LEGAL ISSUES FOR NURSES

LEGAL ACCOUNTABILITY

1. A practitioner is accountable for her actions (and, in certain circumstances, omissions), when caring for a patient. She is accountable to her patient, her professional body,¹ her peers, her employer and society generally. This briefing is concerned with an understanding of legal accountability only.

2. There is no concept in English law of team negligence in the sense that each individual member of a health care team is required to observe the standards demanded of the unit as a whole.²

3. Once she assumes responsibility for the patient or undertakes to exercise her professional skills on the patient’s behalf, the practitioner owes the patient a legal duty of care. She holds herself out as possessing qualifications, skills and competence that can ordinarily be expected of members of her profession. When evaluating the standard of care to be expected of the practitioner the Courts look to the profession to identify what the standard of the ordinary competent practitioner should be.

4. The legal standard was set more than 40 years ago in an English High Court judgement in what became known as the Bolam case.³ The Scottish Courts in Hunter v Hanley had taken a comparable decision.⁴ It was held that a professional must show that she followed a course regarded as proper by a responsible body of [nursing] professionals. The House of Lords recently affirmed this test,⁵ although it is emphasized that it has to be a competent reasonable body of opinion. As one of the judges commented:

¹ Nursing and Midwifery Council Code of Professional Conduct 1st June 2002
² Wilsher v Essex Area Health Board [1986] 3 All ER 801
³ Bolam v Friern Hospital Management Committee [1957] 2 All ER 118
⁴ 1955 SLT 213
⁵ Bolitho v City & Hackney Health Authority [1988] AC 232
“The Court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis.”

Further, the judge on hearing expert testimony as to the appropriate standard of care must ascertain whether:

“...The experts have directed their minds to the question of comparative risks and benefits, and have reached a defensible conclusion on the matter.”

5. The critical question therefore is what is professionally approved practice? This gives rise to a number of secondary issues, such as inexperience, specialisation, keeping up-to-date, and innovative treatment which I will deal with briefly.

6. Inexperience is no defence to a claim of professional negligence. The standard of care required is that of the ordinary skilled practitioner exercising and professing to have that particular skill. That standard is to be determined in the context of the particular post the practitioner is in, or the task which she is performing, rather than according to her actual status or seniority. If one considers an analogous situation, that of a learner driver on the road, the reasoning behind this principle perhaps becomes clearer (i.e. for obvious reasons, the standard expected of a learner driver on the road is no different to that imposed on the ordinary competent qualified driver). For practitioners two things follow:

i) You do not delegate without adequate instructions and some assurance that the relevant person is able to do the work competently.

ii) You seek advice and assistance from those more experienced than you.

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6 Lord Browne-Wilkinson at page 242
7 Wilsher v Essex Area Health Authority [1986] 3 All ER 801
7. Obviously the practitioner must keep up to date in her field of practice, if she is going to act in accordance with the standards of a responsible body of relevant nursing opinion. However, the failure to read a particular article will not necessarily constitute a breach of the standard of care.9

8. The standard of the specialist practitioner is simply the standard of the ordinary competent specialist practitioner. However, there is authority for the view that the specialist should be judged by the standard of general expertise in the particular post which is occupied or the particular procedure which has been undertaken.10

9. A departure from normal treatment may not necessarily constitute professional negligence, provided that the practitioner can demonstrate that the deviation was one of which a person of ordinary skill would have undertaken when acting with ordinary care.11

10. As regards practitioners of complementary or alternative therapies, the High Court has held:12

- In adjudicating on the standard of care given by an alternative medical practitioner, it will often be necessary to have regard to the fact that the practitioner is practising his art alongside orthodox medicine, so judging him by the standard of the ‘ordinary alternative practitioner’ may not be enough (e.g. the prevailing standards among alternative practitioners may be deficient if they fail to have regard to risks which should have been taken into account).
- Where the practitioner prescribes a remedy he has a duty to ensure that the remedy is not actually or potentially harmful.

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8 for an interesting article on the extended roles of nurses see Dowling and others, Nurses taking on junior’s doctors’ work: a confusion of accountability, BMJ, Volume 312, 1996, 1211-1214
9 Crawford v Board of Governors for Charing Cross Hospital, the Times, 8th December 1953; Roe v Ministry of Health [1954] 2 All ER 131; Gascoine v Ian Sheridan & Co. and Latham [1994] 5 Med LR 47
10 Ashcroft v Mersey Regional Health Authority [1985] 2 All ER 96
- He must take steps to satisfy himself that there has not been any report in medical journals of adverse reactions to the remedy, and this may require him to subscribe to an ‘association’ which arranges searches of the relevant literature. The alternative practitioner must then have an awareness of orthodox medicine in some respects.

11. The legal standard in clinical negligence has been subject to considerable academic criticism over the years, as representing an inappropriate degree of deference (or transfer of power) to the health professionals (sometimes described as confusion of what is done, with what ought to be done\textsuperscript{13}). The courts must, so it is argued, exercise a sufficient degree of independence in shaping standards of care in health.

12. The Lord Chief Justice, Lord Woolf, has expressed the view\textsuperscript{14} that:

“\textit{\textasciitilde\textasciitilde until recently the Courts treated the medical profession with excessive deference, but recently the position has changed \textasciitilde\textasciitilde the over deferential approach is captured by the phrase: “doctor knows best”. The contemporary approach is a more critical approach \textasciitilde\textasciitilde It could be said that doctor knows best if he acts reasonably and logically and gets his facts right”}.

13. It is inevitable that the judges will be influenced by national and local clinical guidelines and protocols, the findings of the National Institute of Clinical Excellence, the Royal Medical Colleges’ Guidelines and so on. However, it is important to realise that failure to follow a protocol will not necessarily constitute negligence. The Bolam case remains the authority for the test in clinical negligence claims.

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\textsuperscript{12} Kauser Parveen Shakoor v Kang Situ, unreported, 5 May 2000 (Claim No. 98 S 259)
\textsuperscript{13} The criticisms are discussed, for example, in chapter 4 of Michael Davies (1998) \textit{Text Book on Medical Law}, Blackstone and Chapter 3 of John Healy (1999) \textit{Medical Negligence: Common Law Perspectives}, Sweet & Maxwell.
\textsuperscript{14} Times, 17 January 2002
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