With More Power Comes More Responsibility: The Supreme Court of North Carolina Acknowledges Nurse Autonomy, but Clearer Guidelines Surrounding Liability Are Needed*

In Connette for Gullatte v. Charlotte-Mecklenburg Hospital Authority, *the Supreme Court of North Carolina expanded liability for nurses. This decision signaled respect for growing nurse autonomy and will benefit patients; however, the broad holding leaves open questions for nurse practice. This Recent Development considers how the court could have better clarified nurse liability as well as the implications of this decision in the context of the North Carolina legislature's hesitance to pass a law granting nurses more independence.*

INTRODUCTION

When a patient comes into the hospital, they are likely to interact with a number of healthcare professionals—physicians, nurses, medical technicians, and more. But what happens when something goes wrong for the patient? Specifically, what happens when the medical team is negligent? Who within the hospital is held accountable for that negligence? And who *should* be held accountable? Traditionally, doctors have been held accountable, as there has been a longstanding belief that the doctor is the top of the chain of command within a hospital.[1]

In August of 2022, the Supreme Court of North Carolina decided that other healthcare professionals—specifically nurses—have enough responsibility for patient care that they should also be held accountable for negligent acts. In *Connette for Gullatte v. Charlotte-Mecklenburg Hospital Authority*,[2] the court held that "even in circumstances where a registered nurse is discharging duties and responsibilities under the supervision of a physician," that nurse can be liable if they breach their professional standard of care.[3] The court's decision relied

1. There has also been a recent movement, called the corporate negligence doctrine, to hold hospitals themselves accountable for the negligence of staff members. *See infra* notes 105–06 and accompanying text.

2. 382 N.C. 57, 2022-NCSC-95. In June of 2023, defendants submitted a Petition for Discretionary Review of this case to the Supreme Court of North Carolina. Defendants' Petition for Discretionary Review Before Determination by the Court of Appeals at 35, *Connette for Gullatte*, 2022-NCSC-95 (June 5, 2023) (No. 331PA20). The petition asks the court to resolve whether three justices can reverse a decision of the North Carolina Court of Appeals or overturn precedent, as they did in *Connette*. *Id.* at 2.

3. *Connette for Gullatte*, 2022-NCSC-95, ¶ 21.

heavily on the desire to respect the "increased, influential roles which nurses occupy in medical diagnoses and treatment."[4] However, the final holding did not clarify exactly how this expanded duty will impact nurses. For example, does the holding apply only to nurses with specialized certifications, similar to the nurse in *Connette*?[5] Does it apply only when nurses and physicians collaborate on a treatment plan, as occurred in this case?[6]

Without clarity on these questions, nurses will struggle to understand when they face potential liability. In addition to the questions left open by this decision, the opinion was released in the context of a growing nurse shortage[7] as well as a movement for greater nurse autonomy.[8] In North Carolina, the General Assembly failed to pass the SAVE Act in 2022, a bill that would have granted advanced practice registered nurses more authority to diagnose and treat patients without the supervision of a doctor.[9] The failure of the SAVE Act in combination with the *Connette* decision means that nurses are exposed to broader liability and denied greater autonomy. This combination of limited independence and greater liability is likely to create a poor environment for nurses, which could lead individuals to leave the practice in North Carolina.

This Recent Development assesses the positive outcomes of the *Connette* decision for patients and the tort system, the questions left unanswered, and the implications of the decision in light of the broader conversations in the field of nursing. The analysis of this case proceeds in four parts. Part I provides a background of *Connette* and other North Carolina cases about nurse liability. Part II analyzes how this holding furthers the tort system's goals of compensation and accident prevention, but also points out where the legal reasoning falls short in offering clarity. Part III contextualizes this decision in a broader movement for greater nurse autonomy, highlighting the implications of this decision within that movement. Lastly, Part IV offers suggestions for how the General Assembly and hospital policymakers should respond to this decision and give nurses the reassurance they deserve.

4. *Id.*

5. *See id.* ¶ 2.

6. *See id.* ¶ 4.

7. *See* TANNER BATEMAN, SEAN HOBAUGH, ERIC PRIDGEN & ARIKA REDDY, MERCER, U.S. HEALTHCARE LABOR MARKET 6 (2021), https://www.mercer.com/content/dam/mercer-dotcom/migrated-assets/blogs/us-health-news/2021/12/us-2021-healthcare-labor-market-whitepaper.pdf [https://perma.cc/PEV3-VXEZ].

8. *See* Lynn Bonner, *Hampered by Opposition from Doctors' Groups, Nurse Practitioners Want To Change State Law To Give Them More Freedom To Treat Patients*, NC POL'Y WATCH (Apr. 7, 2022, 6:00 AM), https://ncpolicywatch.com/2022/04/07/hampered-by-opposition-from-doctors-groups-nurse-practitioners-want-to-change-state-law-to-give-them-more-freedom-to-treat-patients/ [https://perma.cc/2S9R-R3LZ].

9. S.B. 249, 2021 Gen. Assemb., Reg. Sess. (N.C. 2021).

I. FACTS AND BACKGROUND OF *CONNETTE*

Brought by the guardian ad litem and mother of juvenile Amaya Gullatte, *Connette for Gullatte v. Charlotte-Mecklenburg Hospital Authority* was originally a negligence suit against several of Amaya's treating physicians, a certified registered nurse anesthetist ("CRNA"), and the Charlotte-Mecklenburg Hospital Authority.[10] In September of 2010, Amaya—who was three years old at the time—was diagnosed with cardiomyopathy,[11] and her medical team recommended that she undergo a surgical procedure to address the disease.[12] To prepare for surgery, one of the physicians, Dr. Doyle, and the CRNA collaborated on an anesthesia plan, determining that they should deliver Amaya's anesthesia through inhalation induction instead of intravenous injection.[13] Though the doctor and the CRNA collaborated, the ultimate responsibility to develop and prescribe the treatment of Amaya's anesthesia rested with Dr. Doyle.[14] After receiving the anesthetic, Amaya's heart rate dropped significantly and her brain was deprived of oxygen, ultimately resulting in cerebral palsy[15] and developmental delay.[16]

During the negligence suit that followed, the plaintiffs attempted to admit evidence of the CRNA breaching his duty of care by failing to recommend an approach to anesthesia delivery other than inhalation induction.[17] The trial court held that this evidence was not relevant because the CRNA could not be held liable for the anesthesia strategy since he was operating under the supervision of a physician.[18] The court of appeals affirmed this evidentiary ruling.[19]

10. *See Connette for Gullatte*, 2022-NCSC-95, ¶¶ 2–4.

11. Cardiomyopathy is a collection of heart diseases that leads to the heart's inability to pump blood, which can cause irregular heartbeat and heart failure, among other symptoms. *Cardiomyopathy*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/heartdisease/cardiomyopathy.htm [https://perma.cc/7NUD-WS9F] (last updated Feb. 21, 2023).

12. *Connette for Gullatte*, 2022-NCSC-95, ¶ 2.

13. *Id.* ¶ 26 (Barringer, J., dissenting). A prominent pharmacology textbook noted that, for a patient with cardiomyopathy, intravenous injection is believed to be a safer way to deliver anesthesia than inhalation. *Id.* ¶ 4.

14. *Id.* ¶ 4 (majority opinion).

15. Cerebral palsy can be caused by damage to developing brain muscles and lead to changes in a person's ability to move and control their muscles. *What Is Cerebral Palsy?*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ncbddd/cp/facts.html [https://perma.cc/4KLM-8QAC] (last updated May 2, 2022).

16. *Connette for Gullatte*, 2022-NCSC-95, ¶ 27 (Barringer, J., dissenting).

17. *Id.* ¶ 5 (majority opinion).

18. *Id.*

19. *Id.* ¶ 6. The court of appeals acknowledged that the plaintiffs made strong policy arguments for existing precedent to be overturned but refrained from commenting on them so as not to overstep the authority of the supreme court. *See id.* ¶ 20.

To come to their conclusions, the lower courts relied on *Byrd v. Marion General Hospital*,[20] which established that nurses can only be held liable for negligent medical treatment in two circumstances.[21] The first circumstance arises when a nurse fails to exercise ordinary care outside of the orders or supervision of a physician.[22] The second arises if the nurse acts under the orders of a physician, but the physician's orders are so "obviously negligent or dangerous" that a reasonable person could anticipate harm to result from such an order.[23] With neither of these circumstances present here, the claim by the plaintiffs was barred by the precedent set in *Byrd*.

However, the Supreme Court of North Carolina reviewed the case and ultimately held that it was time to expand the circumstances in which a nurse can be held liable for negligence beyond those outlined in *Byrd*.[24] Fundamental to the court's analysis of this case was the policy argument that nurses are experiencing increasing responsibility and autonomy in their work.[25] The court noted that medicine has advanced to allow nurses to assume a higher and more respected status, and therefore their responsibility should be elevated accordingly.[26] Specifically, registered nurses in North Carolina can now be held liable for negligence and medical malpractice when they are found to have breached the standard of care, even while executing orders under the supervision of a physician.[27] For nurses in North Carolina, breaching the professional standard of care means engaging in conduct that is "not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities under the same or similar circumstances."[28]

II. THE PROS AND CONS OF *CONNETTE*'S EXPANDED NURSE LIABILITY

The decision to expand liability for nurses in North Carolina is a win for patients but may lack clarity for the nurses themselves. *Connette*'s holding furthers two of the many policy goals of the tort system: harm prevention and compensation for victims, both of which ultimately help patients. That said, the case ended with a broad holding expanding nurse liability. This holding left

20. 202 N.C. 337, 162 S.E. 738 (1932).

21. *See id.* at 343, 162 S.E. at 741.

22. *Id.*

23. *Id.*

24. *See Connette for Gullatte*, 2022-NCSC-95, ¶ 21. For the CRNA, this holding ultimately means that the case is remanded for a new trial in which an expert will be allowed to testify about the CRNA's possible breach of the professional standard of care. *Id.* ¶ 24.

25. *Id.* ¶ 23.

26. *Id.*

27. *Id.*

28. *Id.* ¶ 8 (quoting N.C. GEN. STAT. § 90-21.12(a) (LEXIS through Sess. Laws 2023-36 of the 2023 Reg. Sess. of the Gen. Assemb.)).

open questions for nurses about how their conduct and specialization may impact their likelihood of liability.

A. Connette *Supports Patients and the Policy Goals of the Tort System*

Two fundamental goals of North Carolina's tort system are harm prevention and compensation.[29] Harm prevention is about the person in the position to cause harm—it encourages the potential injurer to be concerned with facing liability, therefore making them less likely to participate in unsafe conduct.[30] Compensation, on the other hand, is about the injured person—it ensures that they and their family are compensated for losses sustained due to negligence.[31]

The Supreme Court of North Carolina in *Connette* based much of its legal reasoning on the idea that nurses have risen to such a level of authority in diagnosis and treatment that they should be legally culpable for potential harm.[32] In particular, the court looked to the statutory basis for nurse authority, the Nursing Practice Act,[33] which grants nurses the power to collaborate with other healthcare providers, to implement treatment plans, and to plan and deliver nursing acts.[34] Under the liability rule established in *Byrd*—which remains in place—nurses are already liable when they negligently perform their own duties.[35]

Connette focused more on a different circumstance—nurse and physician collaboration.[36] There, the court held that the CRNA was given the heightened responsibility of collaborating with a physician to determine appropriate health care for a patient and therefore should face the heightened responsibility of liability.[37] In describing the factual underpinnings of the case, the court emphasized that the CRNA "advised the physician, agreed with the physician, and participated with the physician in the election and administration of the anesthetic."[38] By opening up doctor-nurse collaboration to potential nurse liability, this decision ultimately empowers nurses and benefits patients. Nurses, now faced with greater liability, have a clear incentive to push back on

29. DOMINICK VETRI, LAWRENCE C. LEVINE, JOAN E. VOGEL, IBRAHIM J. GASSAMA & CAROL M. SUZUKI, TORT LAW AND PRACTICE 14 (Carolina Academic Press 6th ed. 2020).

30. *Id.* at 13.

31. *Id.* at 14.

32. *Connette for Gullatte*, 2022-NCSC-95, ¶ 21.

33. N.C. GEN. STAT. §§ 90-171.19 to -171.49 (LEXIS through Sess. Laws 2023-36 of the 2023 Reg. Sess. of the Gen. Assemb.).

34. *Connette for Gullatte*, 2022-NCSC-95, ¶ 12 (citing N.C. GEN. STAT. § 90-171.20(7) (LEXIS through Sess. Laws 2023-36 of the 2023 Reg. Sess. of the Gen. Assemb.)).

35. *Id.* ¶ 21.

36. *Id.* ¶ 14.

37. *See id.* ¶ 23.

38. *Id.* ¶ 4.

physicians when they disagree. This should have a positive ripple effect on patients, who ideally will avoid receiving riskier treatment because a nurse has the ability to speak up. In this way, the *Connette* decision supports the tort goal of harm prevention.

The court did not directly discuss the impact of this decision on the compensation of victims of medical negligence. The dissent touched briefly on the financial implications, suggesting that the decision may lead nurses to need malpractice insurance.[39] As it stands, nurses often do not purchase their own malpractice insurance policies; instead, they are covered by the policies of the hospitals.[40] Additionally, North Carolina tort law follows the idea of joint and several liability.[41] This means that when a single harm is caused by the actions of multiple defendants—a hospital and a doctor, for example—a plaintiff may join the defendants together in one complaint.[42] The plaintiff can collect damages from "either or both, upon proper allegations, for the injuries thus inflicted through such concurring negligence."[43] Under this doctrine, the plaintiff is incentivized to have more defendants because they are likely to "search for a financially viable (that is, well-insured) defendant with a sufficiently 'deep pocket' to ensure full recovery."[44]

Connette's expansion of nurse liability could mean adding an additional defendant who has the ability to compensate the plaintiff. Here, the nurses themselves are not the "deep pocket," but the ability to bring a claim against a nurse also implicates the hospital as vicariously liable.[45] The hospital then becomes the "deep pocket" that a patient can access. Thus, this decision also supports the tort goal of compensation for the victim. This support for compensation coupled with advancing the goal of harm prevention makes it clear that the court's decision in *Connette* furthers core policy outcomes of the tort system.

39. *Id.* ¶ 45 (Barringer, J., dissenting).

40. Terri Heimann Oppenheimer, *Everything You Need To Know About Nursing Malpractice Insurance*, NURSE.ORG (July 29, 2022), https://nurse.org/education/nursing-malpractice-insurance/ [https://perma.cc/PZ22-8JMD].

41. *See* N.C. GEN. STAT. § 1B-1 (LEXIS through Sess. Laws 2023-36 of the 2023 Reg. Sess. of the Gen. Assemb.).

42. *See* McEachern v. Miller, 268 N.C. 591, 594, 151 S.E.2d 209, 211–12 (1966).

43. Brown v. Atl. Coast Line R.R. Co., 208 N.C. 57, 57, 179 S.E. 25, 26 (1935).

44. WILSON ELSER MOSKOWITZ EDELMAN & DICKER LLP, JOINT AND SEVERAL LIABILITY 50-STATE SURVEY 2 (2013).

45. *See* Bost v. Riley, 44 N.C. App. 638, 645, 262 S.E.2d 391, 395 (1980) (explaining that a hospital can be held vicariously liable if the negligence of its employees or agents acting within the scope of their employment causes injury).

B. Connette *Leaves Several Questions Unanswered About Nurse Liability*

The court's reasoning supports tort goals but leaves several questions unanswered for nurses as they navigate their new duty of care. In particular, the court focused on two aspects of this case when making its ultimate ruling: the fact that the CRNA and the physician collaborated to come to their decision as well as the fact that the defendant was an advanced practice registered nurse.[46]

1. Collaboration

As outlined above, the *Connette* court emphasized the collaboration between the CRNA and the physician to come to its conclusion that nurses should have heightened liability.[47] Despite the emphasis on this collaboration, the court's ultimate holding did not require that collaboration must have occurred in order for liability to attach.[48] Instead, the holding only stated that nurses can be liable even while operating under a doctor's supervision.[49] It left open the question of whether collaboration is required and, if it is, what collaboration must look like in order for a nurse to be liable. In the dissenting opinion, Justice Barringer pointed out this lack of clarity, noting "left unanswered is what constitutes adequate collaboration or what happens when the physician and the CRNA disagree."[50] More questions were raised in the brief of amicus curiae from the North Carolina Healthcare Association, an organization representing the state's hospitals: "Could the CRNA subject himself to potential liability only if he actively participated in a discussion with the anesthesiologist, or would staying silent also breach this new standard of care? What if the anesthesiologist did not solicit the CRNA's opinion—would the CRNA be duty bound to speak up?"[51] Without clear answers to these questions, it is unclear how the court would rule if the conduct of the nurse in question was less collaborative than that of the defendant. This, in turn, leaves nurses with uncertainty about their day-to-day conduct and what can subject them to liability.

Nurse and doctor collaboration is further inhibited by the complicated dynamics between physicians and nurses within the hospital. In some cases,

46. *See* Connette for Gullatte v. Charlotte-Mecklenburg Hosp. Auth., 382 N.C. 57, 2022-NCSC-95, ¶¶ 10–17.

47. *Id.* ¶ 4.

48. *Id.* ¶ 21.

49. *Id.*

50. *Id.* ¶ 46 (Barringer, J., dissenting).

51. Brief for North Carolina Healthcare Ass'n as Amicus Curiae Supporting Defendants-Appellees at 16, *Connette for Gullatte*, 2022-NCSC-95 (No. 331PA20) [hereinafter Healthcare Ass'n Amicus Brief].

relations between nurses and doctors can be "strained."[52] One possible explanation for this strain is the power dynamics between the two parties, with doctors often receiving more authority, prestige, and money than nurses.[53] This complicated relationship between nurses and doctors was present in one of health care liability's landmark cases, *Darling v. Charleston Community Memorial Hospital*.[54] In *Darling,* the plaintiff alleged that negligent medical and hospital treatment led to a leg amputation.[55] The Illinois Supreme Court reviewed the jury verdict, and part of its reasoning for upholding liability was because of the nurses' failure to speak up about the patient's condition to both the physician and hospital authorities.[56] Criticisms of this decision, however, question if it was fair to require nurses to challenge physicians, given the nurse-doctor dynamic within hospitals.[57]

This hierarchy of doctors over nurses can also be reinforced by the physicians and hospitals themselves.[58] For example, in the *Connette* case, the North Carolina Healthcare Association's brief argued that there should be a sole decisionmaker regarding medical choices, and that a subordinate employee—in this case, a nurse—should defer to the physician or the "pilot in command."[59] Additionally, an amicus curiae brief submitted by the North Carolina Association of Anesthesiologists argued that doctors appropriately have more responsibility because they have more extensive training.[60] Given that doctors and hospitals are still reinforcing the hierarchy between physicians and nurses, the criticisms of the *Darling* decision continue to ring true—it is likely difficult in some settings for nurses to push back against physician decisions, let alone go over their heads and report their conduct to higher authorities.

The lack of clarity from the court about collaboration in combination with the power dynamics between nurses and physicians puts nurses in a difficult position. Nurse-doctor relations may encourage nurses to be deferential to physicians, but without clear legal guidelines about what is expected of nurses

52. *Physician and Nurse Relationships*, CTR. FOR HEALTH ETHICS, UNIV. OF MO. SCH. OF MED., https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/physician-nurse-relationships [https://perma.cc/RZ6Y-YHEH].

53. *Id.*

54. 211 N.E.2d 253 (Ill. 1965).

55. *Id.* at 255.

56. *See id.* at 258.

57. *See* Richard S. Saver, Darling v. Charleston Community Memorial Hospital*: A Broken Leg and Institutional Liability Unbound*, *in* HEALTH LAW AND BIOETHICS: CASES IN CONTEXT 27, 40 (Sandra H. Johnson, Joan H. Krause, Richard S. Saver & Robin Fretwell Wilson eds., 2009).

58. *See Physician and Nurse Relationships*, *supra* note 52 (explaining that hospitals often have a "physician hierarchy" in which doctors have significant power over nurse conduct and hospital decision-making).

59. Healthcare Ass'n Amicus Brief, *supra* note 51, at 9.

60. Brief for North Carolina Society of Anesthesiologists as Amicus Curiae Supporting Defendants-Appellees at 23–24, *Connette for Gullatte*, 2022-NCSC-95 (No. 331PA20) [hereinafter Anesthesiologists Amicus Brief].

while collaborating, this deference could lead to legal liability. Ultimately, nurses need more guidance about what *Connette* means for their future collaborations with physicians as well as how they can effectively push back on doctors to protect themselves from liability.

2. Specialization

Beyond collaboration, the court in *Connette* also emphasized the additional specialization of the defendant, a CRNA, as part of its reasoning. In North Carolina, CRNAs have the unique ability to "(1) select and administer preanesthetic medications, (2) select, implement, and manage general anesthesia consistent with the patient's needs and procedural requirements, and (3) initiate and administer several palliative and emergency medical procedures."[61] The court quoted a section of the North Carolina Court of Appeals opinion in the *Connette* case, in which the lower court wrote that the defendant was "even more specialized than an ordinary nurse anesthetist because he belonged to the hospital's 'Baby Heart Team' that focused on care for young children."[62]

Despite pointing out the defendant's advanced certification and specialization, the Supreme Court of North Carolina's holding did not require the nurse to have any advanced or specialized credentials to be liable, even when operating under a doctor's supervision.[63] Instead, the holding applies to any "registered nurse."[64] A registered nurse is anyone with a bachelor's or associate degree in nursing, while an advanced practice registered nurse has a master's degree.[65] While the holding applies to any registered nurse, the court's emphasis on advanced certification and specialization left open the question of whether the court's holding would have changed if the nurse in question had less experience and specific knowledge. This creates additional confusion for nurses as they attempt to navigate their newfound liability.

Beyond the lack of clarity within the holding in *Connette,* there are some downsides to expanded nurse liability generally. First, nurses may respond to additional liability by speaking up more frequently about patient care and documenting everything in case of liability. While that may have positive benefits for patients, it could also add additional steps and inefficiencies to the delivery of care if nurses consistently need to second guess physicians and document their every move. Additionally, it may deteriorate the concept that a

61. *Connette for Gullatte*, 2022-NCSC-95, ¶ 14.

62. *Id.* ¶ 18 (quoting Connette v. Charlotte-Mecklenburg Hosp. Auth., 272 N.C. App. 1, 4–5, 845 S.E.2d 168, 171 (2020)).

63. *Id.* ¶ 21.

64. *Id.*

65. Sarah Jividen, *Nurse Levels & Ranks Explained*, NURSE.ORG (Mar. 22, 2023), https://nurse.org/education/nursing-hierarchy-guide [https://perma.cc/Z3WB-BUPF].

single individual must have final authority, with that individual typically being a physician.[66] This idea is meant to support patient care so that when quick, critical decisions must be made, one person can take charge.[67] If both nurses and doctors have liability on the line, they may end up vying for final decision-making power, which could confuse hierarchy and risk proper delivery of care.

Overall, the *Connette* decision is likely beneficial for patients, giving them broader ability to be compensated for medical negligence and supporting the tort goal of harm prevention by encouraging nurses to push back on potentially risky medical treatment. That said, the *Connette* holding lacks clarity for the nurses themselves. Without clear guidelines about the requirements for nurse-doctor collaboration or advanced certification and specialization of nurses, this essential group of hospital employees may be unsure of when their conduct could lead to legal liability. This could make nurses in North Carolina less confident practicing, and, as Part III will outline, this decision in combination with recent legislative decisions may deter nurses from working in the state.

III. *CONNETTE* AND THE NURSE AUTONOMY MOVEMENT

Connette signals the judicial branch's support and acknowledgment of nurse autonomy. This reflects a growing nurse independence movement across the country, particularly for nurses with advanced certifications such as nurse practitioners and CRNAs.[68] While the judicial branch may have acknowledged nurse autonomy, other entities in North Carolina have not. For example, both hospitals and physicians pushed back on the possibility of *Connette* expanding nurse liability.[69] Additionally, in early 2023, when the General Assembly reached a compromise on Medicaid expansion, one of the provisions of the bill that was ultimately cut from the final compromise was an act that would grant advanced nurses more autonomy.[70] This difference in opinion among powerful entities within North Carolina leaves nurses in a difficult position: one in which

66. *See* Healthcare Ass'n Amicus Brief, *supra* note 51, at 9.

67. *See id.*

68. *See* Bonner, *supra* note 8. In North Carolina, the nurse independence movement has been going on for years and has been spearheaded by "nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists." *Id.* The autonomy movement represents freedom for nurses that are frustrated by having to work with physician supervisors, despite the fact that those physician supervisors may not even be involved in the nurses' cases. *See id.* This means that certain nurses who have been working for years remain subject to career-long supervision and management by other health care providers. *See id.*

69. *See* Healthcare Ass'n Amicus Brief, *supra* note 51, at 2; Anesthesiologists Amicus Brief, *supra* note 60, at 24.

70. *See* Rose Hoban, *NC House and Senate Republicans Reach Milestone Medicaid Expansion Deal, but Democratic Governor Questions the Timeline*, N.C. HEALTH NEWS (Mar. 3, 2023), https://www.northcarolinahealthnews.org/2023/03/03/nc-house-and-senate-republicans-reach-milestone-medicaid-expansion-deal-but-democratic-governor-questions-the-timeline/ [https://perma.cc/Y5MM-SE5J].

the court has granted them broader liability while operating under the supervision of a doctor, while hospitals, doctors, and the legislature have not acknowledged their greater independence.

Twenty-four states and Washington, D.C., allow full-practice authority for nurse practitioners, meaning they can treat patients without the supervision of a doctor.[71] North Carolina is not one of those states—in fact, it is one of eleven states with the most restrictions in place on nurse practice.[72] The North Carolina Nurses Association has been supportive of the SAVE Act, a bill recently introduced into the state legislature.[73] The Act seeks full-practice authority for Advanced Practice Registered Nurses, including nurse practitioners, clinical nurse specialists, certified nurse midwives,[74] and CRNAs.[75] As one example, fuller practice authority means repealing a section of the General Statutes of North Carolina that requires nurse practitioners to consult with a doctor before prescribing certain drugs to patients, to have a written explanation from a supervising physician for each drug prescribed, and to engage in periodic review of the drugs prescribed.[76] A core theme of the SAVE Act and the nurse autonomy movement is similar to the opinion of the court in *Connette*: nurses have adequate training to take on expanded authority and independence.[77]

The SAVE Act was part of the Medicaid expansion bill in 2022, which ultimately failed in the General Assembly.[78] In 2023, the act was introduced again as part of Medicaid expansion but was ultimately cut from the bill in an effort to reach a compromise.[79] The SAVE Act is now a separate bill in the

71. *See* Bonner, *supra* note 8.

72. *Id.*

73. *SAVE Act*, N.C. NURSES ASS'N, https://ncnurses.org/advocacy/legislative/save-act/ [https://perma.cc/7CZZ-Z6XX].

74. In June of 2023, the General Assembly granted certified nurse midwives full practice authority as part of its abortion bill. *See* Rachel Crumpler, *After a Decades-Long Stalemate, Nurse-Midwives Can Now Practice Without Physician "Supervision*," N.C. HEALTH NEWS (June 5, 2023), https://www.northcarolinahealthnews.org/2023/06/05/after-a-decades-long-stalemate-nurse-midwives-can-now-practice-without-physician-supervision/ [https://perma.cc/7PLA-X3PB]. This shift only applies to certified nurse midwives, leaving other advanced practice nurses—like nurse practitioners—without full practice authority. *See id.* This may signal the General Assembly's move toward broader autonomy, but nurses still face strong pushback from the medical lobby. *See id.*

75. S.B. 249, 2021 Gen. Assemb., Reg. Sess. (N.C. 2021).

76. N.C. GEN. STAT. § 90-18.2 (LEXIS through Sess. Laws 2023-36 of the 2023 Reg. Sess. of the Gen. Assemb.) (articulating the current state of the law); H.B. 218, 2023 Gen. Assemb., Reg. Sess. (N.C. 2023) (advocating for the repeal of § 90-18.2).

77. *See* Jason deBruyn, *Why Nurses and Doctors Disagree on Part of the Medicaid Expansion Bill*, WUNC (June 3, 2022, 1:22 PM), https://www.wunc.org/health/2022-06-03/why-nurses-and-doctors-disagree-on-part-of-medicaid-expansion [https://perma.cc/787Y-DBUW].

78. *See* Will Doran, *Top Republican Lawmakers Reach Deal on NC Medicaid Expansion*, WRAL NEWS, https://www.wral.com/top-republican-lawmakers-reach-deal-on-nc-medicaid-expansion/20744101/ [https://perma.cc/QL7R-265B] (last updated Mar. 4, 2023, 4:25 PM).

79. *See id.*

General Assembly, but its future is unclear.[80] In 2022, the SAVE Act made it through the North Carolina Senate,[81] and most legislators appear to back the bill,[82] but it faces opposition from some influential lobbying groups.[83]

This opposition to nurse autonomy comes from hospitals and physicians. The North Carolina Medical Society, an organization of doctors, opposes granting full-practice authority.[84] In *Connette*, the North Carolina Society of Anesthesiologists noted in their amicus brief that "there are sound reasons for the restricted scope of practice of nurse anesthetists as opposed to physicians," suggesting support for a more limited scope of practice for nurses.[85] Additionally, as noted above, the North Carolina Healthcare Association, which represents the state's hospitals, believes that nurses should be deferential to physicians.[86] The criticism from these groups tends to come down to training and the belief that, because physicians attend medical school, they should maintain a supervisory role over nurses who do not.[87] This opposition also takes the form of lobbying against the SAVE Act, which has likely contributed to the bill's lack of progress in the General Assembly. The debate "is increasingly looking like a monetary arms race," with both nurse-advocates and physician-advocates making donations to state legislators.[88] Here, however, the doctors can outspend the nurses, which may contribute to the ultimate outcome of the bill.[89]

Nurses tend to respond to arguments about training by pointing to research suggesting that twenty-four states have adopted expanded nurse autonomy without issue—each state has kept the expanded authority in place after implementing it.[90] But more frequently, nursing organizations focus the argument not on training, but instead on the benefit of expanded autonomy for patients—broader authority means more providers in North Carolina, especially in rural counties that may have fewer doctors.[91] This argument about

80. *See id.*

81. N.C. NURSES ASS'N, *supra* note 73.

82. Bonner, *supra* note 8.

83. *See* Doran, *supra* note 78.

84. *See* deBruyn, *supra* note 77.

85. Anesthesiologists Amicus Brief, *supra* note 60, at 6.

86. Healthcare Ass'n Amicus Brief, *supra* note 51, at 9.

87. *See* deBruyn, *supra* note 77.

88. Rose Hoban, *Advanced Practice Nurses Who Want More Independence in NC Tussle with Doctors Who Oppose Granting It*, N.C. HEALTH NEWS (Mar. 6, 2023), https://www.northcarolinahealthnews.org/2023/03/06/advanced-practice-nurses-in-nc-tussle-with-doctors-who-oppose-granting-more-autonomy/ [https://perma.cc/7QQV-UP32].

89. *Id.*

90. *See Bipartisan SAVE Act Introduced; NC Legislators Aim To Increase Access to Quality Healthcare*, N.C. NURSES ASS'N (Feb. 28, 2023), https://ncnurses.org/about-ncna/latest-news/bipartisan-save-act-introduced-nc-legislators-aim-to-increase-access-to-quality-healthcare/ [https://perma.cc/P8XF-HSW6].

91. *See id.*

expanded access has entered the legal arena as well, as five states have issued limited law licenses to nonlawyers in domestic relations matters.[92] As states face shortages of essential professionals, there may be a broader push to allow those with more limited training to offer services as a way to ensure access.

This combination of opinions from entities in North Carolina amounts to an expansion in nurse liability while their authority is largely ignored. Indeed, nurse independence has not been recognized by the legislature or their employers (the hospitals) or their colleagues (the physicians). In addition to that undesirable position, the *Connette* court left nurses with no "discernable standard" in terms of when their conduct may subject them to liability.[93] As Part IV will discuss, this undesirable position and unclear standard coupled with the context of nursing and healthcare today could have negative repercussions for North Carolina's nursing population and, in turn, for patients themselves.

IV. OFFERING CLARITY FOR NURSES MOVING FORWARD

The *Connette* decision and the failure of the General Assembly to pass the SAVE Act fall within the much larger context of a growing nursing shortage. In North Carolina specifically, if trends continue, the state is at risk of having one of the largest projected nursing shortages in the country.[94] The repercussions of this shortage are significant.[95] In North Carolina, nurses—in particular, nurse practitioners—often fill voids at hospitals when there are not enough physicians.[96] This is especially true in rural settings, as doctors are more concentrated in the urban parts of the state.[97]

The SAVE Act is aimed at fixing this problem by giving nurses more independence, thereby incentivizing them to come to North Carolina—

92. *See* Press Release, Colo. Jud. Branch, Colorado Supreme Court Approves Creation of Legal Paraprofessional License (Mar. 27, 2023), https://www.courts.state.co.us/Media/release.cfm?id=2033 [https://perma.cc/JC3N-FFGX].

93. Connette for Gullatte v. Charlotte-Mecklenburg Hosp. Auth., 382 N.C. 57, 2022-NCSC-95, ¶ 47 (Barringer, J., dissenting).

94. BATEMAN ET AL., *supra* note 7, at 6.

95. In North Carolina, when there are not enough nurses to work with each patient, hospitals will "close[] beds," which reduces the number of patients a given hospital can help. Michele Lynn, *North Carolina's Nursing Shortage: A Looming Crisis*, CAROLINA NURSING (Oct. 7, 2022), https://nursing.unc.edu/news/north-carolinas-nursing-shortage-a-looming-crisis [https://perma.cc/TU94-Z4JN]. For a state with a growing population and a significant aging population, this could mean turning away people who need care. *Id.*

96. *See* Bonner, *supra* note 8. People in rural North Carolina have more difficulty accessing health care, and the population tends to be older, lower income, and more isolated. Taylor Knopf, *N.C. Rural Health by the Numbers*, N.C. HEALTH NEWS (Jan. 22, 2018), https://www.northcarolinahealthnews.org/2018/01/22/rural-health/ [https://perma.cc/SC9R-4XSL]. These rural populations also often have higher mortality rates. *Id.* Despite that, they also "have a shortage of almost every type of provider." *Id.*

97. Bonner, *supra* note 8.

ensuring there are more individuals to meet the demand for healthcare needs.[98] Unfortunately, between the expanded liability and lack of autonomy granted to nurses, North Carolina may in fact be disincentivizing nurses to work here. Nurses in North Carolina have reacted to the *Connette* decision along these precise lines, saying that this holding—coupled with burnout, staff shortages, and inadequate pay—may lead nurses to leave the profession.[99] *Connette* does attempt to empower nurses by recognizing their independence, but without greater clarity about their liability and increased recognition of autonomy from the legislature, hospitals, and physicians, the environment in North Carolina may not be an appealing one.

Fundamental changes to nurse autonomy will likely fall to the General Assembly through the SAVE Act or similar legislation. As the dissent in *Connette* noted, certain decisions require "factor weighing and interest balancing" and therefore should be left to the General Assembly.[100] Changing nurse autonomy involves many factors and interests, including those of the hospitals, the nurses, the physicians, and most importantly, the patients. The dissent in *Connette* also stated that the decision about nurse liability should have been left to the General Assembly.[101] The majority, however, noted that the legislature has "been silent" on interpretations of this area of law, giving it reason to grant the holding it did on nurse liability.[102] While leaving the decision to expand nurse liability for the General Assembly would give patients, nurses, doctors, and hospitals the chance to weigh in on any changes to legislation, the ability of the doctor and hospital lobby to outspend other groups suggests that the legislative process may not be the fairest way to reach an outcome here. The majority's choice to step in and create a holding that supports patient care and respects nurse autonomy may—if the SAVE Act continues to stall in the state legislature—be the most efficient way to show that North Carolina does care about nurse independence.

That said, as Part II outlines, the holding of *Connette* needs to be further clarified, and that clarification should fall to the General Assembly because of its ability to weigh factors and interests. First, the legislature should define what kind of collaboration can subject a nurse to liability and how a nurse can disagree with a physician in a way that absolves them of their liability.[103] Ideally, this would include requirements for hospitals to create policies and mechanisms that

98. *See* deBruyn, *supra* note 77.

99. *See* Nina Chamlou, *What the NC Supreme Court Ruling Means for Nurses' Civil Liability*, NURSEJOURNAL (Sept. 15, 2022), https://nursejournal.org/articles/nc-nurses-sued-for-following-doctors-orders/ [https://perma.cc/SH5S-FXRU].

100. Connette for Gullatte v. Charlotte-Mecklenburg Hosp. Auth., 382 N.C. 57, 2022-NCSC-95, ¶ 45 (Barringer, J., dissenting).

101. *See id.* ¶ 47.

102. *See id.* ¶ 22 (majority opinion).

103. *See id.* ¶ 46 (Barringer, J., dissenting).

allow nurses to disagree and to report problems to hospital employees beyond the physician. Additionally, the General Assembly must determine "which nurses' training and responsibilities are so advanced or specialized as to warrant liability."[104] There may be an argument for expanding autonomy and liability only for those advanced practice registered nurses who have more extensive training rather than registered nurses without additional certification. This could help to combat the pushback from hospitals and doctors about nurse training, while still granting nurses some additional autonomy. This question warrants the research and interest balancing done within the General Assembly before a decision is made.

Having this clarity from the General Assembly is in the best interest of hospitals as well. In North Carolina, hospitals have a duty that "runs directly from the hospital to the patient."[105] This is the doctrine of "corporate negligence," and it suggests that a hospital can be held responsible for the negligence of its staff members.[106] Thus, if nurses are better equipped by law to flag negligent behavior of physicians before it escalates, hospitals can potentially save themselves from future liability because of negligent employees and save patients from suffering from that negligence.

Beyond the General Assembly, hospitals themselves have a role to play in the wake of the *Connette* decision. Hospital policies are not legally binding,[107] so they cannot greatly impact the outcome of a medical malpractice or negligence lawsuit. However, hospitals can offer job protections to nurses if and when they do disagree and refuse to carry out a doctor's orders. Having these codified job protections could encourage nurse autonomy in decision-making that would give nurses freedom to push back on decisions that they believe are not in the best interest of the patient. While this solution is not as robust as the statutory changes that could be offered by the General Assembly, it gives hospitals a way to respond to the holding of *Connette* and show nurses that they—and their opinions—are valued and protected.

CONCLUSION

In the wake of the *Connette* decision, North Carolina nurses are in an undesirable legal environment—one in which they have expanded liability

104. *Id.* ¶ 45.

105. Jones v. New Hanover Mem'l Hosp., 55 N.C. App. 545, 547, 286 S.E.2d 374, 376 (1982).

106. *Id.*

107. *See* Gilbert A. Dickinson, *Hospital Policies and the Standard of Care - Perspective from the Trenches*, JACKSON KELLY PLLC (Nov. 10, 2021), https://www.jacksonkelly.com/health-law-monitor-blog/hospital-policies-and-the-standard-of-care---perspective-from-the-trenches [https://perma.cc/KZ2E-W4EV]. "Hospital policies certainly can be considered as part of the evidence related to the expected conduct of a nurse or other practitioner. But a violation of a provision of a policy, alone, does not establish negligence." *Id.*

without any additional autonomy to act outside the supervision of physicians. The *Connette* decision took a step in the right direction by respecting nurse independence and implementing a holding that benefits patient care. However, more must be done. The General Assembly should rectify this current disconnect by passing the SAVE Act and clarifying the Supreme Court of North Carolina's holding in *Connette*. By doing so, the legislature will make North Carolina an attractive state for nurses and adequately service the healthcare needs of the state. Patient safety should be paramount, which is often the physician's argument against expanded practice authority. But the state faces practitioner shortages that already put patients at serious risk. Without these remedies, North Carolina is in danger of expanding its nursing shortage, an outcome that will be detrimental for patients and the healthcare system overall.

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