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ACTS OF DIAGNOSIS BY NURSES AND THE COLORADO PROFESSIONAL NURSING PRACTICE ACT

"The law hath not been dead, though it hath slept."

—*William Shakespeare**

INTRODUCTION

PATIENTS returning from cardiac surgery in Denver's Saint Luke's Hospital are placed in a coronary intensive care unit. Also placed in the unit are patients with serious rhythm disturbances. Saint Luke's Hospital has claimed that the intensive care unit will reduce the mortality from heart failure threatening these patients by 50 percent.¹ The success of the unit owes much to the skill of the specially trained nurses who monitor the heartbeat of each patient, often without a doctor's supervision. The unit will undoubtedly continue to be a valuable addition to Colorado's medical services, until a nurse in the unit is convicted of violating the Colorado Professional Nursing Practice Act.² The charge would be that the nurse made an act of diagnosis.

The Nursing Practice Act states that the "practice of professional nursing . . . shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures."³ The question to be discussed in this Note is the meaning of "acts of diagnosis." To provide a factual focus, the authors interviewed and observed nurses in the city of Denver who have been given broad medical responsibility. In addition, documents were received from Saint Luke's Hospital outlining the duties of nurses in intensive care units.

The written standing orders of Saint Luke's intensive care unit will be used as a factual point of reference for the discussion of diagnosis. It is important to note that doctors have not been stationed in the unit on a full time basis. The unit is so designed that the nurse on duty will continuously monitor the heartbeat and general condition of the patient. If the nurse judges that the patient is having a cardiac arrest she will initiate resuscitative measures. If there is an arrest, the nurse is not to wait for a doctor's directions.

*MEASURE FOR MEASURE, Act II, Scene 2.

¹ Intensive Care Unit Committee & Heart Station Committee, Operational Policies Concerning Coronary Intensive Care Unit (memo received from Dr. Robert Liggett, Medical Director of Education, Saint Luke's Hospital, Denver, Colorado, October 11, 1967) [hereinafter cited as Operational Policies].

² COLO. REV. STAT. ANN. § 97-1-1 to -29 (1963).

³ *Id.* § 97-1-2(1) (1963).

The nurses in the intensive care unit of Saint Luke's Hospital have the following standing orders:

- Emergency:* Respond promptly to alarm by going to bedside.
 Check pulse (carotid or femoral) as well as cardi-
 scope.
 Be sure you aren't dealing with a false alarm.
 Patient in true arrest (asystole or ventricular fibrilla-
 tion) will be unconscious.
 If true emergency:
 Call for help
 Start ventilating patient
 Start External cardiac compression
 If *Ventricular Fibrillation* use defibrillator if no physi-
 cian is present.
 If *Cardiac Standstill* give 1cc 1:1000 Epinephrin intra-
 venously (in the tube of the running I.V. solution)
 continuing external cardiac compression and ventilla-
 tion.⁴

Viewed in one light, the question of whether nurses in the intensive care unit may be violating the statutory prohibition of diagnosis is academic. None of the doctors or nurses interviewed were aware of any prosecution of a nurse for diagnosing. However, interviews did reveal an uncertainty about the meaning of the law. Uneasiness arose when a nursing procedure which appeared to be medically proper was analyzed in light of the statute. Several doctors complained that this uncertainty hobbled the planning of new medical programs designed to relieve overburdened doctors by giving more responsibility to nurses. Therefore, an inquiry into the meaning of diagnosis is far from academic if uncertainty about the diagnosis prohibition is retarding new medical programs for the citizens of Colorado.

I. STATUTORY REGULATION OF WHAT A NURSE CAN DO

Colorado is not the only state which prohibits nurses from making acts of diagnosis; nineteen other states have similar provisions.⁵ Furthermore, the prohibition of diagnosis is not an archaic

⁴ Operational Policies 2.

⁵ ALA. CODE tit. 46, § 189(34) (Supp. 1965);
 ALASKA STAT. § 08.68.410(5) (1962);
 ARIZ. REV. STAT. § 32-1601(5)(d) (Supp. 1967);
 DEL. CODE ANN. tit. 24, § 1902 (Supp. 1966);
 HAWAII REV. LAWS § 67-2(b) (Supp. 1965);
 IDAHO CODE ANN. § 54-1413(e) (Supp. 1967);
 ILL. ANN. STAT. ch. 91, § 35.35(1) (Smith-Hurd 1966);
 KAN. STAT. ANN. § 65-1113(b)(1) (1964);
 ME. REV. STAT. ANN. tit. 32, § 2102(2)(D) (1964);
 MONT. REV. CODES ANN. § 66-1222(1) (Supp. 1967);
 NEV. REV. STAT. § 632.010(5) (1957);
 N.H. REV. STAT. ANN. § 326-A:2(I) (1966);
 N.C. GEN. STAT. § 90-158(3)(a) (Supp. 1967);

statutory provision; all of the states having the provision enacted them after 1947. The prohibition is usually added as a caveat to the statutory definition of the practice of professional nursing.

Most states have a definition of the practice of professional nursing similar to the Colorado provision, which reads:

The "practice of professional nursing" shall mean the performance for compensation of any act in the observation or care of the ill, injured, or infirm or in the maintenance of health or preservation of illness of others or in the supervision and teaching of other personnel or the administration of medicines and treatments as prescribed by a person licensed to practice medicine or dentistry in this state, requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical and social sciences.⁶

The Colorado statute then adds:

The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures.⁷

The question of whether the acts of nurses in the coronary intensive care units constitute acts of diagnosis could be answered if there were a judicial construction of the prohibition by the Colorado Supreme Court. However, the Colorado court has not been called upon to explain the statute's prohibition. The courts of the 19 other states prohibiting diagnosis are also silent.

II. THE VARIED MEANINGS OF DIAGNOSIS

Attempts to understand the prohibition are not completely frustrated because the word "diagnosis" as it appears in other Colorado statutes has been defined both by statute and judicial construction. Colorado chiropodists are allowed to diagnose ailments of the human toe, foot, and leg⁸ and the statute allowing diagnosis says, "Diagnosis shall be held to mean ascertaining a disease or ailment by its symptoms."⁹

In *Hurley v. People*¹⁰ the Colorado Supreme Court held that a man who was conducting a school for healing was not guilty of the unauthorized practice of medicine. Although he discussed disease in general terms, he made no examination of the ailments of any

N.D. CENT. CODE § 43-12-01(2) (Supp. 1967);
 ORE. REV. STAT. § 678.015(1967);
 S.D. CODE § 27.0902(2) (Supp. 1960);
 UTAH CODE ANN. § 58-31-4(5) (Supp. 1967);
 VT. STAT. ANN. tit. 26, § 1552(2)(B) (1967);
 WASH. REV. CODE ANN. § 18.88.030 (1961).

⁶ COLO. REV. STAT. ANN. § 97-1-2(1) (1963).

⁷ *Id.*

⁸ *Id.* § 91-2-2.

⁹ *Id.* § 91-2-2(2)(c).

¹⁰ 99 Colo. 510, 63 P.2d 1227 (1936).

individual. The court said, "Clearly, as we conceive, the first and primary concern of the medical practitioner is to ascertain what afflicts his ailing patient — to make diagnosis; he then determines what will remedy the ills of the sufferer, which he proceeds to administer."¹¹

If the Colorado statutory and judicial definition of diagnosis is used — that it is the ascertaining of a disease or ailment by its symptoms — then a strong argument can be made that nurses in the intensive care unit are not diagnosing. Under the statute, diagnosis would be the determination of the disease based upon an evaluation of symptoms. Diagnosis would be the selection of one disease from a possibility of diseases suggested by the symptoms. On the other hand, diagnosis would not be a judgment of whether a symptom is present or a judgment of the seriousness of the symptom. When the nurse judges that the patient exhibits ventricular fibrillation she is merely observing a symptom, not diagnosing the disease suggested. In determining that the patient is suffering a true cardiac arrest she is exercising judgment as to the seriousness of the symptom, but she is not ascertaining the nature of the disease.

It also can be argued that the diagnosis of the patient has already been made when the doctor assigns the patient to the intensive care unit. The doctor has determined that the patient is suffering from a particular heart disease and that the medication called for in the nurse's standing order is always appropriate to ease the symptoms the patient is likely to exhibit. The nurse's responsibility is not to determine the particular disease nor is she called upon to decide what medication will ease the symptoms. Her responsibility is to judge the gravity of the symptom and to act under the direction of her standing orders.

However, this argument in favor of the legality of nursing duties in the intensive care unit seems to be rebutted by a 1963 letter from the Colorado Attorney General to the Colorado State Board of Nursing:

In reply to your inquiry as to whether professional nurses may legally make a tentative diagnosis and then use a standing order signed by a doctor in the treatment of the particular condition involved, I wish to advise that acts of diagnosis are expressly excluded from the definition of the practice of professional nursing as set forth in C.R.S. '53 (1960 Perm. Supp.), 97-2-2(1). As we construe this section, a professional nurse is not authorized under the law, as part of the practice of professional nursing, to make a diagnosis.

Diagnosis is recognition of a disease from its symptoms. [case cited from California] "Diagnosis means a summary of symptoms with the conclusions arrived at therefrom; determination of the

¹¹ *Id.* at 516, 63 P.2d at 1229.

distinctive nature of disease." [Minnesota case cited] A nurse is not permitted to make a diagnosis, tentative or otherwise.

In answer to your second question as to whether a nurse following this procedure would be practicing medicine, C.R.S. 1953, 91-1-6(1)(a), includes "diagnosis" in the term "practice of medicine." It would appear, therefore, that a nurse who made a tentative diagnosis of a certain condition would be practicing medicine.¹²

Unfortunately, the letter provides no factual focus whereby one could distinguish between a nurse's judgment of symptoms and the act of making "a tentative diagnosis of a certain condition." The effect of the letter is not to clarify the distinction between proper nursing judgments and acts of diagnosis but to warn nurses that if they fail to make the right distinction they are subject to the charge of practicing medicine.¹³

A review of decisions by other state courts reveals two different interpretations of the term diagnosis. Like the Colorado Supreme Court, other courts have had no difficulty in arriving at a definition of diagnosis. Almost all courts would agree that diagnosis is the determination of a disease from its symptoms. Confusion arises when the court applies the definition to the fact situation. According to the rationale of some courts, diagnosis only takes place when the nurse attempts to determine the particular disease. The nurse is properly allowed the responsibility of judging the gravity of symptoms without engaging in diagnosis. In opposition to this view are cases which hold that when a nurse evaluates a symptom and judges that no serious disease is indicated, she is making an act of diagnosis.

The rationale of the first case cited in the Attorney General's letter would seem to give the nurse wide discretion in judging symptoms. In *Maranville v. State Board of Equalization*¹⁴ the court commented that a lay technician who made x-ray pictures and analyzed their meaning in reports to doctors and dentists was not making acts of diagnosis. The court said, "He made no diagnoses from the radiographs. But he did advise the professional men of his conclusions of conditions of anatomies as they appeared to him in the pictures. He 'interpreted light shadows.'"¹⁵ Although one would like to know more facts about the "conclusions of conditions of anatomies," the court in this case allowed the technician wide dis-

¹² Letter from Duke W. Dunbar, Colorado Attorney General, to Mrs. Madolin M. Dickinson, R.N., Director of Nursing Education and Licensing, Colorado State Board of Nursing, Aug. 19, 1963.

¹³ COLO. REV. STAT. ANN. § 91-1-6(1963) defines the practice of medicine in terms which include the word diagnose. Section 91-1-29 makes the unauthorized practice of medicine a misdemeanor.

¹⁴ 99 Cal. App. 2d 841, 222 P.2d 898 (1950).

¹⁵ 222 P.2d at 898.

cretion in evaluating conditions without judging him guilty of diagnosing. It would seem that this court would allow a nurse similar discretion in evaluating symptoms as long as she does not attempt to determine the disease suggested by the symptoms.

Contrary to the reasoning of this case is *People v. Willis*¹⁶ in which an unlicensed chiropractor was convicted of treating the sick without being licensed by the state. The chiropractor defended on the ground that the chiropractic science does not recognize disease and hence no chiropractor could make a diagnosis. The California court rejected this argument by saying:

Indeed, it is difficult to conceive of any one trying to restore to a normal condition a person who is abnormal without a prior investigation and determination, in a general way at least, of the character of the abnormality. Manifestly, there are no fixed limits to a diagnosis. It may not amount to a scientific classification of the ailment, but it may go no further than an observation of the most obtrusive symptoms, and may be accurate or inaccurate, and yet be within the contemplation of the statute. It seems like an unjust aspersion on the character and intelligence of this respectable body of practitioners to intimate that they attempt to restore "the normal activity of the tissues" without any inquiry or investigation as to what tissues are affected and in what manner their activity may be abnormal.¹⁷

This case indicates the problem of using the word "diagnose" in a variety of statutes designed to correct different abuses. Thus, courts may be tempted to adopt a broad definition of the word in a statute such as the Colorado statute which prohibits an unlicensed person to hold himself out "as being able to diagnose, treat, prescribe for, palliate or prevent any human disease . . ."¹⁸ On the other hand, public policy may be better served by a strict definition of the word diagnosis in the Professional Nursing Practice Act.

Another example of a broad judicial definition of diagnosis is contained in *Cooper v. National Motor Bearing Co.*¹⁹ A nurse employed by the company treated a puncture wound in an employee's forehead caused by another employee who let a piece of metal slip from his hand. The nurse swabbed the wound with an antiseptic and put a bandage on it. The employee saw the nurse the next two days and she applied more medication but did not probe the wound.

The nurse worked under standing orders signed by a doctor who would accept patients injured beyond the scope of the nurse's practice. The employees had to see the nurse first and could only see the doctor upon the nurse's authorization. According to her testimony, it was her duty to refer any condition or injury she was

¹⁶ 62 Cal. App. 717, 217 P. 771 (1923).

¹⁷ 217 P. at 772.

¹⁸ COLO. REV. STAT. ANN. § 91-1-6(1)(b) (1963).

¹⁹ 136 Cal. App. 2d 229, 288 P.2d 581 (1955).

not familiar with, or not sure about, to the doctor for diagnosis.

The employee's wound healed except for a small red mark. After two or three months the redness began to spread and started to become puffy. However, the nurse waited 10 months before referring the employee to the doctor. The injury was then diagnosed as skin cancer and skin grafts were required to cure it.

The court affirmed a judgment that the nurse was negligent and said that evidence was sufficient to show that the nurse did not properly probe the wound for foreign matter, and that she unreasonably delayed in referring the employee to the doctor, despite indications that the wound was not properly healing.

The court then concluded that a nurse in evaluating the seriousness of a symptom is making an act of diagnosis:

A nurse in order to administer first aid properly and effectively must make a sufficient diagnosis to enable her to apply the appropriate remedy. Usually she receives some history of the accident or illness from the patient, inspects a wound, and bases her choice of treatment on the deductions thus made. She has been trained, but to a lesser degree than a physician, in the recognition of the symptoms of diseases and injuries. She should be able to diagnose, according to appellant nurse's own testimony herein, sufficiently to know whether it is a condition within her authority to treat as a first aid case or whether it bears danger signs that should warn her to send the patient to a physician.²⁰

The reasoning of the *Cooper* case is persuasive because the nurse, in judging the gravity of symptoms, must base her judgment upon the seriousness of the possible diseases suggested by the symptoms. Her analysis of the patient's complaint duplicates in a less sophisticated degree the analysis of the doctor. Of course, the nurse's treatment of the patient differs from the doctor's in that she cannot prescribe the medicines that the doctor can. In looking at the facts of the *Cooper* case, one can ask whether the diagnosis dividing line can be drawn at the point where the nurse treats the patient. Did the nurse diagnose when she applied the antiseptic? The answer should be no, because the one important action by the nurse was her decision that no doctor was needed. Even if she had applied no medication, her decision that a doctor was not needed would be the factor that determined the patient's future medical care. Thus, a nurse may be guilty of making an act of diagnosis when she decides that no serious disease or symptom is indicated. Or, the nurse in the intensive care unit may be making a diagnosis when she determines that there is no false alarm and that the standing order should be executed. It is this decision that duplicates the decision a doctor would make in a similar situation.

²⁰ 288 P.2d at 587.

The uncertainty surrounding diagnosis is recognized by professional nursing associations and authorities in this field of medical care.²¹ Their approach to the problem is keyed to the actual day-to-day practice of nursing, which recognizes the fact that nurses must observe symptoms and conditions and act on their observations. They define diagnosis as the utilization of intelligence to interpret known facts, and acting upon the decision reached from this interpretation. The differentiation of a "doctor's diagnosis" and a "nursing diagnosis" is based on the courses of action open to each profession after the decision from the observation is made. Nurses cannot prescribe therapeutic measures or positive treatment; this is the sole function of the doctor. However, the nurse can act to avoid further complication or aggravation of the patient's condition based on her observation of the symptoms present. It should be noted here that most of these authorities believe the emergency exception to the diagnosis prohibition allows the nurse to do all she deems necessary and proper, including that which is normally only action allowed a doctor.

The observation by the authors of nursing practices in Denver revealed that the above "professional" definition of diagnosis was the standard used between doctors and nurses. But, to reiterate, the actual practice of nursing under this definition does not correspond to the law of the State of Colorado.

Ironically, an admission that nurses make some type of diagnosis was also made in a paper entitled *Saint Luke's Hospital — Legal Aspects of Coronary Care*.²² The paper approvingly quoted a 1965 statement by the Cardiac Nurse Consultant of the Colorado Department of Public Health:

1. It would appear that defibrillation may fall in the same category as closed chest cardiac massage inasmuch as they both involve a potential diagnosis. However, in an emergency a nurse may be expected to make a diagnosis. Furthermore, if the medical staff of any institution gives written consent and it is accepted as part of the hospital routine, I would feel that the nurse is protected.
2. With the latest monitoring equipment and with proper teaching, a nurse can identify on the cardioscope the particular pattern which indicates ventricular fibrillation.
3. Experimentation being carried out today in specified intensive units for coronary care indicate that *immediate* application of emergency procedures, when necessary, has resulted in reversing the pattern of death from ventricular fibrillation.²³

²¹ M. LESNIK & B. ANDERSON, *NURSING PRACTICE AND THE LAW*, 265-66 (2d ed. 1962).

²² Compiled by Marianne Boettner, R.N., Dec. 20, 1965, from a lecture by Audrey Jones, R.N., Dec. 16, 1965 (received from Dr. Robert Liggett, Medical Director of Education, Saint Luke's Hospital, Denver, Colorado).

²³ *Id.* at 2.

The admission that the intensive care nurse will make a "potential diagnosis" is not the only point of interest in the statement; the defense of nursing conduct is hinged on the emergency exception. The major problem with this defense is that the statutory prohibition against the unlicensed practice of medicine limits the emergency exception to the "gratuitous rendering of services in cases of emergency."²⁴ Since the intensive care ward nurse is a salaried employee of the hospital, the probability of convincing a court to apply the exception to her is almost nil. The inescapable conclusion is that this defense is not available in this situation.

Furthermore, the treatment of a patient in the intensive care unit is at best a planned emergency because the only unforeseen element is the time of the cardiac arrest. The person to be stricken by the emergency, the place of the emergency, and the nature of the emergency have all been anticipated and prepared for. The plan of the intensive care unit is that when the patient is stricken a nurse will initiate resuscitative measures. It is anticipated that no doctor will be in the unit to make the initial decisions.

The final question about the intensive care unit is the legality of standing orders. As the authors of *Nursing Practice and the Law* indicate in the following passage, the problem is based upon an interpretation of the meaning of diagnosis:

Great confusion prevails as to the validity of standing orders. In effect, standing orders presume to constitute medical direction for the execution of medical acts in the physician's absence. To the extent that they constitute instructions for cases *already diagnosed*, such orders are valid. Although no specific statute or judicial decision may be cited, it would appear that such standing orders should be signed by the attending physician.

To the extent that standing orders provide positive measures for cases to *be* diagnosed, such orders are invalid. A physician may not delegate the authority to diagnose, to treat or to prescribe. A standing order for treatment of a headache or a cold is illegal, since it presupposes a prescription based upon a diagnosis.²⁵

It appears that there are three uncertainties about the legality of intensive care units in Colorado: whether the nurse is making a diagnosis, whether the emergency exception applies, and whether standing orders are legal. The Colorado authorities and the judicial authorities of other states give no reassuring answer to ease these uncertainties.

III. OBSERVATION OF DECISIONS MADE BY DENVER NURSES

One can hope that questions about the legality of intensive care units are academic. However, the observations by the authors of

²⁴ COLO. REV. STAT. ANN. § 91-1-6(3)(b)(1963).

²⁵ M. LESNIK & B. ANDERSON, *supra* note 21, at 281.

this Note revealed that the same charge of making acts of diagnosis could be leveled against the activities of other nurses in Denver.

Time was spent with two nurses from the Visiting Nurse Service of the City of Denver. Nurses in this organization visit families and individuals who have medical problems yet who cannot afford private physicians. One such visit illustrates the acts the nurse performs and the decisions she makes.

The Visiting Nurse called on a family that had recently migrated to Denver from a neighboring state. The mother and her three children were at home; the father was at work. The children were all under the age of six and the mother was expecting another child in two months. The mother complained about the poor heating in the house and said that the house temperature went rather low at night. Because of the cold, the family slept and played in the living room. The children had colds the week before but one was feeling much better. One child who had been sleeping on the couch woke up during the visit and complained of a sore throat. After some coaxing the nurse was able to get the child to open her mouth and let the nurse make an examination. The nurse said there was an inflammation but it did not look too serious. The nurse then counseled the mother on the need to keep shoes and clothes on the children and the need to take them to the neighborhood health center for inoculations. The nurse also said that the mother herself should be examined by a doctor. The mother admitted that it might be good for the children to get their shots, but she did not want to be lectured by a doctor. However, she said she would take the children to the health center even though she herself hated pregnancy examinations.

The nurse in this visit evaluated the health of the children and determined that none were seriously ill. Unfortunately, a doctor will not review her decision because the mother's fear of a doctor's lectures will probably overcome her good intentions.

Later that day, the Visiting Nurse went ahead and made an appointment for the mother at the neighborhood health center. Observation of activities at this center revealed that some nurses who have received special instruction in pediatrics give children physical examinations. The nurse, free from the supervision of a doctor, evaluates among other things the condition of the child's heartbeat, reflexes, eyes, ears and throat. A history of the health of the child is taken from the mother. Based on these indications the nurse evaluates the health of the child. She may judge that the child's health is satisfactory. She may judge that the child has a health problem but that the immediate attention of a doctor is not

needed. Finally, she may judge that the child is seriously ill and that immediate medical attention is necessary.

Observations of the work of the Pediatric Nurse and the Visiting Nurse demonstrate that the nurse must contemplate the possible diseases indicated by the symptoms she observes. This is the basis of her decision that the child is in good or poor health. However, she does not attempt to ascertain a particular disease and hence her actions would not come within a strict interpretation of the wording of the Colorado statutory definition of diagnosis — ascertaining a disease or ailment by its symptoms.

The most important aspect of the nurse's activity is her evaluation of the person's condition. That conclusion temporarily determines whether there will or will not be future medical treatment. However, this activity does not distinguish the Pediatric or Visiting Nurse from other nurses with more traditional responsibilities. The nurse on the hospital floor who thinks that a patient's complaints do not merit a doctor's attention is making a similar evaluation or, perhaps, diagnosis.

IV. THE NURSE'S STANDARD OF CARE

The Colorado nurse's legal problems are complicated further by the civil liability imposed upon her for any acts of negligence done in performance of her nursing duties. As noted above, if she does an act determined later to be diagnosis, she has committed a misdemeanor and is subject to a fine of up to \$500.²⁶ Furthermore, she would probably have her license to practice professional nursing revoked.²⁷ However, the duty of care imposed on nurses requires them to do acts and to make decisions which some courts have held to be acts of diagnosis.

This duty of care or standard of skill imposed on the nurse by the law generally requires that the nurse exercise ordinary and reasonable care to see that no unnecessary harm befalls her patient.²⁸ More specifically, a nurse must apply that same degree of skill, learning, and care in treating the sick and wounded similarly suffering in the same or a similar community.²⁹ The problems with diag-

²⁶ COLO. REV. STAT. ANN. § 97-1-25(1),(2) (1963).

²⁷ *Id.* § 97-1-21.

²⁸ *Oldis v. La Societe Francaise De Bienfaisance Mutuelle De Los Angeles*, 130 Cal. App. 2d 461, 279 P.2d 184 (1955); *Ybarra v. Spangard*, 25 Cal. App. 2d 486, 154 P.2d 687 (1944). This standard of care applies to both licensed professional nurses and any unlicensed person who acts in a nursing capacity or undertakes to render nursing services. *Griffin v. Colusa County*, 44 Cal. App. 2d 915, 113 P.2d 270 (1941); *Christensen v. Des Moines Still College of Osteopathy & Surgery*, 248 Iowa 810, 82 N.W.2d 741 (1957).

²⁹ *Cooper v. National Motor Bearing Co.*, 136 Cal. App. 2d 229, 288 P.2d 581 (1955); *Valentin v. La Societe Francaise De Bienfaisance Mutuelle De Los Angeles*, 76 Cal. App. 2d 1, 172 P.2d 359 (1946); *Wood v. Miller*, 158 Ore. 444, 76 P.2d 963 (1938).

nosis arise under this community-standard-of-care test because a nurse has a duty to act upon her observations of symptoms and reactions to the extent of her skill, knowledge, and authority.³⁰

There are numerous examples of imposition of liability upon nurses for failure to act upon this observational duty, which has been termed a "nursing diagnosis," or for failure to observe at all.³¹ The nurse making such a "nursing diagnosis" must employ reasonable care in judging the seriousness of the symptoms to determine what action must be taken.³²

Thus, the nurse in Colorado is caught in the middle of conflicting legal responsibilities. In performing her duties of observation of symptoms, she may be guilty of making a medical diagnosis.³³ Yet, if she fails to do this duty, or does it incorrectly, she is subject to liability under laws of negligence or malpractice. To allow such an uncertain situation as this to exist in a day of expanding health services and care is indefensible and must be corrected.

V. A CONSTITUTIONAL DEFENSE

The dilemma resulting from negligence law, which requires a nurse to make judgments that border dangerously close to the nebulous concept of diagnosis, opens the provision prohibiting diagnosis to the constitutional attack of being void for vagueness. In describing this doctrine, the United States Supreme Court has said that a criminal statute must be "sufficiently explicit to inform those who are subject to it what conduct on their part will render them liable to its penalties. . . . [A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential of due process of law."³⁴ Since the violation of the diagnosis prohibition is a misdemeanor, the Court's language has direct applicability to the nurse's situation in Colorado.

One type of statute that is particularly vulnerable to the charge of unconstitutional vagueness is a statute that inhibits free speech.

³⁰ *Burns v. Bakelite Corp.*, 17 N.J. Super. 441, 86 A.2d 289 (1952).

³¹ See *Cooper v. National Motor Bearing Co.*, 136 Cal. App. 2d 229, 288 P.2d 581 (1955); *Valentin v. La Societe Francaise De Bienfaisance Mutuelle De Los Angeles*, 76 Cal. App. 2d 1, 172 P.2d 359 (1946); *Palmer v. Clarksdale Hosp.*, 213 Miss. 601, 57 So. 2d 473 (1952); *Wisner v. Syracuse Memorial Hosp.*, 274 App. Div. 1074, 86 N.Y.S.2d 150 (1949).

³² *Burns v. Bakelite Corp.*, 17 N.J. Super. 441, 86 A.2d 289 (1952). It should be noted here that the normal nurse's malpractice insurance policy provides coverage for negligence or malpractice in a nursing diagnosis, but does not cover malpractice in a medical diagnosis. The latter is termed an illegal practice of medicine which is a criminal act in most states. M. LESNIK & B. ANDERSON, *supra* note 21, at 290-91.

³³ The uncertainty surrounding the definition of "diagnosis" might not apply to the Colorado situation because of the Attorney General's opinion that nurses cannot make even a tentative diagnosis. Letter from Duke W. Dunbar, *supra* note 12.

³⁴ *Connally v. General Const. Co.*, 269 U.S. 385, 391 (1926).

Mr. Justice Brennan has said that "stricter standards of permissible statutory vagueness may be applied to a statute having a potentially inhibiting effect on speech; a man may the less be required to act at his peril here, because the free dissemination of ideas may be the loser."³⁵ The doctrine that a statute is unconstitutional because of indefiniteness has been developed to create an "insulating buffer zone of added protection" for the Bill of Rights freedoms.³⁶

The dilemma of the Colorado nurse who must chart a course of action between a vague criminal statute and the responsibilities imposed by negligence law is even more intolerable than the dilemma of a person whose free speech is infringed by a vague statutory prohibition. People do not pay damages for failing to exercise the right of free speech. People also do not lose their license to practice their chosen profession by acting in accordance with their first amendment rights. Therefore, to apply the void-for-vagueness doctrine to the nurse's situation would be more than just, and possibly the strongest defense to an action brought under the diagnosis prohibition.

VI. A LEGAL RESOLUTION OF THE PROBLEM

While the void-for-vagueness defense would be applicable to the nurse's situation, it is by no means the best solution to the problem. The diagnostic prohibition for nurses and nondoctors does have a very legitimate reason for being — it protects the general public from medical frauds by assuring that only licensed physicians are allowed to diagnose and prescribe remedies for their physical and mental ills. Complete elimination of the prohibition could easily do more harm than good to all groups involved. Therefore, a more workable solution is called for and fortunately is available.

Since the Colorado courts have not interpreted this section of the Nurses Practice Act, any case brought under it would allow them to adopt a definition of diagnosis which would insure adequate protection of the nurses', the doctors', and the public's interests. It is the opinion of the authors that the professional definition of diagnosis,³⁷ the one used in actual nursing practice, provides the best answer to the problem.

By defining diagnosis as the utilization of intelligence to interpret known facts, the "nurse's diagnosis" is specifically included as permissible conduct. Protection of the public and physicians would come from the limitation on the nurse's action by the statutory pro-

³⁵ *Smith v. California*, 361 U.S. 147, 151 (1959).

³⁶ Note, *The Void-For-Vagueness Doctrine in the Supreme Court*, 109 U. PA. L. REV. 67 (1967).

³⁷ See text following note 21 *supra*.

hibition against her prescription of therapeutic or corrective measures.³⁸ The nurse's allowable area of action on her decision from her "nursing diagnosis" could now be characterized as the prevention of undue injury to the patient or aggravation of the patient's condition.

Under this interpretation of diagnosis, the test for a nurse's liability for malpractice would be: Should the nurse have taken a course of action — from those courses available to her — different from that which she did adopt, based on her observations of the patient's symptoms and reactions?³⁹ This test has two major advantages over previous definitions on nursing malpractice. First, it includes the community-standards test common to malpractice law,⁴⁰ but allows for judicial raising of the standard to protect the public from the possibility of outmoded and harmful nursing practices. Second, it provides a means of separating the questions of whether the nurse's actions constituted the illegal practice of medicine or the negligent practice of nursing, for the test for the former would now be: Was the course of action adopted by the nurse available to her under the prescription of therapeutic or corrective measures prohibition? This is particularly important in light of present nurses' malpractice insurance practices.⁴¹

One of the main shortcomings of this proposed solution is the fact it relies upon a suit against a nurse involving the diagnosis prohibition of the Act. If no suit is instituted, the present uncertain situation must stand uncorrected. While nurses have not been prosecuted under the present state of the law, there is obviously no guarantee that a situation could arise in the future which would warrant such a suit. Thus, the final recourse may have to be with the state legislature and a change of the language of the statute itself.

VII. A NECESSARY STATUTORY CHANGE?

The language of the diagnosis prohibition prevents the nurse from making any act of diagnosis, and has been interpreted to mean just that by the Attorney General.⁴² However, it is arguably possible to reach the proposed solution of the nurse's dilemma under this prohibition without changing the wording of the statute.

³⁸ COLO. REV. STAT. ANN. § 97-1-2(1) (1963).

³⁹ This test has been followed but not specifically enunciated in *Burns v. Bakelite Corp.*, 17 N.J. Super. 441, 86 A.2d 289 (1952), and in *Cooper v. National Motor Bearing Co.*, 136 Cal. App. 2d 229, 288 P.2d 581 (1955).

⁴⁰ Although the community-standards doctrine is currently being questioned and in some cases overruled as applied to physicians and surgeons, the authors feel the test still has validity when applied to professional nursing. See *Brune v. Belinkoff*, 235 N.E.2d 793 (Mass. 1968).

⁴¹ See note 32 *supra*.

⁴² Letter from Duke W. Dunbar, *supra* note 12.

Using the proposed definition of diagnosis,⁴³ it can be argued that the prohibition actually prevents the nurse from doing anything at all under her duty to observe symptoms and reactions. This would eliminate one of the nurse's major functions and place the intolerable burden on the physicians of constantly checking all their patients. Since this is entirely unworkable, the question becomes one of interpreting the statute to make all of its sections and language effective and operative. Because it is inconceivable that the legislature intended this result when the statute was enacted, the solution outlined above would be available to a judge interpreting the statute.

This method of instituting the necessary change is unsure at best. There is no question that amendment of the statute would be a far more effective and safe method of controlling the changes to be made. The simplest way to do this would be to reword the statute to say, "the practice of professional nursing . . . shall not be deemed to include the prescription of therapeutic or corrective measures from any act of diagnosis," and then define diagnosis in the statutes to mean the utilization of intelligence to interpret known facts. If necessary, specific courses of action available to the nurse, based upon the degree of skill, training, and knowledge the particular type of nurse has acquired, could be enumerated for further protection of the public. Further refinements could be worked out by the courts as the need for them arises.

CONCLUSION

The City of Denver's nurses are involved in a number of programs which arguably violate the Attorney General's interpretation of the statute. The value of these programs is great, and the disservice done to the public if they were discontinued by a suit under the diagnostic prohibition would be greater. We live in a time of rapidly expanding health and medical services — both public and private. Many areas do not have enough physicians to handle the increased workload, so the burden is being shifted down to the next best trained group — the nurses. The Denver projects discussed in this Note are good examples of this expansion of nurse's responsibility to free the physicians for more important tasks.

The authors believe that the nurses involved with these projects do an excellent job and are an invaluable service to the people of the city and state. It would be a public disgrace to halt these projects under the diagnostic prohibition — an outmoded, although well intentioned law. The projects will continue as before without a change in the law, but the uncertainty it causes does not contribute

⁴³ See text following note 21 *supra*.

to the effectiveness of the programs. We feel that the adoption of the changes in the law which were suggested in this Note would remove the uncertainty surrounding these projects and allow for expanding present programs or similar medical services conducted by qualified nurses.

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