Law and Ethics for Advanced Practice Nursing
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We lovingly dedicate this book to our fathers
Dr. Abner R. Kjervik and Hugh B. Brous, Jr.
for their inspiration and a lifetime of guidance
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The expertise of advanced practice nurses (APNs) has expanded the standards of care beyond basic nursing care. With increased expertise, additional benefits and obligations are important for APNs to be aware of as they provide both legal and ethical care. *Law and Ethics for Advanced Practice Nursing* provides a comprehensive overview, including the details needed to understand the obligations and rights for APN practice. The authors are experts in understanding the legal and ethical dimensions of advanced practice nursing, and they employed extensive legal research to examine the opportunities and expectations of APNs.

In chapter 1, the history of the changes that have led from limited autonomy to increasing levels of responsibility for APNs is discussed. Legal cases that give insight into successful defenses to malpractice cases involving statutes of limitation, practice standards, and causal connections between patient injuries and APN interventions are presented. These cases demonstrate for the APN how the law evaluates APN liability. Cases that discuss intentional misrepresentation of professional credentials and improper use of controlled substances also provide important lessons for APNs. Legal cases involving the APN’s professional practice, such as third-party reimbursement and the APN’s expertise to testify in civil and criminal cases, clarify both rights and responsibilities for APN practice. Patient privacy rights, antitrust violations, slander, and intentional infliction of emotional distress as causes of action are also discussed in cases addressing hospital and prescriptive authority privileges. The law applying to the APN’s practice is constantly evolving through the findings and holdings of legal cases. The lessons learned through the experiences of APNs in the cases discussed in chapter 1 are important for preventive risk management in the APN’s practice. The relationship between APNs and physicians, including noncompete covenants, is also an important historical perspective in this chapter.

Chapter 2 discusses the interface of nursing law and ethics. Ethical dilemmas present situations that do not always have the same outcomes, because not all people choose to live or die in the same way. The
solutions to these issues are gray areas where there are no right or wrong answers, and these are decisions that should be made by those who have the right to make an informed decision. When members of a society cannot agree on how serious ethical dilemmas should be decided, and who has the right to make the decision, the issue often becomes a legal consideration. Courts then decide how a resolution must be reached. The APN’s role as the patient advocate, and an advocate for the APN’s practice, is considered in this challenging chapter.

Chapter 3 informs the readers about policy changes affecting APN practice. Educational, licensure, certification, and accreditation requirements nationally are all policy decisions that affect the rights of APNs to practice their profession as partners with physicians and other providers. APNs need to stay involved in the process of policy development in order to protect their right to legally provide care based upon their skills, efforts, and responsibilities.

Fair compensation for APN services is also an important policy issue discussed in this chapter. Strategies for building consensus within the profession, as well as support from consumers, employers, and co-workers, are vital in order to enable policy development that will allow APNs to provide high quality and affordable care.

Chapter 4 provides the information needed to understand malpractice, or nursing negligence. The facts needed to understand the APN’s responsibilities as the patient’s advocate and caregiver are discussed in a clear and understandable way that displaces unnecessary fears of malpractice. Statistics on actual malpractice actions against APNs are provided. Insurance issues and reductions in medical errors are discussed as supportive information for the APN’s risk-management planning. Discussion of patient perceptions and why patients sue are especially helpful in assisting APNs to minimize their malpractice risks.

Chapter 5 is especially important to APNs, as the issues of labor and employment become more individualized through the expertise and licensure opportunities of the APN. The different employment relationships available to APNs are discussed in clear and helpful terms. Regulations, rights, and responsibilities based on worker classifications are important to understand when deciding whether to set up a private practice or to accept employment from a physician group or hospital. Recommendations on purchasing professional liability insurance, even when choosing to be employed by another, are shared in this helpful chapter.

Chapter 6 clarifies the foundations of licensure and regulations through an interesting discussion of the history of how the profession
of nursing evolved. The development of Nurse Practice Acts, and finally, the expanded APN role, as well as the role of State Boards of Nursing, are described in this chapter. Licensure is a privilege that APNs must earn. Every state has its individual requirements that must be understood by APNs who practice and are licensed in multiple states. State Boards of Nursing have been delegated the legal authority to ensure compliance with the nursing standards imposed by their state to safeguard the public, as well as the APN’s right to practice. The moral character of the APN may also become a concern of the State Board of Nursing if a complaint is made against the APN. The information shared in this chapter will assist the reader in understanding the system within which APNs work.

Chapter 7, Nursing and Law Pedagogy for APNs, provides an interesting and important opportunity for APNs to learn how to use the connection between law and nursing theory to become policy advocates for patients, families, and communities. Understanding this connection provides the conceptual framework for testing legal, ethical, and nursing phenomena together. Evidence-based information provides a powerful tool for change in building interdisciplinary strength. The future power of the APN’s practice is obvious from the information provided in this chapter, based upon the author’s experience and expertise.

Chapter 8 brings the reader to the global issues of international law and nursing. The nursing shortage that extended throughout the 1990s was a global experience. The impact of the shortage was, however, felt differently across the world, depending on the economic resources of the country. Statistics shared in this chapter describe the accelerated migration of nurses from economically deprived countries to resource-rich countries. The ethics of a global nursing society with the goal of global public health is the message of this important final chapter of the book.

The eight chapters in this book are interesting and offer easy reading. The complex topics discussed are expertly shared through the knowledge, skill, and understanding of the authors, who are both nurses and attorneys. The needs of APN practitioners have been thoughtfully evaluated and presented in this comprehensive text.

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What were the visionaries in nursing seeing as they imagined advanced practice in nursing? A portion of their story involved the law, which, as they found it, stood in the way of their expanded practice. In 1979, Shirley Berglund, a nurse practitioner in St. Paul, Minnesota, became the first nurse practitioner in that state to incorporate her business, establish her office, and “hang out her shingle.” She maintained an active practice until 1991, when she closed her office and sold the building. She led the way in Minnesota, as others did across the country, to pave the way for advanced practice nurses (APNs) who wanted to conduct independent businesses in collaboration with other health providers. Nursing, in their view, was its own professional discipline, not a part of medicine, pharmacy, public health, or social work. Rather, it could and indeed would stand on its own in service to consumers who sought nursing expertise. This book constitutes a tribute to the APNs, such as Shirley Berglund, who fought, suffered, endured, and succeeded in their challenge to the status quo.

With its emphasis on the legal tools used by APN pioneers and the ethical foundations on which they built their practices, this book provides a unique examination of historical and recent legal challenges these nurses faced. Some barriers were overcome, and some yet remain. However, the momentum for advanced practice won’t be slowed in the environment of increased cost constraints and consumer demand for access to high-quality care. APNs are charting their course, and the law can help or hinder these efforts, depending on the degree of engagement and sophistication APNs have about legal process and decisions. This book provides insights to guide nurses and nursing leaders as they develop their strategies for change.

Law as a source of power guided by ethics as a source of philosophical sophistication provides the backbone of a concerted strategy for continuing development of the nursing profession. Conflicting ethical obligations exist, however, challenging the APN’s sense of integrity. This book presents approaches to understanding and resolving several
of these ethical conflicts. Nursing research, theory, and knowledge cannot shine on their own without corresponding policies that are open to these insights. Evidence created by nursing researchers and scholars is best created with attention paid to legal and ethical phenomena. Thus, this book is intended for APNs in practice, nursing educators teaching in APN programs, and for basic and applied nursing researchers who are studying phenomena of concern to APNs. The book will also be a resource for lawyers and ethicists who work with or on behalf of APNs.

From a practical standpoint, the book includes cases that make legal precedent in specific jurisdictions, and as such, are limited to that jurisdiction. However, courts reason by analogy, and although one state's decisions are not binding on another state, each court may use the arguments from another judge or jurisdiction to support its new ruling. Likewise, some cases presented here center on staff nurses, physicians, or other health providers, and not on APNs. However, the precedent set is likely to be followed by the court when faced with a similar case involving an APN. The cases have been selected to illustrate legal principles and the manner in which the courts analyze them, not to highlight their outcomes. Information regarding the dispute's final resolution is actually irrelevant, and may not be available or discussed in cases that were remanded back to the trial level, because it is generally only the appeals court that publishes decisions and opinions. Also, areas of law such as malpractice, contract, and civil rights often intersect. The cases presented here will highlight one area of law, but mention may be made of other, related areas. Important to note is that law that is settled in a jurisdiction is often based on cases that are from years before. Thus, cases cited in this book will, at times, be from older case precedents that have not been overturned. The legal world refers to those cases as still representing “good law.” Additionally, some older cases were selected because they established or changed the law and provide historical perspective.

From a linguistic standpoint, the language of law includes words such as “test” and “theory” that are used differently from the way they are used in health care. A legal test is a set of criteria to help the court decide whether a certain requirement is met. A legal theory is an area of law such as negligence or contract, upon which the parties to litigation rest their complaint against the other party. And, of course, there are obvious differences in use of language, such as “labor law,” which has to do with union relationships and not obstetrical experience. Throughout the book, the authors define terminology specific to the legal deci-
sions they address, and in this way, they serve as translators of legal language for the health care audience.

We present this knowledge with the hope that APNs and those who work with and for them will find these insights and suggestions of help as they build and refine educational, research, and practice programs. We are grateful to our consultants, who assisted us as we developed the book. And we offer a special thanks to our publisher, who envisioned the need for this book and sought our expertise to create this publication.

Diane Kjervik
Edie Brous
Law and Ethics for Advanced Practice Nursing
The question, then, must lie not with the existence of nursing authority, but with people’s recognition of that authority.

—E. Baer

The tale of the evolution of advanced practice nursing (APN) begins with the roles that nurses played in hospitals and their wish to find independence outside the hospital. The law represents a form of power that assisted nurses to move beyond their traditional roles to grasp the ones they hoped to assume over time. Ellen Baer describes the source of this process as nursing’s “growing militancy in its refusal to be dominated by medicine” (Baer, 1993, p. 111). Ethics provided the expression of values in support of nurses’ empowerment, namely, autonomy in practice, beneficence and care-based ethic in doing what is best for patients, and justice (fair treatment of all providers and patients). This chapter will examine exemplary ethically embedded legal cases that, taken together, frame pivotal moments in the history of advanced practice nurses (APNs) from the 1950s through the 1980s.

The earliest nurse practitioner (NP) program, crafted in 1965 by Loretta Ford and Henry Silver in response to a shortage of primary care physicians, emphasized the primary care model of health promotion and disease prevention (McGivern, 1993). As health care reform efforts arose, the need for more primary care providers intensified (Inglis &
Interestingly, many of the early legal cases involving APNs centered on nurse anesthetists and other APNs working in acute care settings.

The cases are divided into two categories: (a) those addressing expanded roles and privileges, such as intentional and unintentional actions (standard of care), expertise and courtroom testimony, and hospital and prescriptive privileges; and (b) those stemming from relationships between APNs and physicians, such as antitrust and insurance, noncompete clauses, and supervision by MDs. Both expanding scopes of practice and substandard levels of performance, as discussed by Bartter (2001), comprise the content of these cases. The results of legal research of cases covered here exemplify controversies that have been taken to court for resolution. Because many cases are settled prior to trial, only the published court decisions resulting in precedents in those jurisdictions are presented here. Some of the cases are transferred back (remanded) to a lower court for final action. Litigants may then settle the case without benefit of trial or further written opinion. Similarly, no written record of trial court opinions on the state level exists, so final disposition of these cases remains unknown. The cases are organized chronologically to highlight the changes in the legal view of APNs over time.

**ROLES AND PRIVILEGES**

**Standard of Care**

The legal standard of care for a health professional sets the expected performance of a nurse, and evolves over time as clinical practice changes and nursing roles expand. Each state sets its own standard of care, and must be researched thoroughly for precedent. The first set of cases addresses negligence, the failure to meet the standard of care that results in injury to a patient.

**Unintentional Acts (Negligence)**

In 1954, a case was brought against a hospital and an MD, which also involved the actions of a nurse anesthetist, for negligent actions during an attempted tonsillectomy. The nurse anesthetist at the hospital intubated the patient so that the tube went to the stomach, rather than the lungs, resulting in painful abdominal distention after the intubation. She was found negligent under *respondeat superior*, the principle that the employer is responsible for negligent acts of the employee. The
surgeon was found not to be responsible for the acts of the nurse anesthetist. The physician, the surgeon in this situation, was an eye, ear, nose, and throat specialist who did not supervise or have control over the nurse anesthetist. She was an employee of the hospital, and her testimony at trial specified that she received no supervision from the surgeon. On appeal, the Supreme Court of Washington affirmed the judgment of the trial court (Kemalyan v. Henderson, 1954).

In contrast, a case involving the administration of penicillin to a patient who was allergic to it resulted in a different legal outcome in Pennsylvania. As a result of the administration of penicillin to the patient, a severe allergic reaction and cardiovascular accident occurred. The respondeat superior doctrine was used to find that an MD was responsible for the acts of a nurse anesthetist and a resident who failed to act on information they had about a surgical patient’s allergy to penicillin (Yorston v. Pennell, 1959).

In 1964, a patient who suffered impaired functionality of her arm following gynecological surgery alleged that the Certified Registered Nurse Anesthetist (CRNA) who administered sodium pentothal punctured a vein, and as a result, the muscle tissue near the site was damaged. In finding for the CRNA, a federal District Court in Michigan found no malpractice, and concluded that the CRNA and the surgeon followed customary practice in the administration of sodium pentothal, with its concomitant risks and lack of direct supervision of the CRNA by the surgeon. The court strongly stated that, “a treating physician, surgeon, or nurse-anesthetist is not a warrantor in performing medical or surgical services. They are responsible for damages for unfortunate results when, and only when, it is shown that they have departed from the standard in the community of treatment and care by skilled doctors and nurses” (Gore v. United States, 1964, p. 549). The court also noted that the Michigan nurse practice act changed in 1952 from the expectation that an MD supervise and direct RNs to the expectation the RNs carry out treatments as prescribed by a physician.

In South Dakota in 1975, a nurse anesthetist chose penthrane, a halogenated anesthetic, for a cholecystectomy. The physician recalled suggesting that she not use a halogenated anesthetic, but the nurse anesthetist had no such recollection. A few days after the surgery, the patient died of liver failure, and this wrongful death legal action was instituted by the patient’s husband. The defendants won in the trial court, but on appeal, the question of the type of witness needed in a malpractice case against a nurse anesthetist, a physician, and a hospital was raised. During the original trial, the court excluded testimony from
the nurse anesthetist and the surgeon who operated about what, if any, direction the MD gave her about the type of anesthetic to use with a patient who had hepatitis in the past. The trial court allowed expert testimony on technical questions and excluded the testimony of facts in dispute. Therefore, the appellate court decided that issues of fact about what was communicated between the nurse anesthetist and the physician remained, and granted the husband’s request for a new trial (Carlsen v. Javurek, 1975).

Inadequate informed consent can also lead to a case of negligence against an APN. In a 1976 wrongful death case, a patient died on the operating table following anesthesia given by the nurse anesthetist. The plaintiff argued that the informed consent given the patient prior to the surgery was inadequate. A Texas appeals court decided that the informed consent the patient was given did not lead to the patient’s death. The plaintiff had to present evidence that the informed consent lacked critical information that would have influenced him to reject the surgery. However, the jury did not find that the plaintiff would have rejected the anesthesia if more details about the risks had been provided (Forney v. Memorial Hospital, 1976).

In a 1978 case, a nurse anesthetist and a first-year resident inserted an endotracheal tube into the patient’s esophagus, rather than the trachea, prior to surgery for a Caesarean section. As a result, the 18-year-old patient died a few days after the Caesarean section. The nurse anesthetist was named as a codefendant with the first-year resident in anesthesiology, along with other staff at Charity Hospital in New Orleans, LA, and the jury found for the defendants. However, on appeal, the court decided that the negligence case against the nurse anesthetist and the first-year resident should be re-heard by the trial court, because evidence that negligent insertion of the tube had occurred was compelling (Aubert v. Charity Hospital, 1978).

In a 1979 case, a nurse anesthetist and others were sued for malpractice after an 11-year-old boy died following cardiac arrest during a cosmetic surgery for pectus excavatum, commonly known as sunken chest. The trial court found for the defendants, and this decision was affirmed on appeal, in which the only issue was whether the doctrine of res ipsa loquitur should have been applied by the jury. This doctrine stands for “the thing speaks for itself,” in which three tests must be met: “1) the accident or injury normally does not occur in the absence of negligence; 2) there exists an absence of direct evidence to explain the activities leading to the injury; and 3) the accident or injury was caused by an agency or instrumentality within the actual or constructive
control of the defendant” (Ewen v. Baton Rouge General Hospital, 1979, p. 174). Even though the cardiac arrest occurred during surgery, this condition can happen with or without surgical involvement and minus negligence of professionals. Therefore, the appellate court supported the trial court’s judgment for the defendants.

The following year, the same defendant nurse anesthetist was named in a malpractice suit for negligent administration of Valium prior to surgery. The patient suffered phlebitis and thrombosis in the arm in which the Valium was injected. Evidence indicated that the nurse anesthetist followed the manufacturer’s recommendations and the standard practice of nurse anesthetists, so the plaintiff’s case failed. Interestingly, in Louisiana, the locality rule applies to generalists, not specialists, whose actions are measured in relation to other “specialists in similar circumstances” (Mohr v. Jenkins, 1980, p. 246). The locality rule is the idea that the standard of care is measured according to the standard in the locality in which the nurse practices, rather than a national standard. So an expert witness must be familiar with the standard in a given community, not the national standard of care, even though education of health professionals uses national standards based upon evidence-based practice (Lewis, Gohagan, & Merenstein, 2007). This creates uncertainty for health professionals about what is expected of them and may promote substandard practice (Lewis et al., 2007).

Until 1975 in Michigan, nurses could not be sued for malpractice, but the state legislature changed the law in recognition of professional judgments nurses made independently. In a 1981 case against a CRNA, the plaintiff argued that the CRNA could not be sued because a nurse had administered the anesthesia. The court did not support this argument, saying that nurse anesthetists have specialized education and certification to administer anesthesia (Whitney v. Day, 1981). As a side point, the standard of care to be used in Michigan was the locality rule, “in the same community” (p. 712).

In a Pennsylvania case, a nurse anesthetist and the surgeon were found jointly liable for faulty arm positioning during a gynecological procedure that resulted in supracapular nerve palsy. As was true in a previous case, the res ipsa loquitur analysis was applied here by the court, and in this situation, the defendants had exclusive control of the positioning of the patient, and therefore were liable for the resulting injury (Jones v. Harrisburg Polyclinic Hospital, 1981).

In a 1981 decision by a Louisiana court, a CRNA was found liable for improper ventilation of a patient who subsequently died. Although a physician had ordered the nurse anesthetist to insert the nasal catheter,
the court found that the MD did not actually “supervise or control” the actions of the nurse anesthetist, and thus was not vicariously liable (Hughes v. St. Paul Fire & Marine, 1981, p. 450). The nurse anesthetist was not an employee of the physician, and argued that he was an independent contractor, which made the link between the MD and the CRNA even more tenuous.

Even when a strong case for malpractice exists, the case will be dismissed if the statute of limitations has been exceeded. A nurse anesthetist in North Dakota was named as a defendant in a suit brought by the family of a man who died from cerebral anoxia following an unsuccessful effort to administer anesthesia prior to surgery. The patient died on August 18, 1977, and the family was informed on December 9, 1977, that they had the right to sue for possible malpractice. In November of 1979, the family began the process by asking for a medical review panel to review the case, and when the judge refused to convene the panel for legal reasons, the patient’s wife filed suit on December 14, 1979. In North Dakota, a suit for wrongful death must be brought 2 years from the time when the legal problem arises, in this case, the death of the patient on August 18, 1977. The statute of limitations ran for 2 years, so a suit could not be brought after August 18, 1979 (Ness v. St. Aloisius Hospital, 1981).

In a 1982 case, a nurse anesthetist and a physician were sued for malpractice following surgery that preceded the patient’s cardiac arrest, brain damage, and subsequent death. The nurse anesthetist introduced testimony of two expert witnesses, who concluded there was no negligence. The plaintiff, however, presented an opposite opinion from an expert witness from a nearby state. The plaintiff’s expert identified the following failures: “failed to make a complete preoperative evaluation of the patient before administering anesthesia...failed to adequately monitor Slayton (the patient) prior to transferring her to the recovery room...took improper steps to reverse the effects of the respiratory and cardiac arrest...failed to properly record the dosage of medication on the anesthesia record” (Slayton v. Brunner, 1982, p. 146). The lower court found for the defendants and dismissed the case. However, on appeal, the court reversed the judgment of the lower court by saying that the plaintiff’s expert could testify on the standard of care, despite being from Oklahoma, not Arkansas. Arkansas’ locality rule allowed testimony from experts who are familiar with the local standard by having accepted referrals from a similar community, consulted with health professionals from similar communities, and having health professionals with similar qualifications at their facilities. Thus, the appellate court decided there were facts in dispute that should be decided by a jury.
In a 1984 North Carolina case against a nurse anesthetist, a surgeon, assistant surgeon, and a hospital, suit was brought by a patient and her husband for malpractice, alleging that ulnar nerve damage the patient suffered following a vaginal hysterectomy was caused by poor positioning during surgery. The lower court dismissed the case, as requested by the defendants, but on appeal, the court held that issues of fact remained about the nurse anesthetist’s liability for poor positioning and whether she was an employee of the hospital. Thus, the plaintiff’s res ipsa loquitur argument was accepted (Parks v. H. B. Perry, 1984).

In a 1984 New York case, the husband of a patient who happened to be a registered nurse (RN) and who died from breast cancer, alleged that a physician and NP had failed to diagnose the condition in a timely manner, which led to his wife’s death at age 36. The NP had seen the patient for a routine physical exam, had reviewed the records of a physician from a prior visit, and concluded that the diagnosis was fibrocystic breast disease. No evidence of the NP’s negligence was provided, so the case proceeded only against the MD. The physician was held to be negligent, and the patient was awarded $950,000. The demeanor of the MD at trial did not support his argument. The court stated that because of his demeanor, the patient’s testimony taken before trial was more convincing than the MD’s statement of the facts (Beckcom v. U.S., 1984). The demeanor was not described in any detail in the judge’s opinion. However, this comment from the judge is a reminder to APNs who present evidence in court that they should be well prepared by an attorney, so that the testimony about the facts is credible.

In North Carolina, a child’s mother received prenatal care from a family nurse practitioner (FNP) under the supervision of a physician. The plaintiffs, who were the child who was born with Down syndrome, the parents, and siblings, alleged that the FNP failed to inform the parents of the option of amniocentesis and genetic counseling. Had she done so, the parents would have been able to terminate the pregnancy. A case of wrongful life/wrongful birth of a child with Down syndrome was brought by the family. Ms. Dowdy was codefendant with the health care agency where she worked and with an MD in the clinic. The Supreme Court of North Carolina decided that neither claim was a viable legal claim in North Carolina. The court stated, “Whether it is better never to have been born at all than to have been born with even gross deficiencies is a mystery more properly to be left to the philosophers and the theologians. Surely, the law can assert no competence to resolve the issue, particularly in view of the very nearly uniform high value which the law and mankind has (sic) placed on human life, rather than its absence” (Azzolino v. Dingfelder, 1985, p. 109).
In a 1985 New York case, a patient in surgery for a gangrenous foot suffered an anoxic brain injury and subsequently died following surgery. The death certificate stated that, “the immediate cause of death was acute renal failure, due to or a consequence of broncho-pneumonia and sepsis, which was in turn due to, or a consequence of post-hypoxic encephalopathy and spastic quadraparesis” (Rosenberg v. New York University Hospital, 1985, p. 91). This case was brought against a nurse anesthetist, a hospital, an anesthesiologist, and a surgeon, and demonstrated the importance of a death certificate as evidence of a causal link between the negligent act and the injury (wrongful death). Thus, the death certificate can provide critical information in malpractice cases, even regarding the requirement of proximate cause (the direct and immediate cause of death).

A 1985 Washington case involved a nurse anesthetist who provided the induction prior to exploratory surgery. During the induction, the patient’s airway became blocked and the nurse anesthetist was unsuccessful in clearing it. She called for help and physicians were able to open the airway, but the patient’s heart stopped, and mental and physical impairments resulted. The nurse anesthetist and an anesthesiologist were sued for negligence and failure to obtain informed consent. The judge dismissed the informed consent claim, the jury found for the defendants on the negligence claim, and the plaintiff appealed. On appeal, the court said that the informed consent claim should have been allowed, because there was evidence that defendants did not provide adequate information about risks and alternatives. The res ipsa loquitur claim was barred in trial, but on appeal, the court said that res ipsa loquitur could be used in the new trial. Interestingly, the court mentioned a potentially coercive comment made by someone in the admissions process, “the little girl told me if I didn’t sign it I wouldn’t get the job done, so I signed the paper” (Brown v. Dahl, 1985, p. 786). However, the court did not rest its decision on this required element of voluntariness for informed consent.

In a 1985 California case, the actions of an NP who worked for the defendant’s medical practice were evaluated by the jury according to the standard of care for physicians, as directed by the trial judge. On appeal of the verdict for the plaintiff, the Supreme Court of California said that this was an error, but not one requiring reversal of the judgment, because the judgment about negligence in this case would not have been changed (Fein v. Permanente Medical Group, 1985). Much evidence existed to demonstrate negligence beyond that involving the NP.
In a 1987 Louisiana case, an 11-year-old child died of aspiration pneumonia and sepsis following an episode of vomiting during the administration of anesthesia by a CRNA. Plaintiffs appealed a judgment that they as parents of a child who died in surgery for appendicitis contributed to the negligence, and that their award of damages should not be reduced by 75%. The court dropped the contributory negligence allegation by the defendants because no evidence to support this proposition was offered, and upheld the award of damages to the plaintiff (*Pierre v. Lallie Kemp Charity Hospital*, 1987). Contributory negligence refers to actions on the part of the plaintiff that partially cause the injury.

In a similar case in Nebraska in 1989 against two CRNAs, an RN was the patient who died following a hemorrhoidectomy. The CRNAs argued that because the patient was an RN, she should have known that her thyroid condition could jeopardize the use of certain anesthetics, and she didn’t disclose this information during the preanesthesia assessment. The trial court had erroneously given a jury instruction about considering contributory negligence when there was no evidence presented indicating this. On appeal, the court reversed the judgment in the defendant CRNA’s favor so that a new trial would omit the contributory negligence claim (*Gehre v. Coleman*, 1989). However, the court said that “there was no evidence that decedent, as a registered nurse educated in the 1920s or 1930s and retired from active nursing for more than 20 years, knew or should have known that a thyroid condition would make the administration of a particular anesthesia dangerous” (p. 38). Thus, a new trial was ordered.

### Intentional Acts

Injuries to patients can come from intended actions by the APN as well as accidental actions. These cases from the 1980s involve intentional claims against APNs.

In 1984, a Massachusetts Board of Registration in Nursing suspended an RN’s license, saying that she practiced midwifery without the Board’s authorization, which it considered gross misconduct. The RN was not certified or formally educated as a nurse midwife, nor had the Board approved her practice as a nurse midwife. The nurse appealed the suspension, arguing that she was not practicing as a nurse midwife, but rather was practicing as a lay midwife attending home births. The Board argued that practicing lay midwifery was the unauthorized practice of medicine. Although the court agreed with the Board about the nursing licensure violation, it remanded (sent the case back) to the
Board for reconsideration of its reasons for the suspension, because the Board's ruling against the nurse was not clearly based solely upon her nursing license violation, and in Massachusetts, lay persons could practice lay midwifery (Leigh v. Board of Registration in Nursing, 1985).

In 1989, the Supreme Court of New York upheld the ruling of the State Commissioner of Health that a nurse anesthetist had obtained and disposed of morphine sulfate improperly and without a doctor's order. The nurse anesthetist was assessed a $7,000 fine as a civil penalty for these violations (Damm v. Axelrod, 1989).

**Expertise and Courtroom Testimony**

Courts hear testimony from parties to a lawsuit on the qualifications of expert witnesses, and allow or exclude their testimony. APNs serve as expert witnesses, but at other times, they testify about the facts of a situation that they witnessed directly. This set of cases presents situations in which the testimony of APNs was important to the resolution of the case.

In a key informed-consent case in Minnesota, Cornfeldt v. Tongen (1977), the Supreme Court of Minnesota decided that testimony of a nurse anesthetist should not have been excluded by the trial court. The defendants in this wrongful death case were physicians, and the issue was the adequacy of the administration of anesthesia and information the physicians had given to the patient prior to surgery. The trial court justified its exclusion of the nurse anesthetist's testimony by the fact that he was not a physician, and thus, could not testify about medical standards. However, the appellate court said that his education and licensure as a physician were not determinative, but rather if the nurse anesthetist, “otherwise had sufficient scientific and practical experience about the matter to which he would have testified, he would have been a competent expert witness” (p. 697). Interestingly, however, the court said that the exclusion of this testimony was not prejudicial to the case, and thus, its exclusion was not enough to reverse the lower court's decision by itself.

In a 1987 case in Louisiana, the plaintiff in a wrongful-death suit argued that the fact that a nurse anesthetist provided the anesthesia rather than another provider was evidence of negligence by itself. In this way, the plaintiff questioned the expertise of the nurse anesthetist. The court rejected this allegation, saying there was no link between the actions of the nurse anesthetist and the cause of the patient's death. In addition, the Joint Commission on Accreditation of Hospitals (JCAH)
accreditation standards included use of nurse anesthetists in hospitals (Garrett v. United States, 1987).

Courts and other legal tribunals have various ways they recognize the expertise of APNs. In the settlement of an Agent Orange case in 1988, a psychiatric clinical nurse specialist (CNS) was appointed by the court to a Class Assistance Advisory Board to make recommendations about how funds from a settlement should be distributed (In re “Agent Orange” Product Liability Litigation, 1988). She was an Army nurse during the Vietnam War, and counseled veterans suffering from posttraumatic stress disorder (PTSD).

Similarly, in 1989, a plaintiff in New York sought to amend a case against a hospital, a surgeon, other hospital employees, and an anesthesiology practice by adding a claim for failure to inform the patient that a nurse anesthetist or medical resident might administer the anesthesia. The court denied this request, saying that informed consent need not go so far as to reveal the qualifications of personnel caring for the patient (Abram v. Children’s Hospital of Buffalo, 1989).

In Georgia, in 1989, the testimony of an NP in a criminal case about vaginal tears during a rape was allowed by the court. The NP’s education provided her with expertise on vaginal tearing. By contrast, the NP’s testimony identifying the father of the 4- or 5-year-old child as the perpetrator was in error due to its status as an out-of-court statement, but due to the fact that other similar testimony was given as to the father’s role in the rape, the error was ruled harmless (Hyde v. State, 1989).

In 1988, the Oregon Supreme Court said that the lower court had misconstrued the phrase “doctor or physician” too narrowly in claims for health care reimbursement. Instead of being limited to physicians, the phrase was inclusive of NPs (Cook v. Worker’s Compensation Department, 1988). The Worker’s Compensation statute in Oregon defined “doctor or physician” as one who is licensed to practice “one or more of the healing arts” (ORS 656.005 (12)).

**Hospital and Prescriptive Privileges**

Access to the services of APNs is critical to the success of their professional relationships and businesses, and therefore, admitting and prescriptive privileges are important to their status as independent providers. The following cases provide examples of judicial treatment of these evolving APN authorities and responsibilities.

In 1983, a federal District Court in California decided that a clinic that provided abortion services had grounds to sue the local medical
society, a hospital, and insurance company for actions that interfered with offering the abortion services. The clinic alleged, among other things, that the defendants threatened to remove hospital privileges of clinic MDs and NPs. The court reviewed various legal grounds that could be alleged, and concluded that a case could be made for interference by the defendants with the right of privacy of clinic clients (Chico Feminist Women’s Health Center v. Butte Glenn Medical Society, 1983).

In 1989, a federal District Court in Georgia dismissed a case brought by a Certified Nurse Midwife (CNM) against a hospital. The CNM alleged that the hospital violated the Sherman Anti-Trust Act and the First Amendment by not allowing her access to patients in the hospital and for expressing her views about natural birth. She had established a nurse-midwifery business, and doctors at the hospital stated publicly that she lacked adequate back-up from physicians and otherwise provided inadequate care, including her statements in support of home birth. The hospital refused to allow her staff privileges. She then sued the hospital for restraint of trade under the antitrust act, violation of her free speech, and intentional infliction of emotional distress. The court decided the dispute was a private one between the CNM and the physicians, and therefore, the hospital was justified in doing what it did to preserve the safety of its clients. Her claims did not rise to the level of harm to the public nor were the actions of the physicians egregious or harassing. In addition, the antitrust action was dismissed because the hospital exercised its right of immunity as a public hospital (Sweeney v. Athens Regional Medical Center, Feb. 1989).

In a subsequent case by the CNM in the same court involving the same parties, but focused on the two women’s health clinics and the physicians, the decision was different. The court found that the CNM did present evidence of an impact on interstate commerce, a conspiracy to restrain her teaching and home-birth practice, and an injury to her practice as a result of illegal actions by the clinics and MDs, and facts supportive of intentional infliction of emotional distress and slander. Thus, the defendants’ motion to dismiss the case was not supported (Sweeney v. Athens Regional Medical Center, March 1989).

Also in 1989, a federal court in West Virginia threw out an antitrust case brought by an NP and an MD against a hospital for denying them hospital privileges. The court pointed out that an impact on interstate commerce required in an antitrust claim was not alleged in the plaintiff’s case (Tempkin v. Lewis-Gale Hospital, Inc., 1989).

By 1989, 26 jurisdictions granted prescriptive authority to nurses in two categories: states in which nurses could prescribe independently
of physicians, and those in which nurses were obligated to collaborate with physicians to prescribe (Hadley, 1989). North Carolina led the way, with licensure of nurses instituted in 1903, prescriptive authority granted in 1975, and in organizing the first educational programs for NPs in the late 1960s and early 1970s at the University of North Carolina at Chapel Hill (Hadley, 1989). However, NPs in North Carolina to this day are restricted by the requirements that both medical and nursing boards must approve them to practice, and a collaborative relationship with one specific physician is required.

In summary, roles and privileges of APNs expanded in scope from the 1950s through the 1980s. APNs were more frequently discussed by name in court opinions over time, with the standards expected of them more clearly defined in the areas of assessment, diagnosis, and interventions. They were more often considered expert witnesses in the areas of their practice, and APNs also began to bring antitrust lawsuits to defend their business interests.

**RELATIONSHIPS BETWEEN APNs AND PHYSICIANS**

Just as standards of care have increasingly recognized the authority and the corresponding legal and ethical responsibilities of APNs to their patients, the relationships between APNs and physicians have evolved toward increasing independence but continuing collaboration between the two disciplines. The following cases demonstrate these APN/MD relationship changes during the 1970s and 1980s.

**Antitrust**

Businesses are encouraged to compete with one another in truthful, reasonable ways, but restraint of trade, monopolization, and other anti-competitive efforts are against the law. Legal actions taken against businesses that fix prices with other businesses or take other actions that keep others from competing fall into the antitrust area of the law. Health care businesses are no exception to this rule, in part because of the large portion of our economy that is involved in these businesses (Jacobs, 1986). In a 1987 case in Mississippi, a CRNA sued a hospital for interfering with her business as an independent contractor for anesthesia services. She was given 60% of the payments the hospital received for her services, whereas a dentist who provided anesthesia for the hospital received 100% of the reimbursement. The federal court said a case
against the hospital could proceed as an antitrust case (Wicker v. Union County General Hospital, 1987).

In Nurse Midwifery Associates v. Hibbett, a 1990 case in Tennessee, a nurse midwifery practice and a physician who provided supervision and other services for the practice sued physicians, hospitals, and an insurance company owned and run by physicians for conspiracy in restraint of trade. In addition to denying the nurse midwives staff privileges at the hospitals, the insurance company refused to renew the supervising physician a continuation of his malpractice policy. Because the nurse midwives could not obtain other physician supervision, they closed their practice and brought this suit. The lower court found for the defendants on most of the claims, but on appeal, the court remanded the case for presentation of evidence on the claim of conspiracy between the physicians and the insurance company to eliminate the physician’s malpractice coverage. In an antitrust case, an entity or party cannot conspire with itself, so if the physicians were agents of the hospital, they could not conspire with the hospital. But they could conspire with each other and the insurance company, because they were in competition with each other and the insurance company was not their employer. One interesting quote from the testimony demonstrates the negative attitudes one of the physicians had toward nurse midwives: “If nurse midwives started delivering babies, the next thing they would want to do is heart surgery” (p. 609).

Noncompete Clauses

Health care practices, like other businesses, protect their interests by expecting new employees to sign noncompete covenants. These contracts bind the employee who leaves employment not to work for a period of time within a certain radius of the employer’s business location. As courts construe these agreements narrowly, and sometimes change their terms if considered unreasonable, the terms should be explicit and time-limited. Because some states do not allow noncompete clauses, APNs need to consult with attorneys as they enter into employment contracts (The American Association of Nurse Attorneys, 2005).

A CNM was employed by an Illinois practice in 1981, and terminated her employment in 1985. In a lawsuit against her by the practice, a practice official testified that an oral noncompete covenant had been accepted by the CNM when she entered employment. However, the CNM said no such oral covenant had been offered to or accepted by her. The plaintiff asked the court to issue preliminary injunctions against
the CNM to keep her from conducting her new practice within the 10-mile radius of the practice, not to use trade secrets (patients’ names and other identifying information), and practice medicine without a license (unfair trade practices). The lower court denied this request, so the plaintiff appealed. The Illinois appellate court agreed with the lower court on the first and third issues, but said the preliminary injunction should be issued for the trade secrets claim, because the CNM herself testified that she had copied names and information about the patients to contact them \( (\text{Prentice Medical Corporation v. Todd}, \ 1986) \).

Evidence wasn’t strong enough in the case for the noncompete agreement to be supported, but if it had been in writing, the court may have supported the plaintiffs. Noncompete covenants also can be used by APNs who own their own businesses, and where the structure and use of these covenants are important to sound business practice.

**Insurance/Third-Party Payment**

Poor reimbursement rates for APN services from public or private sources, such as insurance companies, were challenged by APNs from the beginning. As a result of these concerns, APNs advocated for studies that compared effectiveness of their services with that of MDs. The earliest major study by the U.S. Office of Technology Assessment in 1986 demonstrated the strength and comparability of the APN primary care service \( (\text{Office of Technology Assessment}, \ 1986) \).

When an APN buys his or her own professional liability policy, the insurance company may raise questions that slow resolution of the case. In a 1973 wrongful death case in New York, two insurance companies, one defending the hospitals and the other defending the CRNA, asked the court for a declaratory judgment about which policy should pay for the damages as primary insurer. The CRNA's malpractice company alleged that the CRNA had acted beyond her scope of practice, practicing medicine without a license. Because this issue was raised, the New York court sent the case back to the trial court to resolve the original malpractice case \( (\text{Argonaut Insurance Company v. Continental Insurance Company}, \ 1978) \).

In a malpractice case against a nurse anesthetist, her insurance company and that of the hospital sought a declaratory judgment from the court about which company might be responsible financially for the nurse anesthetist’s actions. Her insurance policy was paid for by the anesthesiologist, and the hospital said it would not cover her as
she was not an employee of the hospital. A New York court sent the case back to the lower court to find facts about whether the contract had been transferred from one anesthesiologist to another, and the effectiveness of the cancellation notice to the nurse anesthetist (Benedictine Hospital v. Hospital Underwriters Mutual Insurance Company, 1984). This case demonstrates the risks associated with not owning one’s own malpractice policy.

In the mid-1980s, the insurance company providing blanket professional liability insurance for nurse midwives went bankrupt. The American College of Nurse Midwives advocated for another insurance company, but couldn’t find a company to provide the coverage. However, shortly thereafter in 1986, several insurance companies joined together in a consortium to provide the coverage (Lefkin, 1988).

**Supervision by Physicians**

Supervision of a nurse anesthetist was at issue in a North Carolina negligence case. The nurse anesthetist anesthetized the patient prior to surgery for laminectomy. A few minutes into surgery, the patient’s blood pressure and pulse dropped to zero, and the anesthesiologist was called and came within a minute to resuscitate the patient. However, the patient had suffered brain damage and died a few days later. Under North Carolina law, nurse anesthetists could only administer anesthesia under direct supervision and direction by the physician. As a result, the defendants lost their motion for summary judgment (a legal decision that the facts do not justify further arguments in the case) (Bentley v. Langley, 1978).

In another 1978 case with a different result, a Louisiana court concluded that a nurse anesthetist did not have to be under the direct control of a physician. She selected and properly administered the anesthetics. The patient died after an adverse reaction to Anectine and subsequent cardiac arrest. The defendant hospital and physicians won this case, as no improper procedures or poor judgments were used (Brown v. Allen Sanitarium, 1978).

In a 1982 Ohio malpractice case, the court decided a surgeon had the right of control over the nurse anesthetist who was not employed by the surgeon. Also, the surgeon stated that he had instructed the nurse anesthetist about the procedures to follow. Therefore, he could be held liable for her actions (Baird v. Sickler, 1982).

In a Missouri case in 1983, several NPs and MDs sought a declaratory injunction from the court to clarify whether the actions of the NPs
were practicing medicine without a license. A declaratory judgment is a decision by a court that determines the rights and relationships between the parties without ordering specific actions or outcomes, such as penalties. NPs were following standing orders and protocols written by the doctors, and the orders varied by each NP, which indicated unique approaches to the skills and abilities of each NP. The court noted the new definition of professional nursing in state law and changes in the field of advanced practice nursing, and decided that the actions of the NPs fell clearly within nursing practice, and thus, did not constitute the practice of medicine. Numerous friend of the court briefs (amicus briefs) were submitted in favor of or opposed to the position of the plaintiff NPs and MDs (Sermchief v. Gonzales, 1983). Clearly, the case was a breakthrough for nursing autonomy in terms of allowing independent judgment.

Sometimes, a medical licensure board attempts to regulate nursing practice too tightly, as happened in Arkansas in 1984. In this case, the medical board imposed a requirement on physicians who employed or collaborated with NPs that they could hire or collaborate with no more than two NPs at the same time. Working with more than two NPs would be considered malpractice. The state nurses association sought a declaratory judgment from the court that this regulation was invalid. The lower court upheld the regulation, but on appeal, the Supreme Court of Arkansas reversed the decision of the lower court, striking down the regulation as inconsistent with similar regulation of physicians who worked with physicians’ assistants (PAs) as interfering with the need for NPs in the state, and because the medical board could not create a nonstatutory restriction on a physician’s license. A basic premise of American law, the separation of powers between the executive branch, in this case the licensing board, and the legislative branch, had been violated (Arkansas State Nurses Association v. Arkansas State Medical Board, 1984).

In a 1985 Georgia case, a student nurse anesthetist, a PA who supervised her during the administration of anesthesia, several anesthesiologists, and others were sued by the family of a woman who suffered cardiac arrest and brain damage following surgery for tubal ligation. The student nurse anesthetist used a mask rather than an endotracheal tube, which an expert testified was not standard procedure. A Georgia statute specified that a CRNA could administer anesthesia only under the “direction and responsibility” of an anesthesiologist [O.C.G.A. § 43-26-9(6)(b)]. Because a student nurse anesthetist had administered the anesthesia under no supervision by an anesthesiologist, the Georgia
statute was violated on its face. The type of violation is known as negligence per se, and results in a shift of the burden of proof to the defendants. The lower court supported the negligence per se ruling, and on appeal, the Georgia Supreme Court agreed (Central Anesthesia Associates v. Worthy, Castro v. Worthy, Moorehead v. Worthy, Executive Committee of the Baptist Convention v. Worthy, 1985).

Courts of law are not the only legal forums facing questions about supervisory relationships between APNs and physicians. In a 1986 Louisiana case brought by the medical licensure board against the nursing licensure board, the medical board prevailed on a statute of limitations question. The nursing board planned to eliminate the phrase, “under the direction of a physician,” from its rules for NPs. The medical board objected and sued the nursing board. The nursing board argued that the medical board should have brought suit within 30 days of the change in the rule. The trial court agreed, and the medical board appealed. On appeal, the court reversed the trial court’s ruling because no 30-day limit was specified in the statute (Louisiana State Medical Society v. Louisiana State Board of Nursing, 1986).

In a 1986 wrongful death case against a VA hospital, including a nurse anesthetist employee of the VA and an anesthesiologist who worked for a private anesthesiology practice, the court held that the VA could be found liable for the acts of its agent, the nurse anesthetist, and the anesthesiologist. Just because the anesthesiologist was an employee of the outside practice, the VA could not shield itself from liability for his actions. The VA hospital held itself out to the public as a full-service hospital, and thus induced the public to rely on the VA’s responsibility for acts of the anesthesiologist (Gamble v. United States v. University Anesthesiologists, 1986). So, if CRNAs are part of a private practice, hospitals that they work in may still be responsible for their actions.

In a 1987 Florida case, a CRNA was found by the court not to be under supervision or control of the obstetrician who was performing a cesarean. Thus, the surgeon was not responsible for the improper insertion of the endotracheal tube, the aspiration of vomitus, brain damage, and subsequent death of the mother. Although the surgeon had the choice of anesthesia, he did not control the procedures used by the CRNA (Fortson v. McNamara, 1987).

As time moves forward, courts allow more responsibility to rest with CRNAs and less to those physicians or other entities involved in surgery. An employment agency that assigned the CRNA to work at a hospital was not supervising or controlling her work in the hospital,
so was not held liable for her administration of anesthesia (Joyce v. National Medical Registry, Inc., 1988). And the same year, a CRNA and student nurse anesthetist were named as defendants in a malpractice case, in which the student and the CRNA who supervised her placed an endotracheal tube in the esophagus, and the patient was deprived of oxygen for 12 minutes and was brain-damaged. The case was dismissed by the lower court, but on appeal, the Tennessee court of appeals held that the physicians in the operating room and the anesthesiologist, who was not on duty, would not be liable for the actions of the nurse anesthetists (Parker v. Vanderbilt, 1988). Growing independence has its downsides.

And in another case yielding increasingly independent responsibility for a mistake in administration of anesthesia by a nurse anesthetist, and not the anesthesia corporation that employed her, a Florida court refused to grant attorneys fees to the corporation that had employed her, commenting that none of the physician shareholders in the corporation had directly supervised the nurse anesthetist, and therefore were not liable for her acts (Gershuny v. Martin McFall Messenger Anesthesia Professional Association, 1989).

In summary, prior to 1990, the relationships between APNs and physicians moved away from the supervisory, and toward increasing collaboration. APNs began to join with physicians in lawsuits to resolve antitrust claims. APNs also learned about problems with insurance companies where company actions at times slowed resolution of APN claims for coverage. Likewise, noncompete clauses became a source of concern for APNs who left a practice that required the noncompete agreement. During this period of time, cases demonstrated increasing independence of APNs from physician oversight, and a corresponding increase in sole responsibility for APN actions.

SUMMARY

The practice of APNs between 1950 and 1990 changed from limited autonomy to increasing levels of responsibility for interventions and patient care results. “In the late 70’s and 80’s the increasingly competitive health care market in conjunction with the professional/autonomy concerns of NPs account for APNs’ seeking autonomous practice, unfettered economic reimbursement, hospital privileges, and prescriptive authority” (Inglis & Kjervik, 1993, p. 196). Most published negligence cases during this time involved errors made by nurse anesthetists in the
administration of anesthetics, positioning of patients during the administra-
tion, and information shared with the team or the patient. Successful
defenses to malpractice cases were arguments that violations of statute of
limitations had occurred, customary practice standards were met, no legal
grounds for the case existed (wrongful life/birth), and no causal
connection existed between intervention and injury. Intentional acts
of an APN were found in cases in which questions of misrepresentation
of one’s professional credentials and improper use of controlled sub-
stances existed.

Other cases involving professional status, such as interpretation of
third-party reimbursement statutes as inclusive of APNs and the expertise
of an APN to testify in civil and criminal cases, were found. Cases
addressing APNs’ hospital and prescriptive privileges pointed to the
importance of the patient’s right of privacy, the APNs claims of antitrust
violations, slander, and intentional infliction of emotional distress.

Cases questioning the control or supervision of APNs by physicians
continued in importance during this time. Claims of conspiracy in
constraint of trade were accepted by courts, as were suits to clarify
which insurance carrier would be responsible to pay damages for the
APN and the validity of noncompete covenants required by medical
practices. The general trend was toward increasing responsibility of
APNs for their professional actions without concurrent liability of the
physician or physician practices. This trend has continued to the present
day with, for instance, all states now allowing prescriptive authority to
NPs, Georgia having been the last state to allow NPs to prescribe
(Ritter & Hansen-Turton, 2008).

Yet the attitudes of physician organizations about APN practice,
although somewhat improved, continue to reflect their equivocal view
of APN practice. For instance, a 2009 policy statement of the American
College of Physicians entitled, “Nurse Practitioners in Primary Care,”
states the physician should be head of the health care team, that NP
skills are not equivalent to the MD’s, that studies showing comparable
quality of care between NPs and MDs should be viewed with caution,
that patients need “access to a personal physician who accepts responsi-
bility for their entire health, working in collaboration with non-physi-
cian clinicians involved in caring for the patient” (American College
of Physicians, 2009, p. 13), and that NPs should not replace primary
care medical practice. In light of the fact that according to the Pearson
report (Pearson, 2009), 13 states have no restrictions on NPs’ diagnosis,
treatment, and prescriptions; and 10 other states have no restrictions
on diagnosis and treatment; the effort to obtain greater autonomy for
APNs is gaining momentum, and physicians’ efforts to require supervision and collaboration are eroding. Studies continue to show cost-effectiveness, patient satisfaction with the care of APNs, and in some ways, more satisfaction with care (Horrocks, Anderson, & Salisbury, 2002; Karlowitz & McMurray, 2000; Mullinex & Bucholtz, 2009; Needleman & Minnick, 2009).

KEY POINTS

1. From the 1950s through the 1980s, advanced practice nursing changed from limited autonomy to increasing levels of responsibility, and the law reflected this trend.
2. Physician attitudes toward advanced practice nursing gradually improved during this time, but continue to display equivocation.
3. By 2009, according to the Pearson report, 13 states had no restrictions on NPs’ diagnosis, treatment, and prescriptions, and 10 states had no restrictions on diagnosis and treatment, demonstrating increased legal autonomy.
4. Studies continue to show cost-effectiveness and patient satisfaction with APN practice.

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