Ethical Dilemma for Non-physician Medical Care Providers: Directly Advise and Advocate for the Patient or Keep Your Job? A Reconciliation of Judicial and Legislative Attempts To Articulate a Public Policy

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I. INTRODUCTION

In our health care system, nurses, physician's assistants, ultrasound technicians, x-ray technicians, paramedics, EMTs, and other non-physician caretakers and diagnosticians (hereinafter "NPCDs") man the front lines as the gatekeepers of patient diagnosis and treatment. Most, if not all of these NPCDs are employed by a hospital, clinic, or nursing care facility, where complying with institutional chain of command reporting procedures and preserving the economic interests of the employer are predominant, although sometimes non-communicated concerns. NPCDs are often faced with exigent and life-threatening circumstances in which their opinion or recommendation may advance the quality of patient care, help to prevent medical malpractice, and in rare cases, save a life. The NPCD's natural instinct and training – in some situations supported by, if not mandated by, a statue or professional code of ethics – is to provide counsel, advice, and advocacy directly to a patient and the patient's family.

In circumstances where such direct advice breaks the institutional chain of command, contravenes or criticizes the advice or treatment plan of the treating physician, threatens to encroach on the boundaries of the physician's exclusive role in patient diagnosis and treatment, or endangers a business or professional referral relationship, the NPCD may be subject to summary discharge from employment. Judicial and legislative

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adherence to the at-will employment doctrine in which an employee, subject to certain exceptions, can be terminated at any time for any reason, provides a powerful counter-force to the NPCD's duty to deliver quality patient care by means of direct advice, counseling and advocacy.

This ethical dilemma can be elucidated by a scenario in which an ultrasound technician employed by an independent clinic performs a routine sonogram on a pregnant woman and observes a serious fetal abnormality in which the abdomen is developing outside of the body. Following proper chain of command protocol, the technician promptly informs the patient's treating obstetrician of the abnormality. However, the obstetrician fails to document the conversation in the patient's chart, neglects to discuss the abnormality with the patient during her next office visit, and takes no proactive steps to address the situation. When the patient becomes seriously ill and delivers the fetus by emergency cesarean section, the abnormality is discovered. The baby only survives for a month after delivery.

The foregoing facts led to a medical malpractice suit against the obstetrician in *Esquivel v. Watters.*[1] Had the technician circumvented the chain of command protocol and directly advised the patient, the patient may have broached the subject with her obstetrician and the obstetrician could have implemented procedures to prematurely deliver the fetus in the course of a planned surgery, while supporting neo-natologists treated the baby. Perhaps the baby's life could have been saved. Does discharging the technician from her employment for giving potentially life-saving advice directly to the patient contravene a clearly mandated public policy?

II. SEEMINGLY CONFLICTING JUDICIAL RESPONSES

It seems counter-intuitive and morally and ethically unfair that accurate and beneficial advice conveyed from a NPCD to a patient could directly result in the discharge of employment of the NPCD without providing the NPCD a legal remedy. However, the holding in *DiLisciandro v. Atlantic Medical Imaging* could

[1] 183 P. 3d 847, 848-49 (Kan. 2008).

be so construed.[2] In *DiLisciandro*, a pregnant patient related to her ultrasound technician that she had been experiencing profuse vaginal bleeding, that her treating obstetrician had advised her that medical treatment was not necessary, and that the obstetrician had prescribed nothing but bed rest.[3] The technician advised the patient that she should have promptly sought medical treatment by going to a hospital emergency room.[4] Two days after the conversation, the imaging clinic terminated the technician's employment.[5]

The technician, Ms. DiLisciandro, filed suit against her employer, the clinic.[6] Ms. DiLisciandro's complaint alleged that the clinic, which had no employment relationship with the patient's obstetrician, terminated her to avoid losing referrals from the obstetrician, who had complained to the clinic's management about her advice to the patient.[7] She asserted that her termination was a violation of the New Jersey Conscientious Employee Protection Act ("CEPA")[8] and common law "whistleblowing" protections.[9] Ms. DiLisciandro submitted evidence from medical treatises that demonstrated the risks of profuse vaginal bleeding from pregnancy.[10] In affirming the validity of the discharge, the Court declined to assess the soundness of the medical advice:

> We do not decide here whether plaintiff gave good or bad advice to the patient, or whether it was the right or wrong thing for her to do. Those are matters for health care professionals and ethics advisors to determine. We only conclude that CEPA did not protect plaintiff's employment for giving advice directly to the patient contrary to that of her treating physician.[11]

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[2] No. A-4635-08T2, 2010 N.J. Super. Unpub. LEXIS 1175 (N.J. Super. Ct. App. Div. May 27, 2010).

[3] *Id.* at *3.

[4] *Id.*

[5] *Id.*

[6] *Id.* at *1.

[7] *Id.* at *3.

[8] *DiLisciandro*, *supra* note 2, at *1; *see also* N.J. STAT. ANN. §§ 34:19-1 to -8 (West 2011). **R**

[9] *DiLisciandro*, *supra* note 2, at *1; *see also* Pierce v. Ortho Pharmaceutical Corp., 417 A.2d 505, 512-13 (1980). **R**

[10] *DiLisciandro*, *supra* note 2, at *12. **R**

[11] *Id.* at *14.

The court in *DiLisciandro* reasoned that Ms. DiLisciandro may only have been protected from discharge by CEPA if she had disclosed her belief that the treating physician had improperly advised the patient *to her employer or to the appropriate regulatory body*.[12] Additionally, the court found that medical treatises do not establish public policy regarding who may give medical advice to the patient, and that the AMA Code of Ethics does not apply to all medical care providers.[13] Finding that the plaintiff overstepped the boundaries of her duty and relationship to the patient, and failed to establish a public policy basis to challenge her discharge, the court held:

> It does not establish a clear mandate of public policy that an ultrasound technician such as plaintiff may follow her own reasonable beliefs in giving medical advice to a patient that contradicts the advice of her treating physician.
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> Moreover, our State's public policy to provide high quality health care is not equivalent to a health care professional taking it upon herself to advise a patient about medical treatment outside the sphere of her expertise or patient relationship.[14]

Deerman v. Beverly California Corporation contradicts the *DiLisciandro* decision and held that a NPCD's direct advice to and advocacy on behalf of the patient successfully formed the basis for a wrongful discharge claim.[15] The plaintiff in *Deerman*, Ms. Deerman, was employed as a nurse at a nursing care facility.[16] Ms. Deerman alleged that she was contacted by a member of the patient's family, who sought advice regarding the patient's deteriorating physical and mental condition.[17] Her complaint averred that she had previously documented and reported the patient's difficulties to the patient's physician, and that the physician did not return her phone calls.[18] Ms. Deerman alleged that she was terminated after advising the family member that she would reconsider the choice of physicians, because appropriate treat-

12 *Id.* at *9.
13 *Id.* at *13.
14 *Id.* at *13.
15 518 S.E.2d 804, 810 (N.C. Ct. App. 1999).
16 *Id.* at 805.
17 *Id.* at 805.
18 *Id.*

ment had not been provided by the patient's current physician.[19] She argued that the termination violated public policy as reflected in the applicable state statutes regulating the practice of nursing.[20]

On appeal from an order dismissing plaintiff's lawsuit, the court exhaustively examined minimal competency standards articulated in North Carolina's Nursing Practice Act ("NPA")[21] and regulations, and held:

> The extensive legislative scheme described therein, including regulations adopted thereunder, thus reflects that our General Assembly intended by law to require of licensed nurses a measure of "teaching and counseling," so as to "ensure minimum standards of competency and to provide the public safe nursing care."[22]

The court in *Deerman* observed that had plaintiff been terminated for refusing to violate the standards of the statutory scheme for the practice of nursing, a cause of action for wrongful discharge would lie.[23] Accordingly, there is no basis to distinguish that circumstance from the fact that plaintiff was discharged for complying with the prescribed standards:

> In sum, we conclude as follows: If plaintiff, as alleged, was terminated for meeting the minimum requirements of the practice of nursing as established and mandated by the NPA and regulations thereunder, then such termination violated the public policy of this state to ensure the public a minimum level of safe nursing care.[24]

The *DiLisciandro* and *Deerman* cases can easily be reconciled. The clearest distinguishing factor seems to be the existing *statutory* scheme setting forth the minimum standards of quality nursing care that Ms. Deerman was able to successfully argue in supporting the public policy exception against her termination. The statutory nursing scheme provided a sufficient basis for the court to find the existence of a public policy in *Deerman*, as op-

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[19] *Id.*
[20] *Id.*
[21] N.C. GEN STAT. §§ 90-171.19–.49 (2010).
[22] *Deerman*, *supra* note 15, at 809 (citation omitted). R
[23] *Id.*
[24] *Id.* at 810.

posed to Ms. DiLisciandro's reliance upon the AMA Code of Ethics and a general standard of sound medical care found in textbooks, which had not been codified into law. The court in *Deerman* noted that the family in that case solicited the nurse's opinion,[25] while in *DiLisciandro* the technician voluntarily offered advice to the patient.[26] Also, the nurse in *Deerman* attempted, albeit unsuccessfully, to contact the treating physician prior to offering advice to the patient.[27]

III. GENERAL STATUTORY SCHEMES EXPRESSLY CREATING EMPLOYMENT PROTECTIONS FOR NPCDS

As posited hereinabove, a statutory scheme clearly enunciating minimum professional standards of quality health care has been found sufficient by at least one court to carve out a public policy which would insulate a NPCD from discharge from employment for striving to meet those standards in the course of giving direct advice to a patient. To the contrary, another court has found that medical treatises defining sound medical treatment and professional codes of ethics are insufficient to establish the public policy exception to at-will employment, at least in situations where the NPCD countermands the physician's orders and fails to consult with the physician.

State legislatures have recently begun to recognize the need to specifically and broadly enunciate a general public policy protecting NPCDs from adverse employment consequences that result from the effective treatment of patients. Such expressions of public policy are typically found in various types of "whistleblower" statutes, which shield health care workers or employees in general from adverse employment consequences if they directly result from the reporting of wrongdoing that is against public policy.[28] For example, Colorado recently enacted a statute which prohibits disciplinary action against health care

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[25] *Id.*

[26] *DiLisciandro, supra* note 2, at *3. **R**

[27] *Deerman, supra* note 15, at 805, 810. **R**

[28] According to a report by the American Nurses Association, as of 2009, whistleblower protections for healthcare employees with varying degrees of protections and provisions exist in 20 states. *Whistleblower Protection*, ANA: NURSING'S WORLD, http://www.nursingworld.org/MainMenuCategories/ANAPoliticalPower/State/StateLegislativeAgenda/Whistleblower_1.aspx (last updated July 15, 2009).

workers in retaliation for good faith reporting or disclosure regarding "patient safety information or quality of patient care that is made without malice or consideration of personal benefit and that the health care worker making the report has reasonable cause to believe is true."[29] The statutory protection is expressly qualified by the requirement that the reporting employee "shall follow the internal reporting procedures of the health care provider, to the extent such procedures exist and are provided to the health care worker in writing . . . ."[30]

Ideally, the Colorado statute should bring about a proliferation of written guidelines governing reporting and disclosure procedures among hospitals and other health care facilities. While this consequence will no doubt provide clarity and certainty for NPCDs in terms of procedure for reports and disclosures of inadequate or unsafe medical care, it provides little if any guidance as to the substantive protections, if any, that may be afforded in the event the situation calls for the NPCD to give advice directly to the patient or the patient's family.

The Maine legislature has enacted perhaps the broadest and least restrictive whistleblower statute designed to protect health care employees from retaliation in the employment context, for direct patient advocacy.[31] The Maine Statute stands as the current model of a statute which clearly articulates a public policy supporting a NPCD's *direct reporting to the patient* of deviations from the applicable standard of medical care, without the risk of suffering an adverse employment consequence:

> No employer may discharge, threaten, or otherwise discriminate against an employee regarding the employee's . . . privileges of employment because:
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> . . . .
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> The employee, acting in good faith and consistent with state and federal privacy laws, reports to the employer, *to the patient involved* or to the appropriate licensing, regulating or credentialing authority, orally or in writing, what the employee has reasonable cause to believe is an act or omission that constitutes a deviation from the applicable standard of care for a patient by an employer charged with the care of

29 COLO. REV. STAT. § 8-2-123(1)(b), (2)(a) (2010).
30 *Id.* § 8-2-123(3).
31 ME. REV. STAT. tit. 26, § 833 (2011).

that patient.[32]

What is even more strikingly employee-friendly about the above-quoted Maine statute, is the provision that "[p]rior notice to an employer is not required if the employee has specific reason to believe that reports to the employer will not result in promptly correcting the violation, condition or practice."[33] This provision would seem to potentially provide even more protection to a NPCD who gives direct advice to a patient that is contrary to or critical of the treating physician's course of treatment, where the NPCD believes in good faith that the violation of the standard of care will not be promptly remedied.

IV. *FORMULATING A COHERENT PREDICTIVE FRAMEWORK FOR CONFORMING FUTURE CONDUCT*

In attempting to formulate a coherent predictive framework to govern future conduct by both NPCDs and health care facility administrators, it may be instructive to construct a sliding scale of factors that come into play in the context of direct advice and patient advocacy.

A) The Ever-Pervasive Influence of the At-Will Employment Doctrine

There is no doubt that at-will employment and the preservation of the employer's ability to terminate an employee for any reason pervades American law, and that courts will go to great lengths to protect that doctrine from erosion. The doctrine is ingrained in our common law, and is primarily designed to preserve the employer's business interests and to provide certainty and predictability to personnel decisions. For those policy reasons, only a discharge in violation of a clearly defined, well-recognized, public policy will defeat those business interests. As one appellate court has observed:

> This important element sets the foundation for the tort and it is necessary to overcome the employer's interest in operating its business in the manner it sees fit. It also helps ensure that employers have notice that their dismissal decisions

32 *Id.* § 833(1)(E) (emphasis added).
33 *Id.* § 833(2).

will give rise to liability.[34]

In the realm of medical ethics and patient advocacy, this postulate is no more starkly illustrated than in an unpublished decision of a U.S. District Court in Virginia, in *Swain* v. *Adventa Hospice, Inc.*[35] In *Swain*, the plaintiff, a registered nurse, alleged that another Adventa nurse over-medicated a patient, and that the plaintiff decreased the patient's medication, thereby saving the patient's life.[36] Ms. Swain alleged that she was wrongfully discharged because the incident "embarrassed" her employer.[37] The court refused to find that Ms. Swain had been discharged in violation of a public policy, because the plaintiff did not allege Adventa requested the plaintiff to violate the law, or discharged her for refusing to violate the law.[38] Even assuming that Ms. Swain saved the patient's life, the court failed to find a "bright line to guide and limit the employer."[39] The court opined that the burden on the court of having to determine whether the patient would have died without the plaintiff's intervention, "would be expensive digressions in the guise of public policy in a wrongful discharge suit by an employee at-will, and they would substantially erode Virginia's employment at-will doctrine."[40]

The *Swain* decision underscores the reluctance of courts to engage in protracted disputes over the quality of medical care waged by expert witnesses, as they are called upon to do in medical malpractice cases, in the context of an action for wrongful discharge from employment. In a footnote, the court also signals its deference to the business perspective of the employment relationship and its impact on productivity, by noting that, "the reason for a business decision may be hard to prove, and the costs of proof plus the risk of mistaken findings of breach may reduce the productivity of the employment relation."[41]

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[34] Tuttle v. Keystone Nursing Care Ctr., No. 8-995/08-1002, 2009 Iowa App. LEXIS 200, at *10 (Iowa Ct. App. Mar. 26, 2009) (citations omitted) (internal quotation marks omitted).

[35] No. 7:03CV00505, 2003 U.S. Dist. LEXIS 22753 (W.D. Va. Dec. 12, 2003).

[36] *Id.* at *1-2.

[37] *Id.* at *2.

[38] *Id.* at *8.

[39] *Id.* at *7.

[40] *Id.*

[41] *Id.* at *7 n.2 (quoting Kumpf v. Steinhaus, 779 F.2d 1323, 1326 (7th Cir. 1985)).

In contrast to the reluctance of the courts in *Swain* and *DiLisciandro* to entertain expert testimony to bolster the plaintiff's contention that the NPCD's advice, action or advocacy was in the patient's best medical interests, the Iowa Appellate Court in *Tuttle v. Keystone Nursing Care* Center, Inc. expressly allowed consideration of expert testimony of a physician at trial.[42] In *Tuttle*, the issue was whether the plaintiff, a licensed practical nurse, was wrongfully discharged by a nursing care facility for, among other reasons, instructing (allegedly yelling at) her subordinate nursing staff in the presence of patients, as to the proper placement of absorbent bed liners on the beds of the residents.[43] Ms. Tuttle argued that she was dismissed for engaging in conduct in furtherance of the public policy in favor of preventing elder abuse.[44] The trial court allowed expert testimony of a physician, who rendered his opinion that the plaintiff "did what she was supposed to do to intervene for the patient's welfare," and that "her conduct was an attempt . . . to prevent neglect, mistreatment, and abuse of her elderly patients."[45] Based in part upon this expert testimony, the court affirmed the denial of defendant's motion for judgment notwithstanding the verdict.[46]

B) Profession-Specific Statutes and Codes of Ethics

As noted hereinabove, the strongest factor that can be advanced by a discharged NPCD is a general statutory scheme expressly declaring the existence of a public policy, and establishing protections for health care employees against adverse employment consequences. This type of general protection can be found in statutes such as the Colorado and Maine statutes cited above.[47]

As in *Deerman*, public policy can also be found in state statutes enunciating minimum standards of quality medical care in a *particular* profession, such as nursing.[48] Most, if not all states

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[42] *Tuttle*, *supra* note 34, at *26-27. **R**
[43] *Id.* at *2-3.
[44] *Id.* at *4.
[45] *Id.* at *19 (internal quotation marks omitted).
[46] *Id.* at *27-28.
[47] *See supra* notes 29, 31 and accompanying text. **R**
[48] *See supra* note 21 and accompanying text. **R**

have "nursing practice acts," which in general terms require nurses to be responsible and accountable for the quality of care they administer to patients.[49] In *Kirk* v. *Mercy Hospital Tri-County*, the Missouri Court of Appeals agreed with a nurse who contended that her discharge violated the clear mandate public policy of Missouri, which was reflected in the Nursing Practice Act ("NPA").[50] The evidence in *Kirk* established that the plaintiff perceived that her patient was dying from improper medical treatment, and that after reporting her views to her direct supervisor, she was told to "stay out of it."[51] The trial court record included the testimony of the hospital's Director of Nursing that the plaintiff had offered to obtain the deceased patient's medical records for the family.[52] The court held that the NPA imposed a duty upon the plaintiff to advocate for her patient when she perceived that the patient was being improperly treated:

> We are convinced the NPA and regulations thereunder sets forth a clear mandate of public policy that Plaintiff not "stay out" of a dying patient's improper treatment. Plaintiff's constant and immediate involvement in seeking proper treatment for Debbie Crain was her absolute duty. Common sense dictates this is the highest duty in the nursing profession.[53]

What is significant to the subject of this article about the Missouri Nursing Practice Act, which governed the *Kirk* case, is its provision that imposes a responsibility upon nurses for "the teaching of health care and the prevention of illness *to the patient and his* [*or her*] *family*."[54]

The argument that the applicable professional code of ethics creates a public policy exception to the termination of the at-will employment of a NPCD has been less persuasive to courts. Most cases attempting to establish the existence of a public policy based upon professional codes of ethics have been unsuccess-

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49 Mable H. Smith, *Legal Basics for Professional Nursing: Nurse Practice Acts*, CENTER FOR AMERICAN NURSES, http://nursingworld.org/mods/mod995/canlegalnrsfull.htm#history (last visited Aug. 11, 2011).

50 851 S.W.2d 617, 620, 622 (Mo. Ct. App. 1993).

51 *Id.* at 622.

52 *Id.* at 618.

53 *Id.* at 622.

54 *Id.* at 621 (emphasis added); *see also* MO. ANN. STAT. § 335.016(15)(a) (West 2011).

ful.[55] For example, in *Jaynes* v. *Centura Health Corp.*, the plaintiff nurse claimed that her discharge (in retaliation for what she alleged was her acting as a "patient advocate" consistent with her ethical obligations as a nurse) violated public policy.[56] Ms. Jaynes contended that the American Nurses Association's ("ANA") Code of Ethics established a public policy which supported her actions on behalf of the patient.[57] The Colorado Court of Appeals rejected her claim, finding that the ANA is not a government entity, and that there are no adverse implications (i.e., sanctions or license revocation) of failing to comply.[58] The court concluded that Ms. Jaynes was not placed in a position of having to choose between violating her ethical obligations or being terminated.[59]

The *Jaynes* opinion provides a clear contrast to *Deerman*, in which the court found that the plaintiff would be entitled to maintain an action for wrongful discharge if she had been terminated for complying with the *statutory* regulations enacted and enforced by a *governmental* agency.[60] In short, the case law stands for the proposition that private codes or organizational guidelines, or general statements of public policy under state statutes are insufficient to support a claim for wrongful termination in violation of public policy.

C) Defining "Public Policy"

Courts continue to struggle to articulate the degree of specificity of statutory schemes that must be present in order to arise to the level of a clear and important public policy, which is sufficient to enable a terminated NPCD to prevail (or at least survive summary judgment) in a wrongful discharge action. The dissenting opinion in the recent case of *Margiotta* v. *Christian Hospital Northeast Northwest* cogently frames the dispositive issue.[61] The majority of the Missouri Supreme Court in *Margiotta* held that

55 *See, e.g.*, Wright v. Shriners Hosp. for Crippled Children, 589 N.E.2d 1241, 1244 (Mass. 1992) ("We would hesitate to declare that the ethical code of a private professional organization can be a source of recognized public policy.").
56 148 P.3d 241, 242 (Colo. App. 2006).
57 *Id.* at 244.
58 *Id.*
59 *Id.*
60 *Deerman*, *supra* note 15, at 809-10. R
61 315 S.W.3d 342 (Mo. 2010).

the plaintiff's wrongful discharge action failed because the regulations cited did not proscribe the *specific* patient safety violations that the plaintiff (a medical image technician) reported to his superiors.[62] In his dissent, Justice Teitelman argued that a public policy can be found by reported conduct that is prohibited not only by the "letter" of the law, but also by the "purpose" of the law.[63] Justice Teitelman is content to search for the definition of public policy on a case-by-case basis:

> This formulation of the wrongful discharge action recognizes the reality that many valid statutes or regulations provide general guidelines designed to regulate the unpredictable and nearly infinite array of specific fact patterns that fit within the regulatory purpose of the law. . . . In these cases, the general statute or regulation, and therefore the definition of "public policy," becomes clear when applied to the facts of a particular case.[64]

One can justifiably contend that such a loose case-by-case standard for articulating the public policy exception may open the floodgates to a potential deluge of litigation and increased legal exposure for health care facilities. The view which would require precise and narrowly-defined definitions of just what constitutes a clearly mandated public policy, which would enable a plaintiff to prevail in an action for wrongful discharge, is eloquently stated by the Illinois Supreme Court, utilizing a balancing metaphor:

> Adherence to a narrow definition of public policy, as an element of a retaliatory discharge action, maintains the balance among the recognized interests. Employees will be secure in knowing that their jobs are safe if they exercise their rights according to a clear mandate of public policy. Employers will know that they may discharge their at-will employees for any or no reason unless they act contrary to public policy. Finally, the public interest in the furtherance of its public policies, the stability of employment, and the elimination of frivolous lawsuits is maintained.[65]

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62 *Id.* at 348.

63 *Id.* at 349 (Teitelman, J., dissenting).

64 *Id.*

65 Turner v. Memorial Med. Ctr., 911 N.E.2d 369, 378 (Ill. 2009). Plaintiff, a respiratory therapist, brought a retaliatory discharge action based upon his reporting to

It will require proactive legislative action to accommodate the foregoing competing views. If legislatures more clearly articulate public policy in the area of direct patient advocacy, the potential legal risk to hospitals and to the public will be minimized, since, if the policy is "well defined" and the "affirmative obligations" placed on nurses are "sufficiently certain," then the courts will be able to "easily identify covered cases."[66] Certainty and predictability will be the direct result, thereby enabling courts to "screen out frivolous cases on summary judgment, while still protecting well-defined public policies."[67]

D) Competing Institutional, Economic, and Professional Interests of Health Care Facilities and Physicians

Competing economic and institutional interests of the employer must be balanced against arguments attempting to establish a public policy sufficient to shield an NPCD from summary termination of at-will employment. In *DiLisciandro*, the court placed heavy emphasis on the fact that the plaintiff failed to follow established reporting procedures, that is, she failed to first report the situation to her employer or to the appropriate regulatory body.[68] This institutional interest in preserving the chain of command is also reflected in the Colorado statute cited hereinabove.[69] In *Rucker* v. *St. Thomas Hospital*, the failure of a hospital's "Patient Relations Coordinator" (a nurse by training) to follow the chain of command in reporting an allegedly impaired nurse was held, in and of itself, sufficient to defeat the plaintiff's claim for common law retaliatory discharge.[70] In *Rucker*, the Court of Appeals of Tennessee observed:

> [T]here were numerous incidents where Ms. Rucker broke the specific chain of command that she was given to follow. Although we concede that Ms. Rucker's motives may have been pure, she simply did not stay within the boundaries of

an accreditation agency of deviations in patient charting that were allegedly jeopardizing patient safety. *Id.* at 372-73. The Illinois Supreme Court affirmed the appellate court's dismissal of his complaint. *Id.* at 378.

66 Hausman v. St. Croix Care Ctr., 571 N.W.2d 393, 398 (Wis. 1997).

67 *Id.*

68 *DiLisciandro*, *supra* note 2, at *9. R

69 *See supra* note 29, 30 and accompanying text. R

70 No. M2007-00716-COA-R3-CV, 2007 WL 4170823, at *1, *7 (Tenn. Ct. App. Nov. 26, 2007).

> her position . . . . Consequently, Ms. Rucker fails to establish the fourth, and final, criterion for common-law retaliatory discharge-that the protected activity was a substantial factor in her discharge from Hospital employment.[71]

From a risk management standpoint, a formalized chain of command policy will reduce potential confusion that can occur in a health care facility in situations calling for a report by an NPCD of questionable patient care or treatment. This is particularly true in cases of emergency or sudden changes in the patient's condition. Ideally, such a reporting protocol will enable the facility to address, manage, and correct any lapse in care before any harm to the patient occurs. It may also serve to insulate the patient and the family from unsubstantiated false alarms based on uncorroborated opinions of NPCDs, and avoid unwarranted investigations by regulatory agencies. From the perspective of the NPCD, such a policy will presumably provide a guidepost with which to weigh the ethical duty to provide advocacy and advice directly to the patient or family, against the risk of forfeiting the ability to assert the protection of a statute defining a public policy, in the event his or her employment is subsequently terminated.

Courts have consistently recognized and strictly protected from encroachment the boundary between a nurse's duty to advocate for her patients, and the exclusive duty of the physician to make clinical decisions relating to patient care and treatment. The protection and preservation of this interest formed the primary basis for the Pennsylvania District Court's rejection of the wrongful termination claim of a licensed practical nurse in *Hays* v. *Beverly Enterprises*.[72] In *Hays*, the plaintiff alleged that she was wrongfully discharged in violation of public policy in retaliation for, among other things, informing a patient's family that proper health care had not been given.[73] The Court granted the health care facility's motion for summary judgment, citing the legitimacy of the confidentiality policy contained in the defendant's employee handbook, and the policy that medical treatment advice be given only by a physician:

[71] *Id.* at *7.
[72] 766 F. Supp. 350 (W.D. Pa. 1991).
[73] *Id.* at 351.

> In the very least, any communication regarding the medical condition of a resident and/or the health care services provided to such an individual, must be accomplished in a controlled manner by competent physicians or those otherwise charged with a resident's care who possess special training or knowledge that would render that individual competent to make such a communication."[74]

These boundaries can become blurred, and the ethical dilemma is magnified, when courts are asked to apply the well-established legal principle that rigid adherence to a physician's orders or treatment plan is not always warranted in cases where the nurse knows that the orders are not in accordance with normal medical practice.[75] In such cases, compliance with doctor's orders may be superseded by a nurse's duty to the patient. As stated by the Kentucky Court of Appeals in *NKC Hospitals v. Anthony*: "[t]he defense that the hospital's nurses were only following a 'chain of command' by doing what Dr. Hawkins ordered is not persuasive. The nurses were not the agents of Dr. Hawkins. All involved had their independent duty to [the patient]."[76]

When is it proper for a nurse to question, or even circumvent the treating physician's orders? In *Utter v. United Hospital Center, Inc.*, the West Virginia Supreme Court of Appeals provides some guidance, at least in situations where exigent circumstances arise, or where collaboration and consultation with the patient's treating physician may be difficult or impracticable:

> Nurses are specialists in hospital care who, in the final analysis, hold the well-being, in fact in some instances, the very lives of patients in their hands. In the dim hours of the night, as well as in the light of day, nurses are frequently charged with the duty to observe the condition of the ill and infirm in their care. If that patient, helpless and wholly dependent, shows sign of worsening, the nurse is charged with the obligation of taking some positive action.[77]

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[74] *Id.* at 355.

[75] *E.g.*, Toth v. Community Hosp. at Glen Cove, 239 N.E.2d 368, 449 n.3 (N.Y. 1968); Poor Sisters of St. Francis Seraph of the Perpetual Adoration, Inc. v. Catron, 435 N.E.2d 305, 308 (Ind. Ct. App. 1982).

[76] 849 S.W.2d 564, 569 (Ky. Ct. App. 1993).

[77] 236 S.E.2d 213, 216 (W.Va. 1977).

Among less significant employer-weighted factors, is the implicit credence the court in *DiLisciandro* appears to give to the economic interests of a health care facility in preserving and maintaining referrals from physicians.[78] Another less significant factor, which was subtly articulated in the court's reasoning in both *DiLisciandro* and *Swain*, is the employer's or the treating physician's interest in "saving face" and avoiding embarrassment, when a NPCD ignores or contradicts the physician's treatment plan.[79]

NPCDS, physicians, and health care facilities must balance the ethical dilemmas underlying the duty of patient advocacy and the risk of termination from at-will employment, not only by analyzing the patchwork created by current case law and statutes, but also in the larger societal context of public policy.

V. A SOCIETAL PERSPECTIVE

When a NPCD is discharged from employment in retaliation for giving direct advice to a patient or the patient's family, a societal ripple effect is created. Overlaying the private employment interests of the NPCD and the health care facility are the direct implications for the patient, the health care system, the legal system, and society as a whole. These loftier considerations have largely been ignored by courts in attempting to define and articulate public policy.

Certainly health care facilities, as every employer, have a strong interest in maintaining employee loyalty and unrestricted flexibility and autonomy in the management of their staff. In the current economy which finds the national unemployment rate above 9%, health care employees are understandably concerned with job preservation.[80] As one scholar has observed, "[i]f a nurse knows there is no legal remedy when she is fired for refusing hospital orders, she has a strong economic incentive to ignore her ethical duty. Most nurses are not in a position to

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78 *DiLisciandro*, *supra* note 2, at *3. R

79 *See Id.* at *3; *Swain*, *supra* note 35, at *2. R

80 According to the U.S. Department of Labor's Bureau of Labor Statistics, the U.S. unemployment rate for July 2011 was 9.1%. *The Employment Situation- July 2011*, BUREAU OF LABOR STAT., U.S. DEP'T OF LABOR (Aug. 5, 2011), http://www.bls.gov/news.release/pdf/empsit.pdf.

sacrifice their jobs to assuage their consciences."[81] The inevitable societal and patient care consequences resulting from this inherent divergence of interests are cogently articulated by Cavico and Cavico in their thoughtful article:

> Thus, to maintain that the continued employment of a nurse could be made contingent upon his or her contravention of the law at the behest of the employer or, conversely, for complying with the law, would be to encourage illegal conduct on the part of both the nurse and the employer, and consequently also would serve to contaminate the entire health care field. Such a conclusion is patently contrary to the health care consumer's, as well as society's, interest.[82]

This is not to suggest that NPCDs should unilaterally be making subjective, clinical patient care decisions. The NPCD's duty to act as a patient advocate cannot, and must not justify substituting her subjective judgment for that of the treating or attending physician. As observed by the Ohio Supreme Court, "[a] nurse who concludes that an attending physician has misdiagnosed a condition or has not prescribed the appropriate course of treatment may not modify the course set by the physician simply because the nurse holds a different view."[83] Where the NPCD does so, she may be subject to disciplinary action, and possibly license revocation.[84] The dual interests of sound public policy and the efficient delivery of health care are promoted when licensing bodies for nurses and other NPCDS strictly enforce unjustified violations of their codes of ethics.

The interests of preserving the boundaries of the physician-patient relationship, insuring that clinical decisions are made only by physicians, and reaping the benefit of an NPCD shielded from adverse employment consequences when directly advocat-

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[81] Susan R. Gornik, *An Exception to the Employment-At-Will Doctrine for Nurses*, 2 HEALTH MATRIX 89, 105 (1992).

[82] Frank J. Cavico & Nancy M. Cavico, *Employment-At-Will, Public Policy and the Nursing Profession*, 8 QUINNIPIAC HEALTH L.J. 161, 229 (2005).

[83] Berdyck v. Shinde, 613 N.E.2d 1014, 1024 (Ohio 1993).

[84] *E.g.*, Finnerty v. Board of Registered Nursing, 85 Cal. Rptr. 3d 364 (Cal. Ct. App. 2008) (affirming the revocation of a nurse's license where the nurse refused to comply with a resident physician's order); Wheeler v. Georgetown Univ. Hosp., No. 10-1441, 2011 WL 2181960, at *4-5 (D.D.C. June 6, 2011) (granting motion to dismiss plaintiff's claim that she was fired because she complied with the Nurse's Code of Ethics "to report incidents adverse to [patients'] care.").

ing for the patent's best interests, need not be mutually exclusive. As Cavico and Cavico observe, empowering trained and skilled health care professionals to directly participate in patient care and treatment, without fear of adverse employment consequences, may have a broader beneficial effect:

> [W]hen the employee is a professional nurse with a concomitant level of health care knowledge and expertise, as well as usually the one health care professional with continual contact with the patient, that type of professional employee actually may be the best one to make decisions regarding patient safety and care. If the nurse, who is an employee at-will, perceives that there is potential legal protection for his or her job, the nurse will feel empowered to make decisions that promote the best interests of the patient. Surely, such autonomy also will inure to the benefit of the nurse's employer, especially a hospital employer, in the long-term.[85]

A trend has emerged, in which both hospitals and state legislatures appear to be striving to promote the foregoing societal and systemic policies. In the interests of encouraging staff reporting, and full disclosure of medical errors to patients and their family, hospitals have begun to implement comprehensive programs designed to respond to use expanded channels of communication for reporting "unexpected adverse events involving patient harm."[86] One of the key components of these medical error reporting systems is that reports of such events can be provided anonymously by hospital staff, to the organization's department charged with managing patient safety or risk management.[87] When combined with a rapid remedy, such disclosure processes are seen as means to maintain the bond of trust between provider and patient, while serving to "mitigate any damages associated with subsequent litigation, thereby benefiting the health care delivery system as a whole."[88]

An even more significant trend is the state legislative enactment of "Patient Safety Acts," which are generally designed to enhance patient safety and minimize patient harm by encourag-

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[85] Cavico & Cavico, *supra* note 82, at 231. **R**

[86] Timothy McDonald, Kelly M. Smith, & David Mayer, *"Full Disclosure" and Residency Education*, ACGME BULLETIN, May 2008, at 5, 5.

[87] *See Id.*

[88] *Id.*

ing anonymous, confidential disclosure of adverse events by health care professionals.[89] The New Jersey Patient Safety Act ("NJPSA") is notable for its provisions that bar the use of certain limited disclosures of "serious preventable adverse events" made by health care professionals (expressly including nurses) to patients or as patient's family member, in an "adverse employment action."[90] This provision is based upon the legislature's expressed recognition that "[f]ear of sanctions induces health care professionals and organizations to be silent about adverse events," which is contrary to the statute's expressed purposes of encouraging "the voluntary, anonymous and confidential disclosure" of certain adverse events, in a "non-punitive culture that focuses on improving processes rather than assigning blame."[91]

It remains to be seen whether these trends will in the long term effectively promote the societal and systemic goals of encouraging confidential and anonymous disclosure of adverse events by NPCDs, reducing medical malpractice litigation, and improving the delivery of safe, quality health care.

VI. CONCLUSION

Imagine separate and distinct concentric circles consisting of the following fundamental policies: (i) the ethical duties of NPCDs to directly advise and advocate for their patients; (ii) the sanctity and exclusivity of the boundaries insulating the physician-patient relationship; (iii) the common law doctrine of at-will employment; and (iv) the value of an expressed institutional chain of command protocol. At the confluence of these concentric circles lie murky waters for both medical care practitioners and health care facility administrators. It is also an uncharted area for both employee and management-side attorneys and for judges, in terms of articulating a public policy which would effectively shield NPCDs from discharge from employment for providing medically-sound, beneficial, and potentially life-saving advice and counsel directly to patients and their families.

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[89] *See also* Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. § 299b-21 to -26 (2011).

[90] Patient Safety Act, N.J. STAT. ANN. § 26:2H-12.25(a), (f)(3) (West 2011).

[91] *Id.* § 26:2H-12.24(e), (f).

The essential problem lies in the expressed reluctance of courts to address quality of care, medical ethics, and larger societal issues in the context of an employment dispute. The task of clarifying the point of confluence between the above-described circles in cases brought by discharged NPCDs, must fall upon state legislatures. It will ultimately be up to the legislatures to define, in either general or profession-specific terms, whether and in what circumstances the advice of a NPCD directly to patients and their families in furtherance of an ethical or statutory mandate, will establish a public policy exception to the termination of at-will employment.

Absent legislative guidance, courts will be forced to carve out the definition of public policy on a case-by-case basis, in a common law environment in which the at-will employment doctrine serves as a powerful force. In doing so, judges must reconcile competing institutional and societal interests, with the NPCD's ethical and statutory duty to directly advise the patient in situations where his or her first-hand observation and training dictates that such direct advice will more safely and effectively treat the patient's condition.