ARIZONA STATE BOARD OF NURSING  
4747 North 7th Street Ste 200  
Phoenix AZ 85014-3655  
602-771-7800

IN THE MATTER OF REGISTERED NURSE LICENSE NO. RN137552  
ISSUED TO:  
AMANDA LUCIA TRUJILLO  
Respondent.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER NO. 13A-1311014-NUR

A hearing was held before Diane Mihalsky, Administrative Law Judge (“ALJ”), at 1400 West Washington Suite 101, Phoenix Arizona, on January 15, 2014 at 8:00 a.m. and February 3, 2014 at 10:00 a.m. Carrie H. Smith, Esq., Assistant Attorney General, appeared on behalf of the State. Amanda Lucia Trujillo appeared in person on her own behalf.

On March 7, 2014, the ALJ issued Findings of Fact, Conclusions of Law and Recommendations. On March 28, 2014, the Arizona State Board of Nursing met to consider the ALJ’s recommendations. Based upon the ALJ’s recommendations and the administrative record in this matter, the Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

BACKGROUND AND PROCEDURE

1. The Arizona State Board of Nursing (“the Board”) has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S.§§ 32-1606, 1663, and 1664. The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 through 1667.

2. The Board issued Registered Nurse License No. RN137552 to Amanda Lucia Trujillo (“Respondent”).
3. On or about April 26, 2011, the Board received a complaint from a hospital in Arizona ("the Hospital") alleging that Respondent practiced beyond the scope of her license in April 2011, by writing an order without the permission of the patient’s physician. Based on this information, the Board opened an investigation.

4. After the Board issued a notice of charges, Respondent obtained the representation of counsel. On or about December 17, 2012, the Board and Respondent entered into a Consent Agreement in which Respondent admitted that the conduct and circumstances described in the Findings of Fact constituted sufficient cause pursuant to A.R.S. § 32-1664(N) to revoke, suspend, or take other disciplinary action against her license, that she agreed to the issuance of an order of probation, and that she waived all rights to a hearing, rehearing, appeal, or judicial review relating to the Hospital’s complaint.¹

5. In the Consent Agreement, Respondent admitted that the following events occurred during her employment by the Hospital:

11. Hospital], Respondent provided more than 100 pages of liver transplant education to [a patient], who had end stage liver disease, but who had not been evaluated for liver transplant surgery, was not on the liver transplant waiting list, was not scheduled for liver transplant surgery, was not scheduled for a liver transplant evaluation the following day, and was not scheduled for any other “major invasive surgery”. . . . [The patient’s] medical record indicated: “We will bridge [the patient] through to see a hepatologist to see if patient would qualify for a liver transplant, which seems to be a viable option at this time. Short of that, [the patient] may become hospice.” Respondent states that when she assessed [the patient], she determined that [the patient] lacked knowledge about her disease, her medications, home care, and liver transplant. Respondent states that although the medical records document that [the patient] was not scheduled for a liver transplant evaluation at [the Hospital], Respondent recalls receiving [a] report from the previous nurse that [the patient] was scheduled for a liver transplant

¹ The Board’s Exhibit 1, Consent Agreement at 5.
the next day.

12. [In April] 2011, while working as a RN at [the Hospital], the Respondent entered an order for a social services case management consult to evaluate “patient for home hospice or inpatient hospice per patient request” under a physician’s name when she had not obtained a verbal or written order from the physician for the consult.

15. Respondent has violated [the patient’s] confidentiality and privacy in written correspondence, on social media, and in interviews about [the patient] including [the patient’s] dates of hospitalization, place of hospitalization, purported diagnosis, purported knowledge deficits, purported nursing care, and purported treatment decisions. Respondent denies breaching [the patient’s] confidentiality and privacy, but agrees that she will not disclose confidential patient information learned in the course of treatment in the future to anyone other than members of the health care team for health care purposes. 

6. In the Consent Agreement, Respondent also admitted the charged violations of former A.R.S. § 32-1601(18)(d) and (j) (effective September 30, 2009), including the following specific sections of A.A.C. R4-19-403 (effective January 31, 2009) that further define unprofessional conduct for a registered nurse:

   1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;

   3. Failing to maintain professional boundaries or engaging in a dual relationship with a patient, resident, or any family member of a patient or resident;

   12. Assuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse . . . .

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2 Id. at 3-4.
3 Former A.R.S. § 32-1601(18) defined “unprofessional conduct” to include the following:
   (d) Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.
   . . . .
   (j) Violating this chapter or a rule that is adopted by the board pursuant to this chapter.
4 See the Board’s Exhibit 1, Consent Agreement at 4-5.
7. In the Consent Agreement, Respondent agreed that her license would be placed on probation for a term of twelve months. Respondent agreed that the terms of her probation would include the following:

2. Psychotherapy

Within thirty days of the effective date of this Order, Respondent shall submit to the Board for approval the name of a behavioral health professional with expertise in treating persons with medical and psychiatric concerns to conduct psychotherapy sessions twice a month for a minimum of six months. Within seven days of receipt of approval from the Board, Respondent shall make an appointment to begin participation in psychotherapy. Respondent shall execute the appropriate release of information form(s) to allow the treating professional(s) to communicate information to the Board or its designee, and Respondent shall immediately provide a copy of the entire Consent Agreement to all treating professional(s). . . . Respondent shall continue undergoing treatment until the treating professional(s) notify the Board, in writing on letterhead, that treatment is no longer needed. . . .

3. Ethics Counseling

Within thirty days from the effective date of this Order, Respondent shall make an appointment to begin professional ethics counseling with a Board approved Fellow from the Lincoln Center for Applied Ethics. Respondent shall execute the appropriate release of information form(s) to allow the ethics counselor to communicate information to the Board or its designee . . . . Prior to the beginning of counseling, Respondent shall furnish a copy of this Consent Agreement and Order to include Findings of Fact and Conclusions of Law to the counselor. Respondent shall cause the counselor to notify the Board in writing within fifteen days of entry into the counseling, and to verify in that same letter receipt of the Consent Agreement and Order to include Findings of Fact and Conclusions of Law.

Respondent shall undergo and continue ethics counseling at a minimum of twice per month for three months (six sessions) or until the counselor determines and
reports to the Board in writing and on letterhead, that
treatment is no longer considered necessary or the
counseling has been successfully completed by the
Respondent. During the duration of the course of
counseling Respondent shall have the ethics counselor
provide written reports to the Board every month. The
Board reserves the right to amend this Order based on the
recommendations of the ethics counselor.\(^5\)

8. At the Board’s regularly scheduled meeting in November 2013, it considered
Respondent’s failure comply with the Consent Agreement by failing to provide the name of a
psychotherapist for the Board’s approval, by failing to begin psychotherapy, by failing to undertake
ethics counseling with a Fellow from the Lincoln Center for Applied Ethics, and by continuing to post
information about the patient at the Hospital on her Facebook page and blog, NURSEINTERUPTED
[sic].

9. The Board voted to refer the matter to the Office of Administrative Hearings, an
independent agency, for an evidentiary hearing on Respondent’s failure to comply with the Consent
Agreement.

10. On December 5, 2013, the Board issued a Complaint and Notice of Hearing, charging
Respondent with having committed unprofessional conduct as defined by A.R.S. § 32-1601(22)(d) and
(j) (effective August 2, 2012),\(^6\) specifically A.A.C. R4-19-403(9) (effective January 31, 2009),\(^7\) and
A.R.S. § 32-1601(22)(g) and (i) (effective August 2, 2012).\(^8\)

\(^5\) Id. at 8-9.
\(^6\) These statutory subsections are identical to A.R.S. § 32-1601(18)(d) and (j) (effective September 9, 2009).
\(^7\) A.A.C. R4-19-403(9) provides as follows:
For purposes of A.R.S. § 32-1601(22)(d), any conduct or practice that is or might be harmful or dangerous to the
health of a patient or the public includes one or more of the following:

\(\ldots\)
(9) Failing to take appropriate action to safeguard a patient’s welfare or follow policies and procedures of the
nurse’s employer designed to safeguard the patient . . . .

\(^8\) A.R.S. § 32-1601(22)(g) and (i) define “unprofessional conduct” as follows:
(g) Wilfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter.

\(\ldots\)
(i) Failing to comply with a stipulated agreement, consent agreement or
board order.
11. A hearing was held on January 15, 2014, and February 3, 2014. The Board presented the
testimony of Valerie Smith, RN, MSN, who is currently a consultant to the Board’s Executive Director,
and submitted four exhibits. Respondent testified on her own behalf and submitted ten exhibits.

HEARING EVIDENCE

12. Ms. Smith testified that she has extensive experience in what works and what does not
work in the context of disciplinary actions involving nurses. Ms. Smith testified that in the nursing
profession, it is important for nurses to be responsible and accountable for their practice and decisions
that impact their practice to ensure that they do no harm to their patients. One measure of accountability
is the nurse’s following through on agreements that she has made to resolve complaints.

13. Ms. Smith testified that Respondent was represented by counsel when she signed the
consent agreement. Ms. Smith testified that the Consent Agreement was significantly pared down from
the original notice of charges as a result to Respondent’s attorney’s advocacy on her behalf.

14. The terms of probation in the Consent Agreement were based on the psychological
evaluation of Respondent performed by Phillip D. Lett, Ph.D. on September 5, 2012. Dr. Lett’s report
noted that Respondent’s employment records suggested a pattern of performance concerns, which he
attributed to “either a lack of knowledge or understanding pertaining to patient privacy or an error in
judgment.”\footnote{The Board’s Exhibit 1, Dr. Lett’s Psychological Evaluation of Respondent at 12.}
Dr. Lett opined that Respondent had the ability to practice nursing safely if she undertook
psychotherapy and ethics counseling, which recommendations were later incorporated into the Consent
Agreement.

Respondent’s Failure to Undergo Psychotherapy and Ethics Counseling

15. Respondent testified that she and her daughter had been homeless and that she had no
income as a result of her inability to find a job in nursing, which she attributed to the Board’s
investigation and the Consent Agreement. Respondent testified that she could not afford to pay for psychotherapy.

16. Ms. Smith testified that the Board’s mission is to protect the public and patients. Ms. Smith testified that if the nurse is doing everything she can to comply with a consent agreement, it is not uncommon for the Board to allow the nurse additional time, for example, 30 to 90 days, to comply if patient safety and the public welfare are not affected. Ms. Smith testified that due to the holidays, on or about January 15, 2013, the Board agreed to a 30-day extension for Respondent to submit the name of a psychotherapist and to begin ethics counseling with a fellow from the Lincoln Center of Applied Ethics.

17. Ms. Smith testified that the Board has many psychotherapists on its approved list and that if a nurse wishes to be treated by a psychotherapist who is not on the Board’s approved list, she need only submit the name of the psychotherapist and that the Board would review the psychotherapist’s qualifications to ensure that he or she has the appropriate experience and qualifications to treat the nurse.

18. Ms. Smith testified that on February 17, 2013, Respondent notified Board staff that she had selected psychologist Mark Treegoob, Ph.D. and had scheduled her initial therapy session with Dr. Treegoob to begin the second week in March. Dr. Treegoob is on the Board’s approved list. However, the Board never received confirmation from Dr. Treegoob that Respondent had started psychotherapy or that Dr. Treegoob had received a copy of the Consent Agreement.

19. Ms. Smith testified that Respondent never indicated that she had undertaken psychotherapy with a Board-approved psychotherapist or submitted the name of a different psychotherapist for the Board’s approval.
20. Respondent indicated that she was receiving healthcare benefits provided by the Arizona Health Care Cost Containment System ("AHCCCS") and that through her AHCCCS benefits, she could obtain psychotherapy from a psychotherapist at Terros behavioral health services in Phoenix. At the January 15, 2014 hearing date, Respondent stated that she would submit the name of a psychotherapist at Terros for the Board’s approval. However, as of the February 3, 2014 hearing date, Respondent had not submitted the name of any psychotherapist for the Board’s approval and had not started psychotherapy.

21. Ms. Smith testified that the Lincoln Center for Applied Ethics offers a fellowship program through Arizona State University ("ASU") that includes some professionals in the ASU School of Nursing. Ms. Smith testified that the Lincoln Center recently started offering a new program free of charge.

22. On February 17, 2013, Respondent informed Board staff that she had contacted the Lincoln Center for Applied Ethics and had been informed that it was not prepared to accept students at that time, but anticipated that enrollment would begin in July 2013.

23. On or about June 24, 2013, the Board sent an email to all nurses who were required to take ethics courses that ASU was offering a free, four-day Board-approved course entitled, “Ethical Foundations and Decision Making for Nursing Practice” that might fulfill the requirements of their consent agreements. Respondent replied to the message, “If you offer other free ethics courses let me know.”

24. Ms. Smith testified that the goal of one-on-one counseling for an individual who has been in trouble for not taking responsibility for poor decisions in her nursing practice was that through such mentoring, the individual could obtain greater insight and accountability.

\[10\text{ The Board’s Exhibit 3 at 3.}\]
25. On or about October 3, 2013, the Board sent a letter to Respondent, informing her that she had not timely submitted evidence of her compliance with the requirements of the Consent Agreement that she obtain ethics counseling from a Board-approved fellow at the Lincoln Center for Applied Ethics and that she obtain psychotherapy from a Board-approved psychotherapist.

26. On October 13, 2013, Respondent sent an e-mail in response to the Board’s October 3, 2013 letter that stated that she was working at a minimum wage job at a gas station for 32 hours a week because although she continued to apply for nursing jobs, “unfortunately once they read what the board has to say about me I usually get raked up and down at every interview and rejected.” As a result, Respondent stated that she could not afford to pay a psychotherapist or take time off work to undertake ethics counseling.

27. On or about November 21, 2013, Respondent’s former attorney sent a facsimile to Ms. Smith about a course in Bioethics offered by Dr. Aimée Koeplin. Ms. Smith testified that she was able to determine that Dr. Koeplin was employed by a California university, though she did not know which one, and that Dr. Koeplin was Respondent’s friend on Facebook. Ms. Smith testified that the Board requires counselors and therapists who provide treatment pursuant to a consent agreement to be independent and to have no prior relationship with the nurse.

28. Ms. Smith stated that although Respondent could submit the name of a psychotherapist for the Board’s approval, because the Consent Agreement specified that she undertake ethics counseling from a fellow at the Lincoln Center for Applied Ethics, staff could not modify the terms of the Consent Agreement. Therefore, ethics counseling from a different provider would not fulfill the requirements of the Consent Agreement. Ms. Smith testified that although she updated her Monitoring Non-Compliance Investigative Report (“Investigative Report”) to include Respondent’s prior attorney’s facsimile, the Board did not approve the substitution.

Respondent’s Postings on her Blog, NURSEINTERUPTED

29. On November 14, 2013, Ms. Smith interviewed Respondent in the presence of her former attorney to discuss her failure to comply with the Consent Agreement. Respondent stated that she could not afford to pay a psychotherapist to undertake psychotherapy or to take time off from her job at Circle K to undertake ethics counseling with a fellow at the Lincoln Center for Applied Ethics. According to Ms. Smith’s Investigative Report, before the interview, Respondent posted the comment, “I’d rather be getting a pelvic exam ----- feeling special at the Board of Nursing.”

30. At the November 14, 2013 interview, Ms. Smith informed Complainant that the Board had become aware of a posting made by her on her Facebook page that appeared to threaten Nikki Austin, a member of the Board’s staff. Ms. Smith’s Investigative Report summarized the remainder of the interview as follows:

   I showed Respondent a copy of the posting “Share this if you know someone who deserves a smack in the face with a shovel!!!! . . . Nikki Austin at the state board of nursing.” Respondent stated that she has a first amendment right and denied that [her posting about Ms. Austin] is a form of harassment or bullying. I shared with Respondent that I had reviewed other postings on her Facebook and although she verbally states she has not entered psychotherapy or ethics counseling due to financial and health related constraints, her postings appear to indicate that she believes she has not engaged in wrongdoing and lacks insight and accountability for her actions and decisions that led to the complaint being filed and her subsequent licensure probation. Respondent stated that it is her perception of reality and she has a right to share that with others. She further stated that the Board does not seem to notice or care that she began a national organization with 13 chapters focused on advocacy and peer support for nurses; that she began a local weekly peer support group for nurses; her Blogs are being used by nursing schools across the country to teach students; and, she is writing a nursing textbook that will be used in nursing curriculums across the country. . . .

12 The Board’s Exhibit 1 at 5.
13 The Board’s Exhibit 1, Monitoring Non-Compliance Investigative Report, at 6-7.
31. After Ms. Smith’s interview, on November 14, 2013, Respondent posted comments on her blog, NURSEINTERUPTED, about her care of the patient at the Hospital, beginning with “I have said this before and I will say it again until the day I die and I will not waver [sic] from it: I did not do anything wrong with that patient . . . .” Respondent then proceeded to identify the name of the facility, the exact date and time of her assessment of the patient, the patient’s diagnosis, and the care that she rendered to the patient.

32. Respondent testified consistently with her remarks to Ms. Smith in the November 14, 2013 interview. Respondent testified that she signed the Consent Agreement because she could not afford to pay her attorney to defend the Board’s complaint at a hearing.

33. Respondent testified that she researched and was very careful not to violate the federal Health Insurance Portability and Accountability Act (“HIPAA”) in her postings on Facebook and her blog about her care of the patient at the Hospital in April 2011. Respondent testified that she conscientiously took care not to use patient identifiers. Respondent testified at length about her responsibility to advocate for patients and for other nurses and the injustices in losing her job at the Hospital and being forced to defend against the Board’s complaint about the care that she rendered to the patient and her postings on social media:

Earlier I talked about what happens when law and ethics overlap, which commonly occurs in the current health care environment. And this occurs because of several misunderstandings between the priorities that a nurse has, that a hospital has, that a regulatory agency has.

And in my ethical beliefs as a nurse, at least what I have applied to my nursing practice, is directly derived from philosopher Immanuel Kant, which is to treat people as a means to an end in themselves, meaning my sole priority is that of keeping my oath to serving and protecting the public, meaning my first priority is to them.

14 The Board’s Exhibit 2 at 3.
When I went forward with what happened to me and my patient, it was after a lot of ethical thought process occurred, and also because it was my ethical obligation to protect the greater public from practices that were unsafe to people at large in a particular facility. This does fall within my duties as a registered nurse, and that is definitely highlighted in the nurse’s code of ethics as well as in our oath.

One of the things I believe in strongly when I work with patients is to promote the best interests of the patient and what the patient wants to do. And in this particular instance, the patient was not allowed to achieve the outcome that they had wanted, nor was I allowed to perform my function as a nurse to the best of my education and preparation and licensure.

In provision 6 of the code of ethics, it says that selfdetermination is paramount, and that the nurse's primary commitment is to the patient, whether individual, family group, or community, and the right to know, and that includes not just one patient but the community at large.

And when something threatens one patient, it threatens a community of people. And in this instance, a patient's rights were violated. The patient's right to determine their course of treatment.

...Because I went up the chain of command to all of my superiors and asked for assistance and asked for their intervention, and nobody came forward or was willing to listen or to help me, on professional obligation, I had to come forward to the media to report what happened to both me and my patient as a means of illuminating where patient errors occur and how they can be corrected for the future.

These are controversial subjects that are discussed every day, not just in social media, but on television, in newspapers, in health-care blogs, in health-care organizations, how to best promote the best interests of the patient and the patient's right of self-determination.

We cannot learn from mistakes that occur in the course of caregiving if what we do is shut down everything that happened and keep it from the public. When we do that, what we do is we put at risk a greater population of people who could be harmed by the same practices.
Social media is a means of communicating, at least in this day and age and within this health-care system. It is a means of communicating with one's colleagues, with other health-care providers, other health-care disciplines, healthcare consumers themselves. And in so doing, these various people come together and discuss ways to keep patient care errors from happening again.

Social media has accomplished that. I have interacted with several people within the nursing community, several nursing organizations. I have interacted with patients, patient advocacy groups. I have been involved in troubleshooting and developing new policies and new regulations within different patient care advocacy organizations that would help promote the greater good of the greatest amount of people, and that is what I seek to do when I take care of patients.

I don't seek to just focus on one. I always seek to focus on doing what is right for the greatest amount of people. And in this case, if I hadn't come forward, and if I hadn't have continued to speak out about what happened to me and my patient via social media, via television interviews, radio interviews, then this problem is going to continue to happen, because nobody listened within the organizational level, from the immediate nurse manager to the CNL to the medical director of the hospital, right up to the CEO of the health-care system.

Nobody listened when I brought forth patient safety concerns and possible conflict of interests pertaining to surgery when the patient wanted something else. So for this reason, I came forward, and I started discussing my case on the blog for other nurses and other organizations to learn from so that this type of mistake would not occur to another nurse or to another patient. . . .

34. After the November 14, 2013 interview, Respondent posted on her NURSEINTERUPTED blog that she had “been desperately trying to figure out some way to make the week feel longer, so that I could put off this latest little field trip to the principal’s office at the Arizona Board of Nursing” and recounted the details of Ms. Smith’s interview.16

16 Reporter’s Transcript January 15, 2014, at 171, l. 20 to 175, l. 20.
On December 7, 2013, Respondent posted the following statements on her NURSEINTERUPTED blog concerning the Board’s complaint against her:

Merry Christmas and good tidings to Amanda Trujillo from the Arizona Board of Nursing. In this latest installment of nursing’s reality TV and social media saga I get a packet (right before Christmas of course) informing me I will be privy to a hearing before an administrative judge on January 15, 2014 where he will decide whether my nursing license is to be suspended or stripped. On the agenda: My failure to protect the interests and well-being of patients, my conduct unbecoming of a professional nurse, and the ongoing favorite—their concern that I am a danger to the public at large. In addition to this the fact I haven’t been able to complete the ethics counseling or the psychiatric care that even the staff at this latest facility have deemed to be completely unnecessary in their professional opinion. Yes, for the second time mental health professionals have found me to be normal after evaluating me. On this occasion the staff went further to say that they are stunned I am still up, walking, and breathing after almost three years of this ordeal and its sequela. Their quote was that I was “the most normal client they have seen in a very long time.” . . .

Respondent did not submit any mental health records and the record in this matter contains no psychological evaluations other than Dr. Lett’s evaluation, which, as noted above, recommended that Respondent undertake psychotherapy and ethics counseling. On December 7, 2013, Respondent also posted another lengthy narrative describing and defending her care of the patient at the Hospital in April 2011.

Ms. Smith testified that Arizona statutes protect the confidentiality of investigative reports and patient records. Ms. Smith testified that based on her education and experience, Respondent’s continued postings about her feelings that the Board’s attempt to enforce the Consent Agreement was unfair and unjustified indicated that Respondent did not take the Consent Agreement

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16 The Board’s Exhibit 2 at 1-2.
17 The Board’s Exhibit 2 at 6.
18 See the Board’s Exhibit 2 at 7-10.
seriously. Ms. Smith testified that Respondent’s continued posting of information defending her care of
the patient at the Hospital and her insistence that she had done nothing wrong either in her patient care
or the continued postings about the patient demonstrated a lack of insight and accountability.

37. Ms. Smith testified that A.A.C. R4-19-403(3) is broader than the patient privacy and
security requirements of HIPAA because the regulation prohibits nurses from publicizing any
information from which the patient could be identified without the patient’s express permission. Ms.
Smith testified that Respondent violated the Consent Agreement by continuing to post information
about the care that she rendered to the patient at the Hospital in April 2011.

National Council of State Boards of Nursing (“NCSBN”). Ms. Smith pointed out the following
information in the NCSBN’s White Paper:

Confidentiality and Privacy

To understand the limits of appropriate use of social media, it is important to have an understanding of confidentiality and privacy in the health care context. Confidentiality and privacy are related, but distinct concepts. Any patient information learned by the nurse during the course of treatment must be safeguarded by that nurse. Such information may only be disclosed to other members of the health care team for health care purposes. Confidential information should be shared only with the patient’s informed content, when legally required or where failure to disclose the information could result in significant harm. Beyond these very limited exceptions the nurse’s obligation to safeguard such confidential information is universal.

Privacy relates to the patient’s expectation and right to be treated with dignity and respect. Effective nurse patient relationships are built on trust. The patient needs to be confident that their most personal information and their basic dignity will be protected by the nurse. Patients will be hesitant to disclose personal information if they fear it will be disseminated beyond those who have a legitimate “need to know.” Any breach of this trust, even inadvertent, damages
the particular nurse-patient relationship and the general trustworthiness of the profession of nursing.

. . . .

**Common Myths and Misunderstandings of Social Media**

While instances of intentional or malicious misuse of social media have occurred, in most cases, the inappropriate disclosure or posting is unintentional. A number of factors may contribute to a nurse inadvertently violating patient privacy and confidentiality while using social media. These may include:

. . . .

- A mistaken belief that it is acceptable to discuss or refer to patients if they are not identified by name, but referred to by a nickname, room number, diagnosis or condition. This too is a breach of confidentiality and demonstrates disrespect for patient privacy.

. . . .

- The ease of posting and commonplace nature of sharing information via social media may appear to blur the line between one’s personal and professional lives. The quick, easy and efficient technology enabling use of social media reduces the amount of time it takes to post content and simultaneously, the time to consider whether the post is appropriate and the ramifications of inappropriate content.19

Ms. Smith testified that Respondent never claimed to have had the consent of the patient at the Hospital to share the details of the patient’s health care on Respondent’s blog. Ms. Smith pointed out that Respondent identified the patient’s health condition, the Hospital in which she received treatment, and the unit, in violation of Respondent’s ethical and legal duty to maintain the patient’s confidentiality.

39. Ms. Smith testified that if Respondent was concerned about mistreatment of the patient by the Hospital and the persons in her chain of command at the Hospital were not responsive to her complaints, she could have notified other organizations that oversee the Hospital or the health care professionals involved in the care of the patient, such as the Board, the Arizona Department of Health Services, the Arizona Medical Board, or the federal Centers for Medicare & Medicaid Services.

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19 Respondent’s Exhibit E at 1-3.
40. Complainant testified that she had attempted to file complaints at all of the organizations that Ms. Smith mentioned, but that after none of them took any action, she had no choice but to go to social media.

CONCLUSIONS OF LAW

1. This matter lies within the Board’s jurisdiction under A.R.S. § 32-1606(B)(10).

2. The Board bears the burden of proof to establish cause to penalize Respondent’s registered nurse’s license by a preponderance of the evidence. Respondent bears to burden to establish affirmative defenses by the same evidentiary standard.

3. “A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not.” A preponderance of the evidence is “evidence which is of greater weight or more convincing than evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not.”

4. The cases that Respondent submitted both involve common-law claims for defamation. These authorities do not limit the Board’s authority to discipline a licensee for failing to comply with a consent agreement and for posting information about a patient on social media that violates the patient’s rights to confidentiality and privacy under applicable state regulation.

5. The Board established that Respondent failed to undertake psychotherapy by a Board-approved psychotherapist or ethics counseling with a Board-approved fellow from the Lincoln Center for Applied Ethics, as required by the Consent Agreement. Because Complainant never submitted the name of a psychotherapist for the Board’s approval, even though she could use her AHCCCS benefits

20 See A.R.S. § 41-1092.07(G)(2); A.A.C. R2-19-119(A) and (B)(1); see also Vazanno v. Superior Court, 74 Ariz. 369, 372, 249 P.2d 837 (1952).
21 See A.A.C. R2-19-119(B)(2).
22 MORRIS K. UDALL, ARIZONA LAW OF EVIDENCE § 5 (1960).
to obtain free psychotherapy at Terros, and did not dispute that the required ethics counseling at the Lincoln Center for Applied Ethics was free, Complainant did not establish that she failed to undertake psychotherapy or ethics counseling due to her financial constraints.

6. The Board also established that Respondent continued to violate the rights to confidentiality and privacy of her former patient at the Hospital by continuing to disclose details about the patient’s treatment on her blog without the patient’s permission, in violation of the Consent Agreement and A.A.C. R4-19-403(9).

7. Therefore, the Board established that Respondent committed unprofessional conduct as defined by A.R.S. § 32-1601(22)(d) and (j), specifically A.A.C. R4-19-403(9), and A.R.S. § 32-1601(22)(g) and (i) by failing to undertake psychotherapy, by failing to undertake ethics counseling, and by failing to refrain from posting confidential and private information about her care of the patient at the Hospital in April 2011, on her blog.

8. Therefore, the Board established cause to revoke, suspend, or otherwise discipline Respondent’s license under A.R.S. §§ 32-1663(D) and 32-1664(N).

9. Respondent’s postings on her blog and testimony at the hearing demonstrate a continued lack of insight and failure to take responsibility for the unprofessional conduct that the Board established at hearing. Therefore, the Board established that Respondent cannot be regulated at this time.

ORDER

In view of the Findings of Fact and Conclusions of Law, the Board issues the following Order:

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25 This statute provides that if the Board determines a licensee has committed an act of unprofessional conduct, the Board may revoke or suspend the license, impose a civil penalty, censure the license, place the licensee on probation, or accept the voluntary surrender of the license.

26 This statute provides that if the Board finds that the licensee has committed an act of unprofessional conduct, the Board may revoke or suspend the license.
Pursuant to A.R.S. § 32-1664(N), the Board REVOLES registered nurse license number RN137552 issued to Amanda Lucia Trujillo.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Pursuant to A.R.S. § 41-1092.09, Respondent may file, in writing, a motion for rehearing or review within 30 days after service of this decision with the Arizona State Board of Nursing. The motion for rehearing or review shall be made to the attention of Trina Smith, Arizona State Board of Nursing, 4747 North 7th Street Ste 200, Phoenix AZ 85014-3655, and must set forth legally sufficient reasons for granting a rehearing. A.A.C. R4-19-608.

For answers to questions regarding a rehearing, contact Trina Smith at (602) 771-7844.

Pursuant to A.R.S. § 41-1092.09(B), if Respondent fails to file a motion for rehearing or review within 30 days after service of this decision, Respondent shall be prohibited from seeking judicial review of this decision.

This decision is effective upon expiration of the time for filing a request for rehearing or review, or upon denial of such request, whichever is later, as mandated in A.A.C. R4-19-609.

Respondent may apply for reinstatement of the said license pursuant to A.A.C. R4-19-404 after a period of five years. Respondent may apply for reinstatement of said certificate pursuant to A.A.C. R4-19-815 after a period of five years.

DATED this 28th day of March, 2014.

ARIZONA STATE BOARD OF NURSING

Joey Ridenour, R.N., M.N., F.A.A.N
Executive Director
COPIES mailed this 28th day of March, 2014, by Certified Mail No. 7011 3500 0001 5219 1039 and First Class Mail to:

Amanda Lucia Trujillo
7977 West Wacker Road #260
Peoria, AZ 85381

COPIES of the foregoing mailed this 28th day of March, 2014, to:

Case Management
Office of Administrative Hearings
1400 W Washington Ste 101
Phoenix AZ 85007

Carrie H. Smith, Esq.
Assistant Attorney General
1275 W Washington LES Section
Phoenix AZ 85007

By: Trina Smith