

Before the
Administrative Hearing Commission
State of Missouri



STATE BOARD OF NURSING,)	
)	
Petitioner,)	
)	
v.)	No. 12-1491 BN
)	
MARILYN HINTEN,)	
)	
Respondent.)	

DECISION

Respondent Marilyn Hinten, a licensed practical nurse, is subject to discipline against her license for incompetency, and for violation of professional trust or confidence. She is not subject to discipline for misconduct.

Procedure

Petitioner State Board of Nursing filed a complaint on August 13, 2012, seeking this Commission's determination that cause exists to discipline Ms. Hinten's license. Ms. Hinten was served with a copy of the complaint, and our notice of complaint and notice of hearing, on August 20, 2012. She answered on August 27, 2012.

We held a hearing on April 2, 2013. The case became ready for decision on June 25, 2013, when the parties concluded briefing.

Preliminary Matter of Uncharged Conduct

Preliminarily, we address Ms. Hinten’s argument that certain evidence the Board presented at hearing over her objection—about her attitude, and remarks she made about a physician—exceeded the bases for discipline on which it relied in its complaint, and so cannot be considered by us in determining whether cause exists for discipline. We agree.

A complaint establishes notice of the bases for discipline. 1 CSR 15-3.350(2)(A)¹; *Ballew v. Ainsworth*, 670 S.W.2d 94, 103 (Mo. App. E.D. 1984). We cannot find cause for discipline related to acts or omissions not charged in a complaint. *Dental Bd. v. Cohen*, 867 S.W.2d 295, 297 (Mo. App. W.D. 1993).

Of course, conduct can be charged at differing levels of specificity, from a general conclusion that a statutory ground has been violated, to such a degree as to set out “each specific individual act or omission comprising the course of conduct.” *Duncan v. Mo. Bd. for Arch’ts Prof’l Eng’rs & Land Surv’rs*, 744 S.W.2d 524, 539 (Mo. App. E.D. 1988) (citations omitted). As a matter of due process, general conclusions are not sufficient because they do not “allow preparation of a viable defense[,]” and extremely detailed recitations are not necessary. *Id.* “Due process requires no more than compliance with” a middle ground, “involv[ing] a greater specificity [than general conclusions] in setting forth the course of conduct deemed to establish the statutory ground for discipline.” *Id.*

Here, the Board identified certain conduct on which it would base its case. But it did not include and so did not put Ms. Hinten on notice that she should prepare to defend allegations

¹ References to “CSR” are to the Missouri Code of State Regulations, as current with amendments included in the Missouri Register through the most recent update, unless otherwise specified.

concerning her attitude and remarks she made about a physician. Accordingly, we do not consider such acts or omissions in determining whether cause exists for discipline.

Findings of Fact

A. Background

1. Marilyn Hinten has held a Missouri practical nursing license since 1990.
2. Starting in 2006, Ms. Hinten worked as an agency, or temporary, licensed practical nurse (LPN) at the University Hospital in Columbia, Missouri. In May 2007, the hospital hired her as a regular employee of the Medical Specialty Clinic, and her LPN job duties expanded. She worked there until November 2010, when she was fired.
3. In the Medical Specialty Clinic setting, an LPN was the liaison between the patient and the physician.
4. The Medical Specialty Clinic was a high volume clinic. Physicians in multiple specialties, e.g., nephrology, pulmonology, gastroenterology, etc., would see their patients at the same time; 60 to 70 patients could have appointments in a day; and the phones constantly rang. Four nurses, including Ms. Hinten, typically staffed and ran the clinic.
5. From 2007 to 2010, Ms. Hinten's job duties in the Medical Specialty Clinic included taking a patient's vital signs, putting the patient in an exam room, checking what medications the patient was taking and whether prescription refills were needed, letting the physician know the patient was there, ensuring during check-out that the patient's questions were answered, making an accurate and complete record, and assisting the physicians as they instructed.
6. Ms. Hinten was responsible for answering phone calls related to patient care. When a patient called, her job was to gather as much relevant information as possible and write a

detailed message, research the patient's questions for the physician, and promptly relay the message and any information she had gathered to the correct physician.

7. Ms. Hinten was also responsible for following up on physicians' instructions and orders relating to patient care, such as scheduling a sleep study that a doctor ordered for a patient.

B. Job Performance Issues

8. As addressed in more detail below, from 2009 until November 2010 when she was fired, Ms. Hinten failed to completely and accurately record information related to patient care; to promptly and adequately follow up on messages, orders, and instructions related to patient care; and to effectively communicate with physicians in regard to patient care. Ms. Hinten's failure to adequately perform her duties created more work for the clinic's other nurses and delayed patient care.

9. On February 24, 2009, Ms. Hinten sent a physician an incomplete message about a facility that needed physician approval to provide services to a patient. The physician instructed her to phone the facility back for more information about what was needed. She did not, and the physician made the call himself.

10. On March 2, 2009, Ms. Hinten sent a physician an incomplete message about a patient's request to increase the dosage of the patient's medication. Ms. Hinten failed to include in the message the patient's current dosage.

11. On March 2, 2009, Ms. Hinten also sent an incomplete message to another physician, stating that a patient's guardian had phoned to ask whether a form had been sent out. But Ms. Hinten did not specify what form. The guardian had to be phoned back twice to see what form was needed.

12. Ms. Hinten's direct supervisor, Lucy Zablow, LPN, had an employee conference with her on March 2, 2009. The conference covered the above incidents, as well as issues Ms. Hinten had with charting vital signs at the time of a patient's visit, and correctly putting in orders for labs. The issues were summarized in a conference report. Ms. Hinten signed the report, acknowledging that she had been made aware of the issues and understood that her failure to improve her work performance as described in the report would result in further corrective action.

13. Ms. Hinten sometimes failed to check which physician a patient was seeing. In March 2009, she instructed clerical staff to set up an appointment for a patient with the wrong physician.

14. On March 4, 2009, Ms. Hinten sent a physician a message stating a patient had called to ask for test results. She provided no other information, for example, what test, whether the results were ready, or what the results were.

15. On March 19, 2009, Ms. Hinten took a message from a patient who wanted test results. She took another call from the patient on March 23, 2009; the patient had not received an answer yet. Ms. Hinten's March 19 and March 23 messages did not specify what test results the patient was calling about, and the request was sent to the wrong physician.

16. Other times, Ms. Hinten forwarded phone messages from patients to physicians, indicating only that the patient had called and what the patient's phone number was.

17. Ms. Zablow had a second employee conference with Ms. Hinten on March 26, 2009, concerning the March 19 and 23 phone messages, and other incomplete messages Ms. Hinten sent to physicians. Ms. Hinten was instructed to send detailed messages to the physicians with as much detail as possible about why a patient was calling. Ms. Hinten signed

the conference report, stating that she had been made aware of the issues and understood her failure to improve her work performance as described in the conference report would result in further corrective action.

18. Ms. Zablow had a third employee conference with Ms. Hinten on April 17, 2009, regarding incomplete messages that Ms. Hinten sent to physicians, and messages she sent to the wrong physicians. Ms. Hinten wrote on the conference report, "I am working on improving on these & I will work harder & be more aware even when we are busy."²

19. On August 27, 2009, Ms. Hinten sent Dr. Johnson an incomplete message: "Dr. Kazmi took care of this patient with you being PCP. Patient was seen last in May[.] Please check patient[']s notes."³

20. On that same date, Dr. Johnson asked Ms. Hinten to follow up with a patient about a prescription refill. She did not, so the patient went to the clinic to get the prescription refilled.

21. Another physician had similar experiences with Ms. Hinten's failure to follow up on prescription refills for patients. That physician talked to Ms. Hinten and her supervisor about such issues at least monthly.

22. Ms. Zablow had a fourth employee conference with Ms. Hinten on September 18, 2009. Ms. Hinten was suspended effective September 22, 2009 for continued issues related to overall job performance, specifically, sending incomplete messages to physicians and sending messages to the wrong physicians.

23. Ms. Hinten failed to improve after the suspension.

24. The University Hospital fired her on November 10, 2010.

² Exhibit A, page marked 1-8.

³ Exhibit A, pages marked 2-4, 2-25.

25. The issues that led to Ms. Hinten’s firing also led to the complaint filed with the Board of Nursing.

Conclusions of Law

We have jurisdiction. §§ 335.066 and 621.045, RSMo.⁴

The Board bears the burden of proving that a basis exists to discipline Ms. Hinten’s license, which it must do by a preponderance of the evidence. *State Bd. of Nursing v. Berry*, 32 S.W.3d 638, 642 (Mo. App. W.D. 2000). A preponderance of the evidence is evidence showing, as a whole, that “the fact to be proved [is] more probable than not.” *Id.* This Commission judges witness credibility and may believe all, part or none of a witness’ testimony. *Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo. App. W.D. 1992).

As discussed above, the Board’s complaint establishes notice of the bases for discipline. The Board alleges here that cause exists under § 335.066.2(5), for incompetency and misconduct, and § 335.066.2(12), for violation of professional trust or confidence:

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096; [and]

⁴ References to “RSMo” are to the Revised Statutes of Missouri (2012 Supp.), unless otherwise noted.

(12) Violation of any professional trust or confidence[.]

We address the bases in turn.

A. Section 335.066.2(5)—Incompetency and Misconduct

Cause exists to discipline Ms. Hinten’s license for incompetency, but not for misconduct.

1. Incompetency

Incompetency is a general lack of professional ability, or a lack of disposition to use an otherwise sufficient professional ability. *Albanna v. State Bd. of Regis. for Healing Arts*, 293 S.W.3d 423, 435 (Mo. banc 2009). Incompetency is not necessarily established by a negligent act, or even a series of negligent acts, but by demonstration that the professional is unable or unwilling to function properly. *Id.* at 436 (citing *Tendai v. State Bd. of Regis. for Healing Arts*, 161 S.W.3d 358, 369 (Mo. banc 2005)).

LPNs promote health, and care for persons who are “ill, injured, or experiencing alterations in normal health processes[.]” using “substantial specialized skill, judgment, and knowledge.” § 335.016(14), RSMo. They provide such nursing care under the direction of physicians or other persons licensed to prescribe medications and treatments, or registered professional nurses. *Id.*

In the medical specialty clinic where Ms. Hinten worked, LPNs were the liaisons between physicians and patients. For a period of almost two years, Ms. Hinten repeatedly failed to completely and accurately record information relating to patient care; to promptly and appropriately follow up on messages, orders, and instructions relating to patient care; and to effectively communicate with physicians about patients. Her failure to perform her duties also delayed patient care.

Ms. Hinten's performance led to her being counseled by her supervisor four separate times and suspended once. At the conclusion of each counseling session, she acknowledged that she had been made aware of the issues, and at the conclusion of one of them stated in writing that she would work to improve her performance. That the hospital repeatedly counseled her and gave her opportunities to improve for two years shows that the hospital anticipated she could improve her performance, and supports the conclusion that she in fact had sufficient professional ability. That she did not improve, though, shows she lacked the disposition to use her otherwise sufficient professional ability.

Ms. Hinten argues that confusion relating to which physician a patient was seeing, and incomplete phone messages, was attributable to the patients themselves. Ms. Hinten and her supervisor, Ms. Zablow, both testified at the hearing that patients might not know exactly who—between the intern, resident, fellow, and attending physician on a care team—was in charge of their care, and so could be confused.⁵ Ms. Hinten also testified that at times patients did not want to talk to anyone except the attending physician who had cared for them for years, and would not tell a nurse what they wanted, so she simply could not send a complete message to the physician.⁶

Her argument is not persuasive. Ms. Hinten admitted that patient charts were available to her.⁷ It was her responsibility to research the patients' issues before sending messages to the physicians, and the charts provided a means to do so. There is also a difference between making

⁵ Tr. 37-39, 97-99.

⁶ Tr. 97-99.

⁷ Tr. 110 (“[I]f the patient doesn’t give you that information, I mean yes, you can look in the chart, but . . . there is information that will not be in a chart on a new patient.”) The only limitation Ms. Hinten identified in regard to using a patient’s chart to look up information was in the case of a new patient, whose chart might not have sufficient information in it yet. But Ms. Hinten does not argue that chart limitations in relation to new patients stymied her efforts to look up needed patient information.

a mistake in picking which physician, out of a team of physicians caring for a patient, should be sent the patient’s phone message—and sending the message to a physician who is a stranger to the patient, as the evidence here tends to show happened. The latter simply demonstrates unwillingness to function properly.

The Board has demonstrated, by a preponderance of the evidence, that cause exists to discipline Ms. Hinten under § 335.066.2(5) for incompetency.

2. Misconduct

In the context of professional licenses and discipline, Missouri courts define “misconduct” as “the willful doing of an act with a wrongful intention.” *See Duncan v. Mo. Bd. for Architects, Professional Engineers and Land Surveyors*, 744 S.W.2d 524, 541 (Mo. App. E.D. 1988).

Although the Board demonstrated Ms. Hinten’s unwillingness to function properly, it did not demonstrate by a preponderance of the evidence that she committed the charged conduct willfully and with wrongful intention. Therefore, we find no cause for discipline under § 335.066.2(12) based on misconduct.

B. § 335.066.2(12)—Professional Trust or Confidence

Cause exists to discipline Ms. Hinten’s license for violations of professional trust or confidence.

1. Definition of Professional Trust or Confidence

The phrase “professional trust or confidence” is not defined in Chapter 335. Nor has the phrase been defined in case law (which we will discuss below). Absent a statutory definition, the plain meaning of words used in a statute, as found in the dictionary, is typically relied on. *E&B Granite, Inc. v. Director of Revenue*, 331 S.W.3d 314, 318 (Mo. banc 2011). The dictionary

definition of “professional” is

of, relating to, or characteristic of a profession or calling...[;]... engaged in one of the learned professions or in an occupation requiring a high level of training and proficiency...[; and]...characterized or conforming to the technical or ethical standards of a profession or an occupation....

WEBSTER’S THIRD NEW INT’L DICTIONARY UNABRIDGED 1811 (1986). “Trust” is

assured reliance on some person or thing [;] a confident dependence on the character, ability, strength, or truth of someone or something...[.]

Id. at 2456. “Confidence” is a synonym for “trust.” *Id.* at 475 and 2456. Trust “implies an assured attitude toward another which may rest on blended evidence of experience and more subjective grounds such as knowledge, affection, admiration, respect, or reverence[.]” *Id.* at 2456. Confidence “may indicate a feeling of sureness about another that is based on experience and evidence without strong effect of the subjective[.]” *Id.*

This Commission has in numerous prior decisions defined the phrase “professional trust or confidence” as the reliance on the special knowledge and skills that professional licensure evidences, basing that definition on *Trieseler v. Helmbacher*, 168 S.W.2d 1030, 1036 (Mo. 1943) (Div. I).⁸ *Trieseler* was a suit for accounting and did not involve the phrase “professional trust or confidence,” let alone a definition of it. Rather, *Trieseler* involved the claim of the administrator of the deceased’s estate that a fiduciary relation existed between the deceased and the defendants, based on theories of constructive trust and conspiracy to defraud the deceased of his money. *Id.* at 1031, 1036. The court occasionally referred in the opinion to a “*confidential or fiduciary relation*,” *id.* at 1036 (emphasis added), but its focus was on the existence of a fiduciary

⁸ *E.g. Watson v. Bd. of Nursing*, no. 08-1132 BN (Mo. Admin. Hearing Comm., April 1, 2009); *State Bd. of Nursing v. Olf*, no. 03-1961 BN (Mo. Admin. Hearing Comm., April 6, 2004); *State Bd. of Nursing v. Naghavi*, no. 01-0717 BN (Mo. Admin. Hearing Comm., March 7, 2002).

relation, not on the definition or violation of a “professional trust or confidence” in the sense that the phrase is used in license discipline.

But in some of the same decisions in which we have cited *Trieseler*, we have also cited *Cooper v. Mo. Bd. of Pharmacy*, 774 S.W.2d 501, 504 (Mo. App. E.D. 1989)—which is a professional license discipline case—for the proposition that professional trust may exist not only between the professional and his or her clients, but also between the professional and his or her employer and colleagues.⁹ In *Cooper*, the Court of Appeals, Eastern District, affirmed our decision, holding in part that a Medicaid provider who submitted fraudulent Medicaid claims, and sold mislabeled, misbranded, and adulterated drugs, violated professional trust or confidence. *Id.* The Court did not define the phrase.

We did address the meaning of the phrase in *Cooper*. There we concluded that professional trust or confidence is “engendered by a party’s reliance on the special knowledge and skills evidenced by professional licensure.” *State Bd. of Pharmacy v. Cooper*, no. PH-86-2258 at p.7 (Mo. Admin. Hearing Comm. Jan. 13, 1988) (citing *State Bd. of Nursing v. Bryant*, case no. BN-83-2930 (Mo. Admin. Hearing Comm. June 25, 1984).

As noted, *Cooper* cited *Bryant*. In *Bryant*, apparently one of the earliest Commission decisions dealing with professional trust or confidence, we explained:

A professional trust or confidence is engendered by a party’s reliance on special knowledge and skill evidenced by professional licensure. It must be concluded therefore that without some sort of relationship between a licensee, in this case a nurse, and a party who relies on her special nursing skills, there can be no violation of a professional trust or confidence. See 70 C.J.S. *Physicians and Surgeons* (1951).

Id. at 10-11 (underlining in original).

⁹ See *Watson*, no. 08-1132 BN, and *Olf*, no. 03-1961 BN.

We were unable to locate a copy of the 1951 Corpus Juris Secundum cited in *Bryant*. But 70 C.J.S. *Physicians and Surgeons* § 76 (2005), apparently describes the physician-patient relationship in a way similar to the provision of the 1951 C.J.S. cited in *Cooper*:

The relationship is predicated on the proposition that the physician has special knowledge and skill in diagnosing and treating diseases and injuries and that the patient has obtained the services of the physician because of this.

In view of the foregoing, we will use our longstanding definition of professional trust or confidence as reliance on the special knowledge and skills evidenced by professional licensure. *Trieseler* provides no such authority. But the plain meaning of the words is consistent with that definition. Moreover, the Eastern District suggested in *Cooper*, if implicitly, that it agreed with that definition when it affirmed the underlying decision of the Commission which did set it out. We further note that the modern C.J.S. description of the physician-patient relationship is consistent with that definition.

2. Whether a Violation Occurred

The definition of the phrase resolved, the remaining issue is whether the Board established a violation here.

We note that the Board put on no expert testimony, the necessity of which may be an open question at present. In *Luscombe v. Mo. State Bd. of Nursing*, 2013 WL 68899 (Mo. App. W.D. Jan. 8, 2013), a nursing discipline case, the Court of Appeals, Western District, addressed circumstances in which expert testimony is required. The Court held that one such circumstance is proof of gross negligence. *Id.* at *12. The Court also held, *sua sponte*, that under the facts and circumstances therein, the Board's allegation of violation of professional trust also required it. *Id.* The Court did not hold that such proof was *always* necessary. But because the Board's allegation of violation of professional trust was a "recast" of its allegation of gross negligence,

the Court concluded violation of professional trust had to be established by expert testimony, too.
Id.

We note that the mandate in *Luscombe* has not been handed down yet; the case has been transferred to the Supreme Court. *See Luscombe v. State Bd. of Nursing*, case no. SC93230.

Even if we were to apply *Luscombe*, notwithstanding its lack of finality, we do not conclude that expert testimony was necessary under the circumstances of this case. First, there is no claim of gross negligence here, so a claim and evidence of such violation cannot be conflated with a claim and evidence of violation of professional trust or confidence, as occurred in *Luscombe*.

Further, the facts and circumstances are relatively straightforward here. In the medical specialty clinic where Ms. Hinten worked, LPNs were the liaisons between physicians and patients. For a period of almost two years, Ms. Hinten repeatedly failed to completely and accurately record information relating to patient care; to promptly and appropriately follow up on messages, orders, and instructions relating to patient care; and to effectively communicate with physicians about patients. Her failure to perform her nursing duties created more work for her coworkers and delayed patient care.

Proper documentation, follow up, and communication are critical for patient care. Patients and other health care providers have a right to expect and rely on an LPN to appropriately perform such duties. They are also entitled to rely on an LPN not to delay patient care. Accordingly, we find by a preponderance of the evidence that Ms. Hinten violated professional trust or confidence.

Cause for discipline exists under § 335.066.2(12).

Summary

Cause for discipline of Ms. Hinten's license exists under § 335.066.2(5) for incompetency, and under § 335.066.2(12) for violation of professional trust or confidence. But cause does not exist under § 335.066.2(5) for misconduct.

SO ORDERED on August 22, 2013.

\s\ Alana M. Barragán-Scott
ALANA M. BARRAGÁN-SCOTT
Commissioner