Education also serves to define the scope of practice. To be eligible for certification as a NP by the ANA, the NP must be educated at the masters level and have completed a supervised course of clinical practice.[79] The ANA position is that the professional organization, not the State Board of Nursing, should award the NP certification.[80] By allowing the national professional organization to award the certification the ANA believes there will be more consistency in the definition of the scope of practice and that the certification guidelines will be written by NPs, not legislators. The counter argument to ANA's proposition is that not all practicing NPs belong (or even desire to belong) to the ANA, while all NPs must be licensed as registered nurses in the state in which they practice. Also, the regulations which would govern NPs would be written by the State Boards of Nursing which are made up of a majority of registered nurses who would presumably seek the advice of specialty NP groups in promulgating their regulations.

If there are no statutory educational guidelines for NPs then any nurse who desires to practice as an NP but who does not belong to ANA could still practice as an NP without certification. Nationwide third party payors such as Blue Cross/Blue Shield would have to decide which certification they would recognize. Courts will have to consider whether certification by the specialty organization, ANA, or by statutory definition will be the yardstick by which to measure scope of practice issues.

Statutes dealing with licensure, regulations defining specialized areas of practice and educational requirements imposed by the professional organization all indicate the presence of boundaries and intersections which define the scope of practice. While the advanced educational requirements and clinical expertise enable the NP to expand his or her scope of practice beyond that of a general registered nurse, the boundaries of that scope of practice intersect and exist in relation to other health care professionals. Since the standard of care is heightened from that of a reasonable person to that of a reasonable professional when the NP is acting with in the scope of practice of an NP, clear definition of the boundaries of the scope of practice would simplify the issue of whether the NP was

79. *See* Stanley Interview, *supra* note 10.

80. *Id.*

acting within that scope when he or she committed a negligent act which resulted in patient injury.

The traditional nursing model defined the scope of practice of the nurse as completely dependent on the physician. As the nursing profession evolved the model grew to include interdependent and independent functions of the nurse. The expanded role of the NP is coextensive in some areas with the practice of medicine.[81] It is possible to have these coextensive areas of practice because of the fluidity of the definition of the practice of medicine.[82] The medical services rendered in this coextensive area are essentially the same.[83] The difference is the model of care delivery.[84]

The overlap of scopes of practice between the physician and the nurse is called an interprofessional intersection.[85] The meeting point of nurses with varying education, knowledge, competence or interest is an intraprofessional intersection.[86] The NP's emphasis on comprehensive assessment and independent decision making about health care needs of individuals and groups has changed the intraprofessional and interprofessional intersection of nurses and other health care providers. The move from dependent functioning to independent and interdependent functioning has caused the boundary of the scope of practice of the NP to encroach further into the scope of practice of the physician while at the same time it has expanded outward from the general registered nurse's scope of practice.[87]

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81. Virginia C. Haggarty, *Doctrine of Delegated Medical Acts*, NURSE PRACTITIONER Apr. 1983, at 9-10.

82. *Id.* at 9. The practice of medicine is not stagnant. As it grows and becomes capable of performing more complex tasks, some tasks and processes are delegated to other health care professionals. Over time these delegated tasks and processes come to be viewed less exclusively as the domain of medicine and in fact can often be better performed by other health care professionals with different training. Physical exams for well baby care and preventative medicine care are examples of these delegated acts.

83. *Id.*

84. *See generally* POTTER, *supra* note 50. A model of care delivery system is the context in which the practitioner renders care. It can be a medical model, based on the disease process with a consummate goal of curing the disease. An alternative model is the holistic model based on addressing the physical, spiritual, and psychosocial needs of the person and aimed at assisting the patient to function at his optimum level of health. This does not necessarily correspond with what the practitioner perceives the patient's potential for health to be, but rather is based on mutually agreed upon goals set by the patient in collaboration with the practitioner. The holistic model is the model used by the NP and encompasses and his total support system.

85. AMERICAN NURSES'S ASSOC., THE SCOPE OF PRACTICE OF THE PRIMARY HEALTH CARE NURSE PRACTITIONER 5 (1986).

86. *Id.*

87. *Id.*

The boundaries have changed because over the years physicians have delegated many medical tasks to NPs. This is known as the Doctrine of Delegated Medical Acts. Such delegation has improved physician productivity and monetary compensation and enhanced patient care. The doctrine holds that all activities performed by physicians in the practice of medicine are "medical acts" and that acts characterized as medical retain that characterization for all time and that only physicians can perform those acts. This theory is difficult to rationalize. If an act can be performed so well by another health care professional that it is virtually always delegated and if in reality the physician often looks to that health care professional for his or her expertise in performing the act, how can it continue to be exclusively a medical act?[88]

Case law does not support this doctrine which makes all acts once performed by a physician forever exclusively within the scope of practice of the physician except for when the physician chooses to delegate the task.

The court in *Sermchief v. Gonzales*[89] held *en banc* that nurses in a family planning clinic who had received postgraduate education and were functioning under standing orders from a physician were not practicing medicine when they examined female patients and prescribed oral contraceptives for the patients. Relying on legislative history to interpret the statute governing nurses, the court held that the legislature had granted the nurses the legal right to make physical assessments and nursing diagnoses. These diagnoses were, however, subject to the diagnoses described in the protocol established by the physician but did not require direct physician supervision for implementation.

In an even more daring decision, the court in *Cook v. Workers' Compensation Department*[90] held that nurse practitioners who practice in Oregon were eligible to be designated as attending physi-

88. An example of such a task is the insertion of intravenous lines for medication administration. As recently as 20 years ago this act was almost exclusively performed by physicians. Now in most large hospitals there are specialty teams of "I.V." nurses who insert and maintain all intravenous lines. They are also responsible for administration of all chemotherapeutic drugs and are responsible for monitoring the patient for efficacy and adverse reactions.

89. Sermchief v. Gonzales, 660 S.W. 2d. 683 (Mo. 1983) (for an extended discussion of this case, *see* Joseph H. Guffey, Note, *The Role of the Nurse Practitioner: Threatened After* Sermchief v. Gonzales, 28 ST. LOUIS U. L.J. 493 (1984)).

90. Cook v. Workers' Compensation Department, 758 P 2d. 854 (Or. 1988) (NP operating her own clinic brought suit to force direct reimbursement from the state worker's compensation department).

cians within the meaning of the Oregon workers' compensation statute.

While these two decisions increase the scope of practice for the NP, there is no "bright line" that will define when the NP has stepped over the interprofessional boundary and into the scope of practice of the physician. Indeed it seems that this boundary is not stationary and that judicial interpretation on a case by case basis may be needed to define the appropriate boundary.

To avoid inconsistent interpretations of the boundary it is important for NPs to define the scope of practice boundaries either through legislative definition in the Nurse Practice Acts or by their own professional association statement. This is also necessary for self regulation. In fact, NPs have already responded to this imperative by bringing an action through the state Board of Nursing in Massachusetts against a nurse who was practicing as a nurse midwife without advanced training or certification from either a specialty group or the ANA.[91] Once the boundaries defining the scope of practice of the profession are established and the authority to enforce those boundaries confirmed by the legislature and judiciary, it will be easier to identify when an action against a NP is malpractice or ordinary negligence. Deciding within which scope of practice the NP is practicing in will be a prerequisite to deciding whether the theory of liability is ordinary negligence or malpractice.

VII. NP THEORIES OF LIABILITY

All NP malpractice claims fall under a general negligence theory. The elements of a negligence action are 1) a duty, 2) a breach of that duty, 3) a reasonably close causal connection between the conduct and the resulting injury, and 4) actual loss or damage resulting from that conduct.[92] Negligence is the failure to act as a reasonable person.[93]

The elements for an NP malpractice action are the same as in a negligence action. However, in a malpractice action there must be a standard of care established beyond the reasonable person standard. The standard of care for NPs should be that of a reasonable and prudent NP acting in like or similar circumstances. There must also be expert witness testimony in most cases as to whether the NP

91. Leigh v. Bd. of Reg. in Nursing, 481 N.E.2d. 1347 (Mass. 1985) (Mass. Supreme Court upheld the Board of Nursing's authority to suspend the nurse's license).

92. W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 30, at 164-65 (5th ed. 1984).

93. *Id.*

defendant met that standard of care.[94] The appropriate standard of care will be discussed in the next section.

It is necessary to have the malpractice theory of negligence applied so that NPs will be held to a professional standard. This increases accountability among members of the profession, encourages excellence in the delivery of nursing care, and protects the consumer from negligent nursing practice.

> [N]egligence rules are applicable in those situations where the issue relating to the exercise of due care may be easily discernable by a jury on common knowledge . . . However, where the directions given or treatment received by a patient is in issue, this requires consideration of the professional skill and knowledge of the practitioner or the medical facility and the more specialized theory of medical malpractice applies.[95]

Historically, nurses have been employees of hospitals, clinics or physicians. Nurses were not paid high salaries and did not carry malpractice insurance. A suit naming only the nurse was unlikely to recover enough money to compensate the victim for his injuries. Today, NPs can and do carry their own malpractice liability insurance. If they are an employee of a hospital or other institution they are also covered by that institution's insurance. By carrying his or her own malpractice insurance the NP is provided with independent counsel who is expected to look after the best interests of the NP. In relying exclusively on the hospital's counsel there could be a conflict of interest between the hospital's best interest and the NP's best interests.

Since the role of the NP is innovative it is helpful to look at theories of liability used in the past against general registered nurses. This overview will give a sense of the direction the law is taking in regard to malpractice liability for nurses and perhaps indicate which direction the courts will take in regards to malpractice actions against NPs.

In malpractice cases where the nurse was negligent the courts have used various theories of agency and vicarious liability to allow the plaintiff to recover for his injury. The earliest theory of vicarious liability employed was that of respondent superior.[96] Since hospitals could claim the defense of the doctrine of charitable

94. *Id.*

95. Coursen v. New York Hosp. Cornell Medical Center, 449 N.Y.S.2d. 52, 114 A.D.2d 254 (1986).

96. HAROLD G. REUSCHLEIN, THE LAW OF AGENCY AND PARTNERSHIP, § 52 (2nd ed. 1990) Respondent superior is a doctrine which makes a principal liable for the acts of an agent which are within the scope of the agent's authority.

immunity,[97] the plaintiff was still unable to recover when the negligent act was committed by a nurse employed by the hospital.[98] When the doctrine of charitable immunity began to erode,[99] the borrowed servant doctrine[100] was invoked by the hospitals to try to convince the court that the hospital was only responsible for the administrative tasks of their nurses and that the physicians were liable for any negligent nursing care that may have been administered by the nurse at the doctor's instruction.[101] By 1965 the public perceptions changed and the overruling of the doctrine of charitable immunity opened the door to imposition of vicarious liability on the hospital for the negligent acts of its nurses. The court in *Darling v. Charleston Community Hospital* held that the hospital itself was liable for negligent patient care.[102]

In the past some courts have had difficulty viewing registered nurses in general as professionals and have refused to extend the protection of the shorter malpractice statute of limitations to nurses.[103] These courts have applied a general negligence standard which would regard the nurse's actions as no different than that of any reasonable person. More recently the increased autonomy and independent practice of the NP has resulted in some courts modifying these theories of liability.[104] As educational levels and expertise have increased and the NP has come to be recognized as an advanced practitioner these attitudes have softened and courts have

97. KEETON ET AL., *supra* note 92, The doctrine of charitable immunity, which has been abolished, stated that it would be improper to impose liability via respondent superior on charitable institutions such as nonprofit hospitals and divert the money donated for charity.

98. VERN L. BULLOUGH, HISTORY, TRENDS AND POLITICS OF NURSING 123 (1984).

99. *Id.*

100. The borrowed servant doctrine imposes liability on one who is in control of another's servant when the negligent act of that servant occurs.

101. Schloendorff v. Society of New York Hosp., 105 N.E. 92 (N.Y. 1914) *overruled by* Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957) (hospital was held liable for the negligent acts of its nurses whether the acts were nursing acts or administrative acts).

102. 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 where hospital was held liable for the failure of its nurses to notify administration of substandard medical care rendered by a physician).

103. Richardson v. Doe, 199 N.E. 2d 878 (Ohio 1964) (court refused to apply malpractice statute of limitations to an action against a registered nurse stating that she was not a professional).

104. The Captain of the Ship Doctrine is restricted when the nurse is functioning in an independent role as a CRNA and not responding to a direct order. *See* Parker v. St. Paul Fire and Marine Ins. Co., 335 S.2d 725 (1976). A physician was found to be negligent in his supervision of a CRNA who he was not directly supervising even though both physician and CRNA were employees of the hospital. *See* Leiker v. Gafford, 778 P.2d 823 (Kan. 1989).

recognized that the increased educational practice of the NP require a different standard than a general negligence standard.[105] In Louisiana NPs are specifically included in the medical malpractice act and are afforded the one year statute of limitations protection.[106]

As NPs become independent contractors and contract with hospitals and clinics to provide their services it could become more difficult for the injured plaintiff to hold the hospital or physicians vicariously liable for negligent actions of NPs. [107] However, under the doctrine of corporate liability, the contracting agency could be liable if it is found to have been negligent in its selection and hiring of the NP.[108]

The courts may still find liability for the hospital under agency law.[109] In *Pamperin v. Trinity Memorial Hospital*,[110] the hospital was held liable under the theory of apparent authority for the actions of a radiologist who was an independent contractor. If NPs incorporate and contract out to clinics and if it appears to the patient through the representations of the clinic that the NP is an employee of the clinic, the clinic may be held liable for the NP's negligence.

As courts come to view NPs as professionals capable of independent practice, it follows that the NP should be independently liable for his or her actions under a negligence theory of malpractice. This is evidenced by the legislative approval of the expanded

105. Hill v. Leigh Memorial Hospital, 132 S.E. 2d 411 (Va. 1963) The court indicated that it would entertain different theories of liability based on educational preparation of the nurse.

106. Broussard v. Sears Roebuck and Co., 568 S.2d 225 (La. 1990) (malpractice statute interpreted in a case against an optometrist, nurse practitioner was enumerated as a provider covered in the state Medical Malpractice Act).

107. Parker v. St. Paul Fire and Marine Insurance Co., 335 So.2d 725 (La. 1976) A nurse who administered the incorrect blood was held liable for her act. The physician who ordered the blood was not liable under the borrowed servant doctrine.

108. Elam v. College Park Hospital, 132 Cal App. 3d 332, 183 Cal. Rptr. 156 (1982) A podiatrist who was an independent contractor, and never an employee or agent of the hospital committed malpractice on the plaintiff. The hospital which granted the podiatrist privileges and which was the site where the malpractice was committed was held liable for the negligent acts of the podiatrist. The court held that under the doctrine of corporate negligence the hospital was negligent in granting the podiatrist privileges.

109. *See supra* note 96, at § 23. Under the doctrine of apparent authority, the principal is and ought to be bound for unauthorized acts of his agent which appear to be authorized just as he is for acts the agent performs which are properly authorized.

110. 423 N.W. 2d. 848 (Wis. 1988) The court found liability for the hospital for the acts of an independent contracting physician under the agency theory of apparent authority. For a discussion of this case, *see* David J. Wigham, *From* Hannola to Albain: *The Rise and Fall of Ohio's Hospital Agency By Estoppel Doctrine*, 39 CLEV. ST. L. REV. 635, 642 (1991).

scope of practice,[111] authority given to the state Boards of Nursing to regulate that practice,[112] protection of the malpractice statutes of limitations,[113] and heightened educational requirements.[114] All these factors support the position that the proper theory of liability for a professional is malpractice.

VIII. STANDARD OF CARE

The legal standard of care in a malpractice action is that of a "reasonable and prudent practitioner acting in like or similar circumstances."[115] A professional standard may be viewed as a model established by a recognized authority in the profession. It is a level or degree of quality considered adequate for a specific purpose. Professional standards define what should be done and identify conditions under which one can reasonably expect quality care to be given.[116]

A professional association is a recognized authority in a profession and has an inherent obligation to create standards.[117] If the profession fails to create standards, the standard of care will be defined by others in a courtroom setting. Those standards may not reflect the standard the profession would like to see enforced. It is the author's opinion that not only must the profession set the standard, they must enforce the standard through such measures as mandatory certification. The profession must establish a system, which is accessible to the constituency to which it owes a duty, and which will encourage reporting of breaches. Further, the profession must establish either statutorily or through its professional association a method for effectively disciplining the NP.

To ensure that the standard of care protects patients and the ability of NPs to survive financially the standard must be established by those who have a unique understanding of the role of the NP and the scope of practice. The standards can be set statutorily by the State Boards of Nursing. NPs could assist in writing these

111. *See* Pearson, *supra* note 59, at 24-27.

112. *Id.*

113. *See* N.Y. EDUC. LAW, Sec. 6901, 6902 (McKinney Supp. 1977). New York, long a leader in the development of professional nursing, distinguishes between medical diagnosis and nursing diagnosis and affords NPs the protection of the shorter statute of limitations.

114. AMERICAN NURSES' ASSOCIATION, THE SCOPE OF PRACTICE OF THE PRIMARY HEALTH CARE NURSE PRACTITIONER (1985).

115. *See supra* note 92, at § 32.

116. EDYTHE L. ALEXANDER, NURSING ADMINISTRATION IN THE HOSPITAL HEALTH CARE SYSTEM 71 (1978).

117. MARY M. CUSHING, NURSING JURISPRUDENCE 41 (1988).

regulations. In the alternative, the NP professional associations could write practice standards to be used as a guide by expert witnesses who testify to the standard of care in malpractice cases against NPs. NPs must ensure that the high standards are enforced thereby protecting the consumer from unscrupulous practitioners, that the patients receive the care they are entitled to receive and so that the NP can maintain administrative autonomy and financial independence.

If the profession does not set its own standard of care or sets a standard too low, or if the usual and customary practice does not rise to an acceptable standard, or the court finds the standard of care set by the expert witness to be inadequate, the court will refuse to use that standard.[118] The court will find a way to allow recovery for a victim of malpractice if the only thing preventing the recovery is an inadequate standard.

In the past, courts have applied different standards of care to nursing malpractice actions. In general in nursing malpractice cases the courts have tended to focus on the task performed by the nurse in deciding what standard to apply. When the nurse was performing a task which did not require special skill, an ordinary person standard of negligence has been applied.[119] The NP is an independently functioning, advanced practitioner, and as such a heightened standard of care should be applied in malpractice actions against the NP. The proper standard of care should be that of a "reasonable and prudent nurse practitioner in the same or similar circumstances."

Another standard of review is the similar locality rule.[120] The similar locality rule was applied in *Hilden v. Ball* [121] to the care given by a NP. Although thought to be outdated because of modern methods of education and communication of technology and research advances, the similar locality rule holds the practitioner to

118. *See* Helling v. Carey, 519 P.2d 981 (Wash. 1974). The Washington Supreme Court held *en banc* that the usual and customary practice of ophthalmologists not to routinely perform glaucoma tests on persons under the age of 40 was an unsatisfactory standard.

119. Johnson v. Grant Hosp., 286 N.E.2d 308, 313 (Ohio 1972) Even though specially trained, a nurse must also exercise the standard of care of an ordinary prudent person. Where the issue is one of an exercise of judgment or skill requiring the specialized training of a nurse, expert-opinion evidence would be required. In this case a nurse left a patient unattended even though she knew the patient was suicidal. The patient subsequently committed suicide while unattended.

120. Wickliffe v. Sunrise Hosp., Inc., 706 P.2d 1383,1387 (Nev. 1985). The locality rule provides that the medical treatment of a patient is measured against the standard of care acceptable in the local community.

121. 787 P.2d 112 (Idaho 1989).

the same level of care as a reasonable and prudent NP practicing in the same or similar locality.[122] This standard was established to protect rural practitioners.[123] Although many nurses will practice in rural areas, this standard is not the proper standard to apply. It fosters the perpetuation of negligence and status quo practice. The NP's practice does not depend on a high level of technology that would be unavailable in a rural area. The NPs assessment tools are standard office equipment and access to a laboratory and x-ray equipment. These hardly seem to merit special consideration for the extension of the similar locality rule.

The standard of care should be heightened from that of the general RN to that of an NP by the additional duties imposed on the NP. Those duties are: the duty to refer, and the duty to disclose the NP's status as that of an NP. The duty to refer is imposed when the patient's condition is or becomes such that it is not within the scope of the NP's practice to treat the condition. The NP must recognize the limits of the profession and not compromise the patient's safety.[124]

The duty to inform the patient of the NP's identity can be considered from two directions. The first is to impose the duty because there is the presumption that the care will be inferior to that rendered by a physician. This approach allows the patient to contract for the type of health care he desires based on the amount of money he can afford to spend. This assumes several factors: (1) that the patient is free to choose, (2) that the patient is capable of choosing, and (3) that a choice does, in fact, exist.

The second perspective from which to view the duty to inform is that of allowing the patient to choose between models of delivery of care. Viewed from this perspective, the informed consent is not obtained because the patient is at risk for negligent care from the NP but rather to inform the patient as to his choices and educate him as to what he can expect from the NP. In this case informed consent is an educational tool so that the patient may choose the type of health care delivery system he desires, a curative medical model or a participatory nursing model.

122. *See* Wickliffe, 706 P.2d 1383 (where the court refused to exclude testimony of a nursing expert because she did not have knowledge of the locality).

123. *Id.*

124. Cooper v. National Motor Bearing Co., 288 P.2d 581 (Cal. 1955). (occupational health nurse and employer held liable for nurse's failure to refer patient who had received puncture wound which could not be adequately debrided by the nurse and which later became cancerous).

In the past, defining the standard of care of an NP has been predicated on which function the NP was performing when the alleged negligence occurred. Some commentators[125] are of the opinion that if the NP is carrying out a generic nursing function the standard of a reasonable and prudent nurse should apply. Likewise if the NP is carrying out a medical activity permitted by law, the standard can be established by a medical practitioner also practicing in that field. If the NP is carrying out an advanced nursing practice then the standard should be established by an advanced nurse practitioner practicing in the same field. While appealing in a logical sense, this approach assumes that the practitioner separates her knowledge and philosophy of practice when entering each of these areas of practice. This schizophrenic approach leaves the court with three questions to answer; 1) what function is the NP performing, 2) how can it tell which function is being performed, and 3) what standard should it apply?

In the reality of every day practice the NP is functioning at the level of advanced practice in every task the NP performs. The holistic approach of nursing demands that if the NP is to perform any task it must be integrated within the framework of the advanced nursing practice of the nurse practitioner. This is easy to conceptualize when speaking of generic nursing tasks and the well accepted NP tasks. However, it becomes more difficult to apply when the NP is functioning in an area of coextensive practice with other health care disciplines.[126]

Because it is too confusing and too difficult to apply the functions theory the NP should have its own standard of care. The scope of practice of the NP is not subordinated to the physician or superior to the general registered nurse. Instead the scope of practice overlaps and extends beyond these other spheres. NP functions are not separate or additional to the general registered nurses functions or the physicians. The scope of practice merely overlaps so the standard of care of the NP does not excuse any nonperformance of NP duties while functioning as a generalist and it requires that the NP bring with him or her the unique skills of the NP when functioning in the portion of the sphere which overlaps the physician's scope of practice. This creates a whole new scope of practice, thereby mandating a whole new standard of care. That standard of

125. CUSHING, *supra* note 117, at 31.

126. Such areas are primary health care delivery, family counseling (psychiatric nurse practitioners frequently perform the same services as a psychologist) and social work.

care should be that of a reasonable and prudent NP practicing in like or similar circumstances.

When the physician renders care in the part of the sphere which overlaps with the NP, the physician is held to the standard of a reasonable physician, not that of an NP. The physician retains his or her unique standard and so should the NP. Although the NP functioning in the area of overlap with the physician is performing some tasks which are also performed by physicians, the NP is expected to combine the performance of those tasks with NP nursing knowledge. The imposition of these extra requirements separates the NP standard of care in the coextensive areas of practice from that of the MD, so the appropriate standard is not that of medicine, but that of an NP performing those tasks.

For example, if the NP is following a patient with a chronic disease such as diabetes mellitus, the NP will be expected to monitor the patient's disease process, adjust medications, recognize complications and refer the patient to the appropriate specialist.[127] The additional nursing functions are to provide education for the patient and his family, encourage the patient to participate in his care, screen family members at risk, evaluate the cooperative plan of care, evaluate the patient's financial ability to comply with the treatment regime, intervene with the appropriate agencies if necessary and adjust the plan to meet the realistic goals set collaboratively by the patient and the nurse.[128]

The MD in the same situation would employ a model based on a curative concept. The MD's focus would be on closely following laboratory tests and physical signs and symptoms of the patient's illness, and treating the complications as they arise. Preventative care and adjunct therapy such as education, diet instruction and exercise would be delegated to allied health professionals such as nurses, dieticians, and physical therapists.

The general nurse would provide education and monitor the patient's progress as he or she returned to the physician for follow up care. The general nurse would perform those "medical" functions the physician delegated such as drawing blood. The primary difference between the general nurses's care and the NP is that the NP's care of the patient is autonomous and the general nurse's care must of necessity depend in large part on the delegation of duties by the

127. AMERICAN NURSES' ASSOC., THE SCOPE OF PRACTICE OF THE PRIMARY HEALTH CARE NURSE PRACTITIONER 5-7 (1985).

128. *Id.*

physician. The patient remains the "physician's patient" not the nurse's client or patient. The NP functions in an independent fashion with referral to a physician only when complications arise. The NP is responsible for the patient's primary care; the general nurse is responsible for assisting in the patient's primary care.

Courts have been willing to differentiate between the standard of care of the NP and that of the physician. In *Fraijo v. Hartland Hospital*[129] the court held that,

> Today's nurses are held to strict professional standards of knowledge and performance, although there are still varying levels of competence relating to education and experience. There is an increasing emphasis on high standards for nurses, and those with superior education and experience often exercise independent judgment as to the care of patients whether in a hospital setting or elsewhere. While nurses traditionally have followed the instructions of attendant physicians, doctors realistically have long relied on nurses to exercise independent judgment in many situations.

The court in *Fein v. Permanente Medical Group* also held that the standard of care to be applied to an NP was not the same as a physician.[130] The modern trend is to recognize that to be applied to the existence of overlapping functions and permit the sharing of those functions to enhance patient care through a collaborative approach to health care.

IX. EXPERT WITNESSES IN MALPRACTICE CASES AGAINST NPs

In a malpractice action against an NP, once the appropriate theory of malpractice has been applied and the standard of care established as that of a "reasonable and prudent nurse practitioner in like or similar circumstances"; it is important that the court recognize

129. Fraijo v. Hartland Hospital, 160 Cal Rptr. 246 (Cal. Ct. App. 1979).

130. Fein v. Permanente Medical Group, 695 P2d. 665 (Cal. 1985). The plaintiff was examined by a NP for complaints of chest pain and was sent home without an EKG being run. The patient later returned to the emergency room and saw a physician who also did not run an EKG. The patient was sent home. The patient subsequently suffered a heart attack and sued for residual disability. The court relied on legislative intent which stated that the legislature would "recognize the existence of overlapping functions between physicians and registered nurses and permitted the additional sharing of those functions with in organized health care systems which provide for collaboration between physicians and registered nurses", to find that the standard of care was to be measured by the standard of a NP as established by the State Board of Nursing. For a more extensive discussion, *see* Daryl L. Jones, Note, Fein v. Permanente Medical Group: *the Supreme Court Uncaps the Constitutionality of Statutory Limitations on Medical Malpractice Recoveries*, 40 U. MIAMI L. REV. 1075 (1986).

the correct expert witness. The basic qualifications of the expert witness are that the witness possess knowledge distinctly related to some science, profession or business which is beyond the understanding of laymen and that the witness have sufficient skill, knowledge or experience in a particular field whereby the expert's opinion will probably aid the trier of fact in their search for the truth.[131] The final test is whether the witness possesses special knowledge about the precise matter as to which the expert will testify.[132]

An expert witness must possess specialized knowledge in the area of practice about which he or she will testify. However, the witness does not necessarily have to practice in that capacity to testify. This leads to the difficulty of one specialist testifying to the standard of care of another and of specialists testifying to the standard of care of generalists. Permitting professionals with the same baseline knowledge but different expertise to testify as to the standard of care for NPs will result in the promulgation of ambiguous and inconsistent standards of care upon which juries will be expected to render fair decisions.

Physicians are sometimes used interchangeably with nurses to testify to the standard of care of a nurse.[133] This might be permissible if the NP still functioned as a handmaiden of the physician, following orders without independent thought and judgment making capacity. But the status of nursing has changed and physicians no longer have the special knowledge required to testify in cases of nursing malpractice.[134] NPs must be judged according to the practice of other members of their profession. Courts have recognized the need to have nursing experts testify to the care given by nurses and have refused to allow the jury to base their conclusions on the standard of nursing care based on their personal experience.[135] Courts have recognized the registered nurse as a professional with unique knowledge. The NP has additional expertise and the appro-

131. *See generally* CUSHING, *supra* note 117 (1988).

132. Margo Sneller Scholin, Note, *The Use of Nurses as Expert Witnesses*, 19 HOUS. L. REV. 527, 559 (1982).

133. Fein, 695 P2d. 665. Although the court used the NP standard for judging negligence, it still allowed a physician to testify to the nursing care provided.

134. AMERICAN NURSE'S ASSOC., THE SCOPE OF PRACTICE OF THE PRIMARY HEALTH CARE NURSE PRACTITIONER (1985).

135. Hiatt v. Groce, 523 P.2d 320 (Kan. 1974). An instructor of maternity nursing was allowed to testify to the care given by an obstetrical nurse. The court further stated that in determining whether a registered nurse used learning, skill and conduct required was not for the jury to decide arbitrarily or from their own personal experience. The standard of care required of registered nurses is established by members of the same profession in the same or similar communities under like circumstances.

priate expert witness is an NP or NP instructor with expertise in the same field.

The use of physicians as expert witnesses leads to credibility problems with the jury. Juries are likely to give great weight to the medical expert and fail to consider that the physician is testifying to nursing standards which the physician has never practiced one day in his or her career. The physician may only testify to what other NPs do, not from his or her own personal experience as a NP. This does not establish a NP standard and works an injustice to the NPs involved.

It will be tempting to argue that the physician can testify in areas in which the NP and MD practice coextensively. If, however, the court sees this area as only encompassing medical tasks then the physician should only be allowed to testify to the proper performance of those tasks. Conversely, the NP should be able to testify to the standard of care provided by a physician practicing in this area.

The trend is to recognize that nurses have knowledge peculiar to nursing and to use nurses as expert witnesses in malpractice cases against nurses.[136] NPs accept responsibility for their own actions and are held liable in the same manner as are other professionals. Only NPs should be allowed to testify as expert witnesses in malpractice actions against NPs.[137] General registered nurses do not have the advanced education and clinical expertise to testify to the standard of care of the NP. Nursing educators have been permitted to testify to the standard of care of the NP.[138] Because of their advanced education this would be an acceptable substitute for an NP. The educator's advanced education, which has a substantial clinical component, has exposed him or her to the nursing theories underlying the NP's practice and would allow the educator to render a fair opinion on the appropriate standard of care.

X. CONCLUSION

The role of the NP has expanded because of their cost effective manner of providing quality care. This role is likely to continue to expand as third party payors authorize direct reimbursement for

136. Wickliffe, 706 P.2d 1383 (Nev. 1983) The court found that there was no difference in education of nurses from one locality to another. The trial court erred in not allowing expert nurse testimony to go to the jury. The nurse's testimony contained knowledge peculiar to nursing practice and should have been admitted. *See also* Fraijo v. Hartland Hospital, 99 Cal.App.3d 331, 160 Cal.Rptr. 246 (1979); Sermchief v. Gonzales, 660 S.W.2d. 683 (1983).

137. Scholin, *supra* note 132, at 555.

138. *See* Fraijo, 160 Cal.Rptr. 246.

NP services and NPs gain administrative autonomy. The NP will become more visible in his or her role as the primary health care provider and will be put at risk for increased malpractice actions. In order to insure the best care for the patient and the fairest standard of judgment for the NP it is important to articulate the appropriate theory of liability and standard of care to be applied in these malpractice actions.

The scope of practice of the NP has been demonstrated to include areas of coextensive practice with other health care disciplines and areas exclusive to the NP. Since the NP is a professional capable of independent practice the appropriate theory of liability is malpractice. The standard of care to which the NP is to be held to is that of a "reasonable and prudent NP in the same or similar circumstances." This standard should be defined by the adoption of the professional national standards and the similar locality rule should be abandoned. The appropriate witness in a malpractice action against an NP is another NP practicing in the same field. Use of the NP as the expert will allow NPs to set the legal standard of care to which they must be held.

NPs in independent practice should be independently responsible for their actions. Even if the NP must charge the patient more to cover the NP's cost of a higher level of malpractice insurance, there will still be economic benefits to the consumer. NPs will still charge less than MDs. The advancement of autonomy and accountability for NPs also demands that the NP accept the burden of insuring against malpractice actions. Acceptance of independent responsibility will lead to increased collaboration between physicians and NPs as physicians come to realize that the NP is not just one more "para professional" for whom the physician must be responsible. Acceptance of independent liability would also encourage hospitals to allow NPs staff privileges and the ability to refer to their institutions for use of technical services such as x-ray, lab, and physical therapy.

Implementation of these higher standards, the application of the malpractice theory of liability and the removal of vicarious liability as a relief from judgment could result in NPs being assessed higher judgment awards in malpractice actions brought against them. This is acceptable because it protects the consumer, educates him to what he should expect, encourages accountability in the profession, and promotes self regulation. As NPs attempt to take the lead in providing new health care delivery systems they must consider and prepare for the legal challenges they will encounter.