DIANE WARLICK
Attorney at Law
State Bar License # TX 24010854
2233 St. Charles Ave.
Suite 105
New Orleans, LA 70130

Attorney for Proposed Amicus Curiae
The American Association of Nurse Attorneys

COURT OF APPEAL FOR THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION EIGHT

ELLEN HUGHES FINNERTY PETITIONER-APPELLANT, VS. BOARD OF REGISTERED NURSING RESPONDENT-APPELLEE.	COURT OF APPEAL NO. B 200659

BRIEF OF AMICUS CURIAE

THE AMERICAN ASSOCIATION OF NURSE ATTORNEYS

STATEMENT OF ISSUE

Where the Code of Ethics for Nurses as well as general standards of competent nursing performance require a professional nurse to serve as a vigilant advocate for the health, safety and rights of a patient, does public policy permit harsh disciplinary measure against a nurse when that nurse has acted in accordance with these guidelines in the face of orders or practices which are believed in good faith by that nurse to endanger the patient for whom she/he is advocating?

THE FACTS AS FOUND BY THE BOARD OF REGISTERED NURSING[1]/:

The Amici rely upon the following findings of fact entered by the Administrative Law Judge and adopted by the Board of Registered Nursing, to establish the context for consideration of its policy arguments:[2]/

1. The incident which triggered the investigation, hearing, proposed findings d decision of the Board of Registered Nursing occurred "… August 16 and early morning hours of August 17, 2002". (App. 1 Pg 61 ¶ 4)

2. "Health care providers involved in the care and management of this patient during the "incident" included respondent, registered nurse Ann Mugi (RN Mugi), medical intern on call Hengameh Monsef, D.O. (Dr. Monset), medical resident Jennifer (Nguyen) Hubert, D.O. (Dr. Nguyen), and respiratory care therapists Hiran Obeyesekere (RT Obeyesekere) and Joey Lee (RT Lee)". (App. 1 Pg 61 ¶4)

3. "A resource nurse at Huntington Memorial Hospital performs functions similar to a charge nurse, including making nurse assignments, monitoring patient conditions, and facilitating admissions, bed assignments and patient transport." (App. 1 Pg 61, fn.1)

4. " The patient's medical records contain a follow-up telephonic physician's order received at 5:30 am from Dr. Jackson's physician

---

[1]/ The Facts are taken verbatim from the findings of the Board of Registered Nursing.

[2]/ The Amici do not intend to argue questions of fact or to contest the facts as found by the Administrative Law Judge and Board of Registered Nursing.

assistant. The order, again recorded by RN Mugi, directed that the patient be transferred to the intensive care unit (lCU) for "respiratory failure impending code and for the "medical resident to intubate [patient] stat" (i.e., immediately or without delay)". (App. 1 Pg 62 ¶4e)

5. "Dr. Monsef was just licensed as an osteopathic physician and surgeon on August 4, 2003. She began her internship at Huntington Memorial Hospital in August 2002." (App. 1 Pg 62 fn. 5)

6. "Between 6:00 and 6:15 a.m., respondent also responded to Station 25 for patient James C.'s respiratory distress. Respondent asked RT Lee to accompany her for assistance. When respondent arrived at the patient's room, RT Obeyesekere was taking the patient's blood sample. RT Lee . … After Dr. Monsef conferred with RN Mugi, Dr. Monsef ordered the patient to be transported to the lCU. Respondent then left the room and made a telephone call to reserve an lCU bed for the patient**."** (App. 1 Pg 63 ¶4h)

7. "At approximately 6:30 to 6:37 a.m., the on-duty resident, Dr. Nguyen, received a page from Dr. Monsef to immediately respond to Station 25. Dr. Nguyen informed RN Mugi to get a respiratory care technician and that she was on her way. Dr. Nguyen estimates that she arrived in the patient's room within five minutes of receiving the page. Upon arriving at the patient's room, Dr. Nguyen found Dr. Monsef, respondent, and the two respiratory care practitioners, Obeyesekere and Lee, present. As the senior on-site physician, Dr. Nguyen assumed full responsibility for the patient's care." (App. 1 Pg 63 ¶4j)

8. "Dr. Nguyen was first licensed in California as an osteopathic physician and surgeon on August 13,2002. On August 16-17, she

was the resident-in-charge at Huntington Memorial Hospital and Dr. Monset's immediate supervisor." (App. 1 Pg 63 ¶ fn. 7)

9. When Dr. Nguyen instructed RT Obeyesekere to get the intubation supplies, respondent told Dr. Nguyen that the doctor could not intubate the patient on the floor and that the patient was first to be taken to the ICU. Dr. Nguyen again stated her intention to intubate the patient immediately. However, respondent again countermanded the order by proceeding to unplug the bed from the electrical outlet and maneuver the bed out of the room. Although Dr. Nguyen made it clear that she wanted to intubate the patient in his room, respondent continued moving the bed out of the room. Respondent testified that Dr. Nguyen had abdicated her responsibility for the patient and given that responsibility to respondent." (App. 1 Pg 64 ¶4l)

10. "Transport of the patient from Station 25 to the lCU took approximately five minutes. The patient was transported without any device for monitoring his cardiac status or vital signs. During transport the top of the bed was upright and the patient was receiving oxygen from a portable tank ". (App. 1 Pg 64 ¶4m)

11. "The patient, respondent, Dr. Nguyen, and Dr. Monsef arrived at the lCU at approximately 6:50 am….." (App. 1 Pg 65 ¶4n)

12. "On arrival at the lCU, the patient had normal sinus cardiac rhythm and blood pressure of 124/88. (App. 1 Pg 65 fn. 12)"

13. "Dr. Monsef successfully secured the patient's airway with an endotracheal tube, which was then attached to a ventilator. At 7:00, the patient's respiration rate was 20 breaths per minute. (App. 1 Pg 65 ¶4n)"

14. ‘Following the incident, respondent entered a note in patient lames C’s progress record for August 17,2002 at 9:00 a.m., wherein she acknowledged that she "countermanded the order of Dr. Nguyen." Her rationale was that the staff and equipment on Station 25 were not adequate for intubation on the floor; the patient was awake but lethargic, breathing spontaneously, with palpable pulses; there was no monitor on the floor; there was a risk due to the obvious complications (not further defined); and that the calling of a code would compromise all patients in the unit during a shift change.” (App. 1 Pg 65 ¶6)

15. “On August 22, 2002, Huntington Memorial Hospital terminated respondent's employment. The hospital listed "gross negligence - failure to follow direction from treating physician" as reason for the termination. The employee discharge memorandum supporting the termination stated that respondent was found to have interfered with the physician's ability to perform the intubation by refusing the physician's order, proceeding to remove the patient from his room, and transporting him to the "Critical Care Unit" without a cardiac monitor or secure airway…” (App. 1 Pg 66 ¶7)

16. “A representative from the hospital's human resources department and registered nurse Betty Downey, respondent's immediate supervisor, signed the termination notice… “ (App. 1 Pg 66 ¶7)

17. “Respondent did not communicate any of these concerns to the patient's medical team at the time of the incident. She merely substituted her own clinical judgment for those of the two attending physicians…” (App. 1 Pg 66 ¶11)

18. “Ms. Turner testified that the standard of care for registered

nurses dictates that respondent should have followed Dr. Nguyen's orders. While it is permissible for a registered nurse to disobey an order that is inaccurate or unsafe, the documentation that Ms. Turner reviewed before rendering an opinion this matter did not indicate that such was the situation involving the incident. … Although respondent may have believed that she was acting in the best interest of the patient, she was wrong and she was not in a position to countermand the physician's orders. Under the circumstances, respondent's conduct thus constituted both gross negligence and incompetence…" (App. 1 Pg 67 ¶13)

19. "Zulfiqar Ahmed, M.D., is a California-licensed physician who specializes in internal and pulmonary medicine and is familiar with respondent, in that respondent works in the hospital where "he goes." He testified that he has confidence in respondent's judgment. Dr. Ahmed testified that, given a choice, it is preferable to intubate in an lCU. He also stated that a patient's vital signs are key factors in determining whether to intubate before transfer to an lCU. He opined that it is appropriate for a nurse to question a doctor's order, if the nurse deems the order to be inappropriate and that, in the case of patient James C., respondent's actions were reasonable under the circumstances." (App. 1 Pg 68 ¶14)

20. "Respondent failed to perform her duties competently; She failed to work collaboratively with Dr. Monsef and Dr. Nguyen at the time of the incident, and usurped the responsibility and decision making authority of the senior health care provider without effectively communicating any concerns respondent may have had. Respondent failed to follow a physician's repeated orders." (App. 1 Pg 68 ¶17)

ARGUMENT

Introduction:

The true hallmark of a profession is the setting of its own standards and scope of practice. There is a long history of tension between the medical and nursing professions when their respective scopes of practice began to overlap and appear to be in conflict. After decades of struggle over where the line separating the professions is or should be, the question has been answered – there is no specific dividing line – there are clearly areas of overlap in the scopes of practice of nursing and medicine, yet they remain clearly separate and distinct professions.

Joel has explained:

> A body of knowledge and skills unique to the discipline, and a considerable educational investment distinguish the professions. The art of professions is cognitive artfulness. It consists of the ability to manipulate in the mind circumstances that have never been experienced, and see relevancy between situations that on the surface have little in common. . . . What has never been challenged is the fact that the credential to practice is awarded to an individual in ***recognition of a primary obligation to the recipient of service*** as opposed to any employer or third-party payer….

Joel, L. Education for Entry into Nursing Practice[3]/

---

[3]/ "Education for Entry into Nursing Practice: Revisited for the 21st Century". *Online Journal of Issues in Nursing*. Vol. #7 No. #2, Manuscript 4. www.nursingworld.org/ojin **Lucille A. Joel, EdD, RN, FAAN** joel@nightingale.rutgers.edu Lucille Joel is widely recognized as one of nursing's most distinguished and influential members. She is a professor at Rutgers-the State University of New Jersey College of Nursing, and was Director of the Rutgers Teaching Nursing Home from 1982 to 1998. Dr. Joel is a past president of both the American Nurses Association and the New Jersey State Nurses Association. She is also immediate past First Vice-President of the International Council "Education for Entry into Nursing Practice: Revisited for

The legislatures of every state and territory of the United States have recognized the distinctions between nursing and the medical profession by enacting separate licensing statutes, mandating different educational requirements and supporting standards of practice the differ with respect to nursing and medical standards of practice. The Supreme Court of Illinois relied on these statutory distinctions in *Sullivan v. Edward Hospital* 209 Ill.2d 100, 806 N.E.2d 645 (Ill 2004) to prohibit a physician from testifying as an expert witness to establish the standard of care for a nurse. The Court explained:

> Dr. Barnhart was not competent to testify regarding the standard of care for the nursing profession and nurse Lewis' deviations there from . . .Clearly, this exact issue was contemplated by this court in *Dolan,* which unequivocally required that a health-care expert witness must be a licensed member of the school of medicine about which the expert testifies. ….However, the proposition that "[t]here is nothing which a nurse can do which a doctor cannot do" presumes a universal standard of treatment among physicians and nurses. *Dolan* expressly rejected this assumption. *Dolan,* 77 Ill.2d at 284, 32 Ill.Dec. 900, 396 N.E.2d 13 (rejecting the assumption "that science and medicine have achieved a universal standard of treatment of disease or injury"). TAANA persuasively reasoned:
>
> "***A physician, who is not a nurse, is no more qualified to offer expert, opinion testimony as to the standard of care for nurses than a nurse would be to offer an opinion as to the physician standard of care.*** * * * Certainly, nurses are not permitted to offer expert testimony against a physician based on their observances of physicians or their familiarity with the procedures involved. An operating room nurse, who stands shoulder to shoulder with surgeons every day, would not be permitted to testify as to the standard of care of a surgeon. An endoscopy nurse would not be permitted to testify as to the standard of care of a gastroenterologist performing a colonoscopy. A labor and delivery nurse would not be

---

the 21st Century". *Online Journal of Issues in Nursing*. Vol. #7 No. #2, Manuscript 4. www.nursingworld.org/ojin

> permitted to offer expert, opinion testimony as to the standard of care for an obstetrician or even a midwife."

Scholars of nursing law share this reasoning:

> "Physicians often have no first-hand knowledge of nursing practice except for observations made in patient care settings. The physician rarely, if ever, teaches in a nursing program nor is a physician responsible for content in nursing texts. In many situations, a physician would not be familiar with the standard of care or with nursing policies and procedures, which govern the standard of care. Therefore, a physician's opinions would not be admissible in jurisdictions, which hold the expert must be familiar with the standard of care in order to testify as an expert. An example of a common situation, which gives rise to allegations of nursing negligence occurs when a nurse fails to follow the institutional 'chain of command' in reporting a patient condition to a physician who subsequently refuses to attend to the patient condition. It is unlikely that a physician would be familiar with the policy and procedure involved in handling such a situation. It is as illogical for physicians to testify on nursing standard of care as it would be for nurses to testify about medical malpractice." E. Beyer & P. Popp, *Nursing Standard of Care in Medical Malpractice Litigation: The Role of the Nurse Expert Witness,* 23 J. Health & Hosp. L. 363, 365 (1990). . . .
>
> "These cases represent a growing recognition on the part of courts that nursing, as a profession, has moved beyond its former dependence on the physician, and into a realm where it must and can legally account for its own professional practices.

Because each profession has a duty to protect patient health and well being, according to their own standards of practice, it is inevitable that conflicts will arise between a physician and a nurse, as in this case, over the proper action to take in a particular situation. The established standards of nursing practice ***require*** the nurse to challenge physician orders that in the RN's professional judgment are against the best interests of the patient. The registered nurse should not be harshly punished when intervening in good faith for her patient's well being.

I. The Professionalism of the Nursing Practice

The professionalism of nursing practice is the result of many decades of tireless effort by nursing leaders. While nursing, as a healing art, has been practiced for more than 200 centuries, it has only achieved "professional" stature in the last half of the 20th century. Nursing's historical roots lie in the poorhouses, battlefields and industrial revolutions in Europe and America. Contemporary nursing has "evolved from an occupation that provided skilled domestic care by trained workers into a profession with a distinct body of knowledge, university-based education, specialized practice, standards of practice, a societal contract (*Nursing 's Social Policy Statement.* 2003) and an Ethical Code (*Code of Ethics for Nurses with Interpretive Statements,* 2001). Joel, L. (May 31, 2002).

The meaning of "nursing" has shifted and expanded through the advancement of nursing science and clinical practice. Not only the image and values, but also the behavior of registered nurses has transformed to the point that the nurses of the 21st century think and act very differently from those of the 18th and 19th, or even of the mid-20th century.[4]/ The essence of today's nursing combines the art of caring with the science of health care. Nursing places its focus not only on a particular health problem, but on the whole patient and his or her response to treatment...nurses work in many areas but the common thread of nursing is the nursing process - the essential core of how a registered nurse delivers care. ANA, *The Nursing Process: A Common Thread Amongst All Nurses*, retrieved

---

[4]/ Christine Hallett (2007) Editorial: A 'gallop' through history: nursing in social context Journal of Clinical Nursing 16 (3) , 429–430 (Blackwell Publishing) retrieved from http://www.blackwell-synergy.com/doi/10.1111/j.1365-2702.2006.01672.x

from http://nursingworld.org/EspeciallyForYou/StudentNurses/Thenursingprocess.aspx May 21, 2008

No longer are nurses required or expected to be blindly obedient to physicians, regardless of the nurse's belief that carrying out the order could harm the patient. The ANA Code of Ethics requires a nurse to challenge a questionable physician order. The Institute of Medicine's 2000 groundbreaking report, *To Err is Human,* breaks the silence on error rates and adverse patient consequences[5]/ in America's health care system. The IOM report that 44,000 to 98,000 patients die each year from medical mistakes spurred the current intense study of patient safety and preventable errors. Nursing's role in preventing potentially harmful mistakes has been well documented by the IOM. For example, in its recent publication, *Preventing Medication Errors, Quality Chasm Series* (2007) at 80 the Institute acknowledged the significance and relationship of nursing intervention to the prevention of medication errors. The IOM stated

> … These nursing activities are indispensable to patient safety.
>
> Perhaps most important, the nurse is often the last professional to evaluate the appropriateness of the medication that has been prescribed. In fact, a study of medication errors found that nurses were responsible for intercepting 86 percent of all errors made by physicians, pharmacists, and others involved in providing medications for patients. Nurses' involvement and vigilance during the preparation process is thus central to accurate medication administration. (*internal references omitted*)

Questioning physician orders has undoubtedly saved many patients from harm.

Burkhardt and Nathaniel conclude:

---

[5]/ *To Err is Human: Building a Safer Health System* Committee on Quality of Health Care in America, Institute of Medicine, (Nat'l Academies Press 2000)

The exercise of independent nursing judgment should be welcomed by institutions because of the safeguards that are afforded. It is not unusual to hear about a nurse who refused to carry out a physician's order that is later found to be incorrect. Such actions protect patients from physician negligence and thus prevent litigation against the nurse, the physician and the institution. The fact that nurses are often found to be legally negligent for following questionable physician orders, or failing to follow through with the hierarchical chain of command when questioning or disagreeing with acts or omissions of physicians or others proves that the courts not only recognize, but expect nursing autonomy.

II. Standards of Nursing Practice

A. Nursing Code of Ethics with Interpretive Statements sets non-negotiable duties of professional nursing

While the literature contains endless definitions of the characteristics of a profession, there seem to be three areas of agreement: the professions are service-oriented, learned, and autonomous. Each of these characteristics allows for a broad range of interpretation. It helps to further consider these essential elements and identify the point beyond which compromise is impossible, Joel at 10

The nursing profession has clearly defined this point. The standards set by the Nursing Code of Ethics with Interpretive Statements (1985)(hereinafter the "Code" of the "Code of Ethics") are ***non-negotiable.*** *Position Statement: The Non-negotiable nature of the ANA, Code for Nurses with Interpretive Statements*, (12/04/94)[6]/

B. A nurse's primary duty to advocate for patient

The Code of Ethics mandates the following:

> **Provision 2** ***The nurse's primary commitment is to the patient, whether an individual, family, group, or community***.

---

[6]/http://nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/EthicsandHumanRights.aspx, retrieved May 21, 2008.

2.1 Primacy of the patient's interests **-** *The nurse's primary commitment is to the recipient of nursing and health care services -- the patient--whether the recipient is an individual, a family, a group, or a community. Nursing holds a fundamental commitment to the uniqueness of the individual patient; therefore, any plan of care must reflect that uniqueness. The nurse strives to provide patients with opportunities to participate in planning care, assures that patients find the plans acceptable and supports the implementation of the plan. Addressing patient interests requires recognition of the patient's place in the family or other networks of relationship. When the patient's wishes are in conflict with others, the nurse seeks to help resolve the conflict. Where conflict persists, the nurse's commitment remains to the identified patient.*

Provision 3: ***The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.***

3. 5: Acting on Questionable Practice*, As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interests of the patient in jeopardy.... When the nurse is aware of inappropriate or questionable practice in the provision or denial of health care, concern should be expressed to the person carrying out the questionable practice.*

Provision 5: ***The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.***

5.4 Preservation of Integrity*. Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardize both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds.*

The mandate of the Code of Ethics is clear and unquestionable. The nurse's primary duty, before loyalty to the institution and before blindly obeying a physician's order *is to protect the patient*. The California Nurse Practice Act, consistent with the Code, recognizes the continued evolution of the

commonly accepted scope of practice and the overlap of nursing practice with the practice of medicine. The intent of the California Legislature is crystal clear. The preamble to the California Nurse Practice Act, California Business and Professions Code Section 2725 provides:

> (a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses.

C. It is the nurse's obligation to refuse to follow a physician order he/she believes would cause harm to the patient

California law clearly recognizes, accepts, supports and protects the commonly accepted standards of nursing practice. The unanimity of authoritative nursing bodies on the issue before this Honorable Court firmly establishes that the standard of practice of nursing requires a nurse to refuse to follow a physician order that in the nurse's professional judgment could cause harm to or otherwise not be in the patient's best interest.

In its first in a series of California Nurse Continuing Education Home Study Programs dealing with the Registered Nurse Legal Scope of Practice, published in March-April 2004, the California Nurses Association starts from the premise that:

> As patient advocates, registered nurses must consistently act in the best interest of the patients. This includes assuring that all health care personnel are acting within their respective legal scope of practice/activities and are trained and competent to care for patients. This also includes challenging orders, which in the RN's professional judgment are against the patient's interest.

A clear example of the essential role nurses play in challenging physician orders and actions was reported in the Annals of Medicine of *The New Yorker,* Dec. 10, 2007[7]/ parts of which were also reported in the New England Journal of Medicine. The study starkly illustrates the positive impact the nurses' questioning and intervening in potentially harmful physician behaviors can have on patient outcome. An investigation was designed to determine how frequently physicians failed to follow all the requisite steps to aseptically insert arterial, subclavian and central venous lines. Five distinct steps were identified and nurses were instructed to stop physicians if they saw the physician skip any of the five steps. The nurses were also required to ask physicians daily whether lines should be removed in their patients.

> Pronovost and his colleagues monitored what happened for a year afterward. The results were so dramatic that they weren't sure whether to believe them: the ten-day line-infection rate went from eleven per cent to zero. So they followed patients for fifteen more months. Only two line infections occurred during the entire period. They calculated that, in this one hospital, [the checklist of steps and nurse intervention with non-compliant physicians] had prevented forty-three infections and eight deaths, and saved two million dollars in costs.

The Joint Commission, an independent non-profit organization that surveys and accredits more than 15,000 health care organizations in the United States strongly support the nurse's role in preventing errors and adverse

---

[7]/http://www.newyorker.com/reporting/2007/12/10/071210fa_fact_gawande?currentPage=1 retrieved from internet May 21, 2008

patient outcomes.[8]/ In its book, *Front Line of Defense: The Role of Nurses in Preventing Sentinel Events, 2nd Edition, 2007 at 10*, the Joint Commission recognizes the essential need for, but difficulties inherent in a nurse's challenging a physician's order:

> "Because nurses often identify gaps in systems and processes that could led to patient harm - a near miss or sentinel event - they need to know how and when to speak up. However, impediments to their ability or willingness to speak up might include the hierarchical structure in health care, difficult behavior of a manager or physician with whom a nurse must work, uncertainty about how to approach or resolve the problem, a perception that the problem is just part of health care and cannot be resolved, real or perceived lack of support from coworkers, less experience than coworkers who seem unbothered by the issue, and *fear of retaliation."* (*emphasis added)*

Recent research in the culture of safety in health care strongly supports the essential role nurses play in improving patient safety by questioning physician orders. Thus decisions by hospitals to terminate nurses for speaking out, and a Board taking harsh disciplinary action against a nurse's licenses for doing so would be directly adverse to public policy.

D. Factors to consider in refusing physicians' orders

1. Time frame and urgency. Numerous factors must be considered in exercising judgment about whether to follow a physician order. The time and manner of questioning or refusing a physician order is necessarily dependent upon the urgency of the situation. Nursing researchers describe a ***spectrum of urgency*** [9]/ in making an independent judgment related to

---

[8]/http://www.jointcommission.org/AboutUs/Fact_Sheets/joint_commission_facts.htm retrieved from the internet on May 22, 2008.

[9]/ Burkhardt & Nathniel, *Ethics and Issues in Contemporary Nursing, (Delmar Publishers 1998)* at page 163.

carrying out a physician's order.

> If medical care constitutes incompetent, illegal or unethical practice, the nurse is clearly obligated to disobey orders. (ANA, 1985). When deciding what course to take in situations in which nurses disagree with physicians' orders, Benjamin and Curtis (1986) suggest that nurses apply the test of the *spectrum of urgency*. At one end of this spectrum are problems that are minor and may be solved at a leisurely pace. At the other end are problems that are urgent and require quick solutions and immediate actions.

Petitioner faced a problem at the high-urgency end of the spectrum and had to make a snap judgment based on her knowledge and expertise.

2. Potential harm: The BRN accepted the testimony of "Ms. Turner, as an expert nurse witness that "it is permissible for a registered nurse to disobey an order that is inaccurate or unsafe . . ." and that "the [Petitioner] may have believed that she was acting in the best interest of the patient…" (App. 1 Pg 67 ¶13). The [Petitioner] "acknowledged that she "countermanded the order of Dr. Nguyen" in her progress notes, accepting full responsibility for her decision. Her stated rationale was that:

- the staff and equipment on Station 25 were not adequate for intubation on the floor;
- the patient was awake but lethargic, breathing spontaneously, with palpable pulses;
- there was no monitor on the floor;
- there was a risk due to the obvious complications (not further defined); and
- that the calling of a code would compromise all patients in the unit during a shift change." (App. 1 Pg 65 ¶6)

The inadequate staff and equipment on Unit 25, and the potential harm to other patients were critical factors required to be taken into consideration by the Petitioner when fulfilling her responsibilities and duties as the "resource nurse ." (App. 1 Pg 61, fn.1).

3. Available resources: The record reflects significant difference in the resources available on Unit 25 and those available in the ICU. In fact, while one of the three criticisms of respondents actions that lead to her

termination was that she "remove[d] the patient from his room, and transport[ed] him to the "Critical Care Unit" without a cardiac monitor ……" (App. 1 Pg 66 ¶7), The testimony reflects Petitioner's belief that there was "no monitor on the floor" readily available. This was a factor that weighed in favor of moving the patient to the ICU before intubating him, if, as the termination letter implied, the availability of a cardiac monitor was a critical factor in the equation.

"Zulfiqar Ahmed, M.D., a California-licensed physician who specializes in internal and pulmonary medicine, who is familiar with [Ms. Finnerty] and the hospital environment, testified that "he had confidence in [Petitioner's] judgment" and that, "given a choice, it is preferable to intubate in an lCU". He testified that the "patient's vital signs are key factors in determining whether to intubate before transfer to an lCU." Dr. Ahmed also strongly emphasized that "it is appropriate for a nurse to question a doctor's order, if the nurse deems the order to be inappropriate" and that, "in the case of patient James C., [Petitioner's] actions were reasonable under the circumstances." (App. 1 Pg 68 ¶14)

4. Relative experience of practitioners: The relative professional experience of the intern and resident as compared to Petitioner strongly militated in favor of [Ms. Finnerty's] exercise of her professional judgment to transfer James C. to the ICU before intubation. The incident which triggered the investigation, hearing, proposed findings and decision of the Board of Registered Nursing occurred "… August 16 and early morning hours of August 17, 2002." (App. 1 Pg 61 ¶ 4) "Dr. Monsef was not licensed as an osteopathic physician and surgeon until a year later, and had just begun her internship at Huntington Memorial Hospital the month that the incident occurred. App. 1 Pg 62 fn. 5). "Dr. Nguyen had been licensed in California as an osteopathic physician and surgeon only three days before the incident. (App. 1 Pg 9 ¶ fn. 7). On the other hand, Petitioner had more than 20 years experience as a registered nurse. She had been employed at Huntington Memorial Hospital for five (5) years by August 2002. Clearly her experience and knowledge of available resources in

Station 25 and the ICU vastly outweighed those of the two physicians together. Her position as a resource nurse recognized her experience and charged her with the duty of "…monitoring patient conditions and facilitating admissions, bed assignments and patient transport." (App. I Pg 61, fn1).

A recent study sponsored and funded by the Department of Health and Human Services Agency for Healthcare Quality and Research investigated the incidence of medical errors involving trainee physicians, i.e. interns and residents such as Drs. Monsef and Nguyen.[10]/ The study reviewed almost 900 cases involving interns and residents that resulted in errors that caused injuries. Four categories of cases were included in the study: those that involved obstetrics, surgery, medications, and delayed or incorrect diagnoses. Twenty-seven percent of the cases examined involved physician "trainees" in which their involvement was "at least moderately important". Eighty-seven percent of those cases involved residents, with the remainder involving interns and fellows. The study found that the majority of the injuries suffered were serious, one-third of which resulted in death. The researchers concluded that 72 percent implicated errors in judgment, and more than 50 percent involved the trainees' lack of "adequate technical knowledge", or "failure of vigilance or memory". These research findings decisively support the respondent's decision to use her own professional judgment under the circumstances.

III. Impact of Decision on Nurses Individually and the Nursing Profession: Policy Issues

---

[10]/ **Medical Errors Involving Trainees: A Study of Closed Malpractice Claims From 5 Insurers**, Hardeep Singh; Eric J. Thomas; Laura A. Petersen; David M. Studdert *Arch Intern Med.* 2007;167(19):2030-2036

A. The Board's decision infringes upon nursing profession's duty to exercise professional judgment

In the present case, the Board acknowledged that the Petitioner "substituted her own clinical judgment for those of the two attending physicians…" (App. 1 Pg 66 ¶11). The ethical dilemma that would be created by the Board of Nursing's decision would have a negative impact upon nurses' work environment, retention and patient well being. It would have a "chilling effect" on the proper exercise of independent clinical judgment. Nurses might be more likely to simply follow the physician's order rather than question it under the urgent circumstances similar to what the Petitioner faced. It would simply be easier, but as recent evidence-based studies have documented, many patients would be harmed by preventable errors. This would be an abdication of the nurse's primary obligation – to protect the patient. It would violate the ANA Code of Nursing and the California Nurse Practice Act. It puts the nurse, the patient and the profession in a potentially lose-lose situation.

The word "judgment" in this context is defined by the Mirriam-Webster Dictionary[11]/ as "the process of forming an opinion or evaluation by discerning and comparing". The exercise of professional judgment is not a black and white issue with a clearly delineated line of separating opposing options. The harsh nature of the discipline imposed on the Petitioner would unduly constrain the exercise of nursing judgment. The retrospective analysis from a boardroom over a lengthy period of time following a full investigation must recognize the exact factual scenario in place when the exercise of judgment was made. There must be a mild and middle range of possible disciplinary action between no the action at all and revocation of a license. The legislature did not, by amending the Nurse

---

[11]/ Online at www.M-W.com .

Practice Act in 1974, intend the scope of nursing practice to require or even accept the blind following of questionable physician orders. To the contrary, standards of practice require the nurse to question, and any doubt about the imposition of discipline in such circumstances should favor lesser sanctions. Professional ethics, legislative intent and patient welfare thus strongly militate against the imposition of harsh discipline, which constrains the exercise of nursing judgment.

B. If errors in judgment are not negligence or malpractice, the good faith exercise of judgment does not deserve harsh penalties

The California Nurse Practice Act, sec. 2761 authorizes the Board to deny an application for a certificate or license for any of the following:

> "(a) Unprofessional conduct, which includes, but is not limited to, the following:
> "(I) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions

Title 16, California Code of Regulations, section 1442, defines gross negligence, as used in Section 2761 of the code as,

> an ***extreme departure*** from the standard of care which, under similar circumstances, would· have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or-life."

Petitioner's conduct, as described in the facts, does not meet the "extreme departure" standard. Petitioner rapidly considered the options and the potential impact upon her patient and exercised her judgment to take him to the ICU, which had the staffing, equipment and expertise to handle "complications" she believed could occur as soon as James C. was intubated. (App. 1 Pg 63 ¶4h) It took only five minutes to reach the ICU

(App. 1 Pg 64 ¶4m), where he arrived still breathing on his own and with normal vital signs. It could not have taken much less time, if any, to call a Code and assemble the Code team and equipment in James C.'s room. Ms. Turner, testifying as an expert witness, acknowledged it is permissible for a nurse to disobey a physician order, that Petitioner may have believed she was acting in good faith, but she was "wrong". (App. 1 Pg 67 ¶13

The courts have long recognized in malpractice cases a "mere error in judgment", and mere proof that the treatment was unsuccessful is not sufficient to establish negligence. *Huffman v. Lindquist* (1951) 37 Cal.2d 465, 475 [234 P.2d 34, 29 A.L.R.2d 485]; *Fay v. Mundy***,** 246 Cal.App.2d 231, 54 Cal.Rptr. 5911 Cal.App. 5 Dist. 1966. The physician's assistant had reached the same conclusion, that the patient should be transferred to the ICU, although Petitioner was not aware of it at the time. (App. 1 Pg 62 ¶4e). The intern, Dr. Monsef, after conferring with RN Mugi also ordered the Petitioner to transfer James C. to the ICU, and Petitioner initiated the transfer by making the necessary arrangements with the ICU. (App. 1 Pg 63 ¶4h) Petitioner also spoke with her supervisor about James C. and his condition and that the resident's desire to intubate in his room. The supervisor said, "***Go to the ICU".*** (App. 3 pg 422, lines 12-14).

Only the resident Dr. Nguyen, wanted to intubate James C. in his room on Station 25. The good faith exercise of professional judgment by an experienced nurse advocating for the patient cannot be gross negligence and cannot serve as the basis for the harsh discipline Petitioner received when three other medical and nursing professionals, in the exercise of their professional judgment reached the same conclusion - James C. had to go to the ICU.

Conclusion:

Gross negligence is an ***extreme*** departure from the applicable standards of care. Legal authority generally requires some element of willfulness, wanton or reckless disregard for the welfare of another. Petitioner complied with the Code of Ethics and the California Nurse Practice Act. The fact that in the exercise of her professional judgment she disagreed with the resident who had just come on the scene, does not reach that level of negligence. Her disagreement alone would not even rise to the level of ordinary negligence.

The foregoing, the laws, nursing ethics and the standards of nursing practice required the Petitioner to act as her client's advocate. The decision to harshly discipline the Petitioner under the circumstances would chill the exercise of nursing judgment, to the detriment of many future patients. The Amici respectfully believe that sustaining the Board's decision would be against public policy, and against the best interests of the nursing profession. Accordingly, Amici respectfully request that the Court not support harsh discipline for good faith, lawful and ethical exercise of professional judgment and to vacate the Order of the Board of Registered Nursing.

Respectfully submitted,

_____

/s/ Diane Trace Warlick, RN, JD for Amici
The American Association of Nurse Attorneys.

CERTIFICATE OF WORD COUNT

I hereby certify that I have counted the number of words in the foregoing brief with my computer program, and it contains less than the limit of 14,000 words.

_____

/s/ Diane Trace Warlick