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# ANGELS OF MERCY?

## THE LEGAL AND PROFESSIONAL IMPLICATIONS OF WITHDRAWAL OF LIFE SUSTAINING TREATMENT BY NURSES IN ENGLAND AND WALES

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# ANGELS OF MERCY?

## THE LEGAL AND PROFESSIONAL IMPLICATIONS OF WITHDRAWAL OF LIFE SUSTAINING TREATMENT BY NURSES IN ENGLAND AND WALES

In circumstances where life sustaining treatment appears merely to be drawing out the inevitable, English law<sup>1</sup> does not allow the life of a patient to be actively brought to an end. However, death by omission is allowable in these circumstances and it is usual practice for agreement to be sought between the healthcare team and a patient or their immediate family to withdraw aggressive life sustaining measures such as mechanical ventilation or vasoactive drugs<sup>2</sup>. It is highly unusual for withdrawal to take place without the agreement of all these parties, and it is often possible to time withdrawal so relatives and religious representatives can be near. In practice withdrawal is as simple as removing an endotracheal tube and turning off an infusion pump and this can be performed by any member of the healthcare team, be it a consultant, a junior doctor, or a nurse. The choice may be dictated by family wishes, the skill levels of staff or how busy the intensive care unit (ICU) is. The identity of this professional is not free of implications, yet where it is a nurse these implications have thus far not been explored. It is on the legal and professional implications of nurses undertaking the withdrawal of life sustaining treatment that this paper is focused. I shall hereafter refer to this act as *withdrawal of treatment* and, where it is undertaken by a nurse, *nurse actioned withdrawal of treatment*.

Due to the highly emotive nature of withdrawal of treatment there are multiple pitfalls that may make staff performing these duties vulnerable to complaints and perhaps legal action. Family members may not fully accept the inevitability of the death of a loved one and change their minds at key stages of the process. After withdrawal, the dying process may last for several days<sup>3</sup> during which patients may experience symptoms that distress witnessing family members, such as agonal

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<sup>1</sup> While Scottish and Northern Irish law is largely similar in this area, in preparing this paper I have not examined the possibility of separate approaches in other countries in the United Kingdom.

<sup>2</sup> Although there is arguably a positive component to such activities (i.e. D Price, 'Assisted Suicide and Refusing Medical Treatment: Linguistics, Morals and Legal Contortions' (1996) 4 *Med.L.Rev.* 3, 270-299), these are classed as omissions by the law. For a full discussion of the act / omission distinction see: G Williams, 'Acts and Omissions,' in *Intention and Causation in Medical Non-Killing* (2007), 55-88.

<sup>3</sup> M. Chiswick, 'Parents and end of life decisions in neonatal practice', (2001) *Archives of Disease in Childhood Fetal and Neonatal Edition* 85 F1-F3

breathing, a reflexive gasping. Further complaints may arise from members of the healthcare team who disagree with the clinical path taken.<sup>4</sup> Depending on the nature and forum of a complaint, nurses may find themselves defending their activities against civil action or criminal prosecution, and, because of differences in professional and legal standards, whatever the outcome of such an action, they would also face the scrutiny of the nursing regulator, the Nursing and Midwifery Council (NMC), as well as a local disciplinary tribunal.

While the Mental Capacity Act 2005 explicitly considers withdrawal of treatment in section 4 (5), this consideration is not comprehensive. It is within common law that we find doctors named as the professionals with a special dispensation to legally bring about death. In *Bland*<sup>5</sup> Lord Goff suggests:

*I also agree that the doctor's conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine because, although the interloper may perform exactly the same act as the doctor who discontinues life support, his doing so constitutes interference with the life-prolonging treatment then being administered by the doctor.*<sup>6</sup>

While doctors have several defences under common law to the charge of murder<sup>7</sup> and allegations of malpractice, this paper discusses the criminal, civil and professional defensibility of nurses undertaking this role. In the absence of a specific body of law related to nurse actioned withdrawal I shall discuss the probable legal and professional responses by considering parallel cases. Examining some of the circumstances in which doctors are allowed undertake activities that result in a death,<sup>8</sup> I argue that the unique dispensation by which doctors are legally permitted to perform these tasks rests largely on their identity as doctors rather than any distinctive feature of their activities themselves, which in the case of withdrawal have been classed as

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<sup>4</sup> I think particularly of the complaint brought against the paediatrician Leonard Arthur, and described at length in: MJ Gunn, JC Smith, 'Arthur's case and the right to life of a Down's syndrome child' *Crim.L.R.* (1985) 705-715.

<sup>5</sup> *Op. Cit.*, n. 5

<sup>6</sup> *Ibid.*, at 866.

<sup>7</sup> J Herring, 'Dying and Death,' in *Medical Law and Ethics* (2006) 405-491.

<sup>8</sup> I acknowledge this wording is controversial, but use it descriptively, in order to clearly contrast the legality of such activities when undertaken by doctors with the illegality of their being undertaken by others, as the status of nurses can begin to be clarified by their identity in this instance. I do not use it lightly or wish to imply the type of value judgement that conventional formulations such as 'withdrawal' have been constructed to avoid. Similar caveats apply to my discussion of termination of pregnancy.

manslaughter or assisted suicide in similar cases involving members of the public.<sup>9</sup> This uniqueness of doctors in the eyes of the law means that, while it is tempting to think of medical law for nurses as indistinct from that for doctors, in reality it follows the quite separate principles of vicarious liability. While these principles may nevertheless avoid classing nurses (and presumably others acting in a similar capacity) as Lord Goff's "interlopers",<sup>10</sup> it depends not, like medicine, on a judicial recognition of the difficult realities inherent in healthcare provision, but instead upon a judicial view that nurses are *instruments* of doctors with scant capacity for independent activity. While nurses may thus have practical exemption from the legal consequences of their actions so long as they were acting on the orders of a doctor, this judicial position puts them at odds with their professional responsibilities, which envisage nurses as independent professionals who are to be held liable for their own actions. This fracture between judicial and professional expectation creates the possibility of nurses being legally exonerated but professionally censured – a possibility made all the more immediate by the multiple, sometimes conflicting, layers of regulatory and managerial expectations of the scope of nursing practice which can produce strict judgements against individual practitioners. The privations of dismissal or deregistration are not slight, and a harmonisation of judicial and regulatory views is urgently needed to remove such jeopardy from nurses carrying out ethically and professionally legitimate duties.

## I. MEDICAL TERMINATION OF LIFE SUSTAINING TREATMENT

It is tempting to interpret medical law for nurses as indistinct from that which governs doctors; indeed some writers appear to do just that.<sup>11</sup> As the law permits doctors to undertake activities that result in a death in distinct situations, such a hypothesis would imagine similar legal protections belonged to nurses. Yet I suggest such a hypothesis is incorrect, as nurses are governed by quite distinct legal

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<sup>9</sup> Note however that identity as a doctor alone is not a defence in itself: *R. v Cox* [1992] (unreported) concerned a doctor who was convicted of attempted murder after hastening a patient's death, is a good example. In that case, features that would have allowed Dr Cox to use the doctrine of double effect as a defence were missing, resulting in his conviction— although he was treated leniently. Given the degree to which the facts of the case transgress the Director of Public Prosecution's 2010 guidance on prosecuting assisted suicide, it is likely his treatment would be less lenient today. (See Crown Prosecution Service 'DPP publishes assisted suicide policy' (2010) <[http://www.cps.gov.uk/news/press\\_releases/109\\_10/](http://www.cps.gov.uk/news/press_releases/109_10/)> accessed 5 September 2011).

<sup>10</sup> *Op. Cit.*, n. 5 at 866.

<sup>11</sup> N Fletcher and J Holt, 'Nursing the dying,' in *Ethics, Law and Nursing* (1995) 201-222.

mechanisms, and the nuance of these creates a quite different set of problems for the profession. Because of the potential for confusing the law for doctors with the law for nurses, it is necessary to start the discussion by clarifying the way the law protects doctors. Through this discussion I wish to underline a central issue: in these distinct situations where doctors undertake activities that result in a death, the law distinguishes doctors from other actors, a distinction Lord Goff employs in *Bland* with the terms ‘doctors’ and ‘interlopers’.<sup>12</sup> This distinction means that members of the public risk severe penalties for undertaking activities that, if performed by a doctor, would be viewed as appropriate medicine. As nurses are patently neither ordinary members of the public nor doctors, and are not clearly recognised in either the statutory or case law that concerns withdrawal of treatment, this raises the question of what legal mechanism, if any, exists to allow nurses to carry out acts that would risk such penalties.

One answer to this is that the mechanisms by which the law refrains from criminalising these activities are circumspect, and that judges try hard to mould the law so that properly conducted medicine is not criminalised.<sup>13</sup> Yet, although medical case law can be circumspect,<sup>14</sup> its rulings are dominated by the central position of doctors to them to such an extent that they cannot comfortably be said to include nurses, or other arguably legitimate persons, in their remit. Instead, I shall argue later, the only way we can infer permission for similar actions by nurses is to rely on a lack of judicial appreciation for nurses as separate and distinct actors, an attitude that creates tensions with nurses’ professional responsibilities under their code of practice.

### *Protecting medicine*

How does the law protect doctors? Although there are a number of examples it is only necessary to consider two particular instances: Termination of pregnancy, and withdrawal of life sustaining treatment in incompetent persons.<sup>15</sup> In each of these

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<sup>12</sup> *Op. cit.*, n. 5 at 866.

<sup>13</sup> T James, ‘The Appeal to Law to Provide Public Answers to Bioethical Questions: It All Depends What Sort of Answers You Want’ (2008) *Health Care Analysis* 16, 65-76.

<sup>14</sup> M Brazier and C Bridge, ‘Coercion or Caring: Analysing Adolescent Autonomy’ (1996) *Legal Studies* 16, 84-109.

<sup>15</sup> The law also allows three other circumstances where death ensues that shall not be examined here. These are withdrawal of treatment following the competent request of the patient as in *Ms. B v An NHS Hospital Trust* [2002] EWHC 429, (Fam); unintended killing as a by-product of the administration of painkillers (the doctrine of double effect) and, in *Re: A (Children) (Conjoined Twins: Medical Treatment)* (No.1)[2001] Fam. 147, the killing of one conjoined twin to save the life of another. Discussion of these is unnecessary for my argument.

cases the law distinguishes medical acts from their criminal corollaries, even where the act is similar or the same. Because it is the most explicit, it is to the terms of the Abortion Act 1967 I will turn to first.

The Abortion Act offers a defence to medical practitioners who would otherwise fall foul of the Offences Against The Person Act 1861 or the Infant Life Preservation Act 1929. Although it is not important to detail its exact mechanisms here, it is worthy of some interest because the explicit statutory defence it provides is given only to *doctors*, despite the fact many others are involved in a termination of pregnancy. The nuances of this caveat were discussed at length in *RCN v DHSS*<sup>16</sup> and the conclusion of the court is that the Act envisaged a team effort – on what legal basis such a 'team effort' rested shall be returned to later. For now it is worth considering if such a notion suggests a conflation of the roles of a nurse and a doctor in medical law, or if instead nurses' roles are governed by some other principle, as my suggestion is that the law governing each role is distinct. As the practice of much hospital medicine is also a 'team effort' the implications of such a conclusion are far reaching.

Unlike termination of pregnancy, withdrawal of life sustaining treatment is not protected by statute.<sup>17</sup> Therefore, because of its circumstantial similarities, a defence against murder is needed to demonstrate that, although the death that takes place in withdrawal is foreseen, the doctor neither causes the death, nor intends that the death takes place,<sup>18</sup> the components of a successful murder conviction.<sup>19</sup> Even before the watershed of *Bland*<sup>20</sup>, where precedents were established governing withdrawal, academics had proposed the mechanisms by which withdrawal could legally take place<sup>21</sup>. The first element of murder, *causation*, could be evaded by classifying withdrawal of treatment as an omission rather than a positive act; in other words it is the underlying health condition that positively causes death. Yet classifying withdrawal as an omission carries with it a further potential liability. *Duty of Care*, which, under the ordinary principles of the law of negligence, conceivably imposes on doctors a compulsion to act positively to save life. While the existence of such a duty brings with it the risk of civil liability arising from withdrawal of treatment, it also has

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<sup>16</sup> *Royal College of Nursing v Department of Health and Social Security* [1981] 1 All ER 545

<sup>17</sup> Although it is referred to by the Mental Capacity Act s.4(5), the Act contains minimal guidance for practice.

<sup>18</sup> This is not strictly true of cases involving persistent vegetative state inasmuch as they do appear to accept there is an intention to end life. This distinction is acknowledged at the end of this section.

<sup>19</sup> *Op. cit.*, n. 7

<sup>20</sup> *Op. cit.*, n. 5

<sup>21</sup> R Huxtable, 'Beyond Bland - hedging bets on the value of life?' in *Euthanasia, ethics and the law: from conflict to compromise* (2007), 115-140.

implications of criminality, as failing to follow that duty would be negligent, and the resulting death would lead in all likelihood to a prosecution for gross negligence manslaughter. However these unwelcome outcomes might be ameliorated if, instead of simply acting to save life, this duty was to act in the best interests of the patient. In this case it could be concluded that a patient's best interests might sometimes be served by a doctor's *inaction*. In the case of the competent patient such interests could be determined by the patient's wishes, in the case of an incompetent patient, by reference to established medical practice, as defined by the *Bolam*<sup>22</sup> test. While this position clearly unfolds in *Bland*<sup>23</sup> there are inconsistencies in its approach: in particular the death that results from withdrawal of treatment in *Bland*<sup>24</sup> is in some senses intended (albeit lawful because it results from an omission). The more common position is now most coherently found in the Mental Capacity Act 2005, where section 4 (5) makes it clear that death must only be an unintended side-effect of acting in a patient's best interests.

#### *Doctors and interlopers*

Between the Mental Capacity Act and *Bland*<sup>25</sup> we can describe the legal mechanisms for withdrawal in detail. But do these mechanisms apply to nurses? The answer to this seems at least debatable because *Bland*<sup>26</sup>, which contains the fleshed out thinking of the legal position, appears quite specific about *who* should be doing the withdrawal, inasmuch as Lord Goff's speech explains the sharp differentiation between withdrawal of treatment by a doctor and withdrawal by another.<sup>27</sup>

Members of the public taking actions that bear all the hallmarks of withdrawal of treatment – non-malicious removal of life sustaining equipment in futile medical cases – have found themselves subject to legal penalty. Few authors have researched the law's attitude to members of the public involved in quasi-withdrawal, and I am indebted to the work of Huxtable<sup>28</sup> who analyses two of these rare cases: *Watts*<sup>29</sup> concerned the conviction of a mother for the involuntary manslaughter of her

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<sup>22</sup> *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583

<sup>23</sup> *Op. cit.*, n. 5

<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.*

*bid.*

<sup>27</sup> *Ibid.* at 866.

<sup>28</sup> *Op. cit.*, no. 21

<sup>29</sup> C Barsby, 'Case Comment - Manslaughter - ingredients of offence where death caused by gross negligence' *Crim.L.R.* (November 1998) 833.



daughter, a severely brain damaged 14 month old, for acts analogous to those of a withdrawing doctor. The daughter, Abigail, was so brain damaged she was unable to breathe without help<sup>30</sup> and had already been subject to a *not for resuscitation* order.<sup>31,32</sup> After leaving her bedside for a few minutes, Abigail's mother claimed to have returned to find Abigail's tracheostomy tube out of her neck; despite shouting for help Abigail died soon afterwards. The crown prosecution service obtained a successful conviction on the basis that Abigail's mother had in fact removed the tube before leaving the bedside. She was convicted by the jury and given an eighteen month suspended jail sentence for Abigail's manslaughter. Although the conviction was eventually quashed on appeal, it was due to a legal technicality.

In the second case a grandson tried to disconnect life sustaining equipment from his grandmother.<sup>33</sup> Shara Karapetian, described by the judge as “devoted” to his grandmother, barricaded himself in the side-room where she was being treated and switched off machines, before cutting her intravenous drug line with scissors. Again the close resemblance of these actions to those of a withdrawing doctor did not prevent a suspended sentence for attempted murder being imposed, the judge describing it as a bizarre attempt at mercy killing.

In his examination of these cases, Huxtable<sup>34</sup> suggests that it is neither the interests of the patient nor the actions of the withdrawer that allow withdrawal to legally take place, but instead the identity of the withdrawer as a doctor. In such a way these cases, of the outcome of surreptitious and unilateral action outside the specific plans or orders of a doctor, demonstrate precisely what Lord Goff meant by “*interference with the life-prolonging treatment then being administered by the doctor*”.<sup>35</sup> Doctors represent the properly constituted authority for such decisions, and without their authority, withdrawal cannot take place. Yet the authority is not just the fiat of the doctor; as the case of *Cox*<sup>36</sup> (where a doctor was convicted of attempted murder after administering potassium to a patient to hasten their death) demonstrates, identity as a doctor is not a defence in itself. A process must be followed, where the doctor must be seen to arbitrate best interests with the patient or their proxies, a process that is now

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<sup>30</sup> I Burrell, ‘Appeal clears mother of killing disabled baby’ *The Independent* (London, 19 May 1998)

<sup>31</sup> *Op. cit.*, n. 21

<sup>32</sup> Although we should note she was being treated, and not subject to any planned withdrawal.

<sup>33</sup> G Finn, ‘Graduate in mercy killing bid freed’ *The Independent*, (London, 21 August 1999).

<sup>34</sup> *Supra.*, n. 31

<sup>35</sup> *Op. cit.*, n. 5 at 866.

<sup>36</sup> *R. v Cox Op. cit.*, n. 9

detailed in the Mental Capacity Act.<sup>37</sup> It is perhaps as part of this process of the exercise of properly constituted authority, that we begin to see the place of nurse actioned withdrawal begin to emerge.

### *Are Nurses Lord Goff's Interlopers?*

We now come to the crux of the issue – the question of who should perform the actual act of withdrawal of life sustaining treatment. The preceding section shows that doctors are central to the decision to withdraw, as the properly constituted authority, that the death that follows withdrawal is allowable as the switching off of the life support machine by a doctor is classified as an omission rather than an act, and that doctors are not compelled to act otherwise because their duty of care is to the patient's interests, rather than to their health. These are unique dispensations that do not apply to the interloper, and even if their actions are *identical* to those of the doctor, the interloper will be at a fault that the doctor does not commit. Where does this leave nurses? Obviously a nurse who acts surreptitiously and unilaterally will be classed as an interloper, and treated as such. But in consideration of a nurse's role in withdrawal of treatment, particularly a nurse, who, without direct medical supervision (although with medical and familial agreement) stops pumps, removes wires and switches off machines, a question hangs on how we should interpret Lord Goff's words – as his interloper is identified as "malicious", could his "doctor" be any healthcare professional acting without malice? Or, instead, are doctors to be differentiated from all others, including other health professionals, as Greene MR did in *Gold v Essex* where he commented: "...nurses are taken as the type of skilled person on the hospital staff other than medical men".<sup>38</sup>

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<sup>37</sup> This need for medical *arbitration* of best interests is underlined by the process by which those competent to judge their own best interests can refuse life sustaining treatment. In this case the principle of autonomy takes a central role by dictating that the individual is the one best placed to determine their interests. Yet in this central role autonomy contends with the notion capacity, that is, whether an individual is competent to make such a determination of their interests for themselves. It is in this need for collaboration of mental competence that the doctors professional role in both confirming capacity, and in informing the determination of best interests that arises from it, is quite unique from members of the public, however closely they know the individual and however allied to that individuals interests they may appear. Indeed, where a doctor's duty of care may allow them to omit to act, the duty of a family member may be such that passivity in the face of attempts to end life may be viewed as a sort of active assistance and thus potentially open to charges of assisting suicide. See Huxtable's contrast of legal treatment of passive assistance of suicide by doctors and family members in R Huxtable, 'Assisted Suicide in 'the shadowy area of mercy killing'', in Euthanasia, ethics and the law: from conflict to compromise, *Op. cit.*, n. 21, 69-70.

<sup>38</sup> *Gold v Essex County Council* [1942] 2 KB 293, at 303.

There are several answers to such a question, and that only a test of the law would fully resolve them. The multifaceted nature of the answer may lie in the subordinate professional nature of nurses, and it is to a more general discussion of nurses in the law that I turn in the next section. As we have seen, although not settling the place of nurses, it is evident from these that Lord Goff's words were not symbolic: The cases considered by Huxtable demonstrate that for parents and relatives, Lord Goff's comments adequately express the law. Even a person as seemingly legitimate as a close relative or the parent of a child is an interloper where withdrawal of treatment is concerned. Yet there is a further case that takes us a little closer to establishing legal attitudes to nurse actioned withdrawal.

John Lovell, an emphysema patient who had been dependent on a ventilator for eight years, began repeatedly disconnecting his ventilation tubing, begging his nurses to be allowed to die.<sup>39</sup> After several days of this behaviour, his consultant instructed a senior nurse to turn off his ventilator's disconnection alarm. He was subsequently given diamorphine<sup>40</sup> to make him comfortable and was found dead soon afterwards having apparently disconnected his own ventilation tubing once more. The coroner had no doubt that this was a case of upholding patient autonomy and mentioned the House of Lords Select Committee Report on medical ethics in his verdict, which he recorded as death by natural causes. The case was therefore treated as a competent withdrawal of treatment, with the senior nurse's actions somewhat analogous to a doctor's, and, like a doctor, the nurse avoided the legal pitfalls of her actions. The exoneration of these actions by the coroner takes us a step closer to surmising that nurse actioned withdrawal of treatment may not result in prosecution; however there are caveats to this conclusion: Coroners cases carry no weight of precedent, and the silencing of an alarm is conceivably further removed from withdrawal than the physical disconnection of a ventilator. Furthermore there is another issue raised by this case, although not one unique to its circumstances – that of the ever present potential for civil action by a dissatisfied family: Following the coroner's verdict Mr Lovell's widow, who, at Mr Lovell's request, had not been consulted about the decision and was away from his bedside when he died, expressed dissatisfaction with the verdict and registered a formal complaint with the hospital. Although a threatened civil action seems not to have materialised from this quarter, it underlines the risks of disgruntled family members taking such action: such threats are not infrequently

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<sup>39</sup>E Rowe, 'Fundamental decisions' (1994) 8 Nursing Standard 27, 21.

<sup>40</sup>J Cassidy, 'Nurse defends her role in turning off patient's alarm' (1994) 90 Nursing Times 12,

heard from distraught relatives searching for someone to hold accountable for the tragedy they are experiencing. Of course, such risks must not be overplayed as they are ever present within healthcare practice, but with unclear legal and professional attitudes to the practice of nurse actioned withdrawal, the delicate balance between clinical necessity and the everyday risk of litigation is disturbed. The bringing of a civil action, even one that fails in the courts, would precipitate an investigation by the both the hospital authorities and the nursing regulator where a nurse would need to defend their actions according to quite different standards to those that apply in law, and censure could have shattering effects on a nurse's career.

We have seen that the law governing withdrawal of treatment uses a complex formula to protect Doctors from legal repercussions of their actions, and that this protection does not extend to members of the public even when they undertake analogous acts. The case of John Lovell suggests nurses may somehow be protected by the law yet does not explain why such a position is so. In the next section I shall look at legal and professional treatments of Nurses and argue that both the law and the professional regulator have simplified views of the role of the nurse, suggesting nurse actioned withdrawal may have unpredictable results. It seems to be a reasonable assumption that, if the nurse had multidisciplinary support, a judge would view their case sympathetically, perhaps using their ability to weave a defence in the nurse's favour. We should note, however, that in both the *Watts*<sup>41</sup> and the *Karapetian*<sup>42</sup> cases the judge showed considerable sympathy to the defendant, handing down short, non-custodial sentences in both cases. Judicial sympathy may therefore result in lenient treatment rather than exemption. Even in scenarios where a nurse is found neither guilty or liable (depending on the type of action) in law, they face the additional hurdles of a managerial structure that may not accept (or understand) their role and a nursing regulator mandated to protect the public. Depending on the regulator's perceptions of public protection, a nurse may still be subject to harsh penalties for their part in the act of withdrawal; this double jeopardy will also be examined more closely below.

## II. NURSES AS WITHDRAWERS – LEGAL AND PROFESSIONAL POSSIBILITIES

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<sup>41</sup> *Op. cit.*, n. 29

<sup>42</sup> *Op. cit.*, n. 33

In this section I shall examine the legal and professional consequences of nurse actioned withdrawal of treatment. As no cases exist it will be necessary to reflect on the treatment of nurses in other scenarios, although the virtual invisibility of the nursing profession from the law makes the task of deciding legal consequences more arduous. I examine the approaches to nursing that exist under the current law and suggest that, by viewing nursing duties as an extension of medical acts (or omissions), the law gives sufficient leeway for a nurse to escape liability for an act of withdrawal that can be demonstrated to be under the control of a doctor. The issue of professional liability is somewhat more vexed as professional responsibility extends far beyond the court's expectation of nurses merely obeying doctors' orders and provides scope for sharp differences of response between courts and regulators. I argue that a harmonisation of judicial and regulatory views would provide a less unpredictable working environment for nurses; such developments may ultimately rely on the formulation of statute by parliament and such a move is likely to be some time away. In *RCN v DHSS*<sup>43</sup> counsel for the DHSS suggests at 816:

*If a highly skilled gynaecologist, having cut his hand, watched a highly skilled nurse perform an operation, the act would be his act. It does not matter who does what so long as the direction and supervision is by the doctor and what is done is according to normal recognised medical practice.*

In 1994, Valerie Tomlinson, a theatre sister of 30 years experience was reported by a colleague for conducting three parts of an appendectomy while supervised by a surgeon with whom she had "a mutual trust and understanding", Mr Bhatti. Both she and the surgeon were suspended but reinstated with a final written warning following a disciplinary hearing at the NHS trust.<sup>44,45</sup> Meanwhile, a hospital sister at a geriatric day unit who followed the instructions of her consultant and surreptitiously tranquillised an aggressive patient who was refusing compulsory admission to the wards for deteriorating mental health was reported by a colleague and suspended from duty. At her disciplinary tribunal she was given a final written warning and told she had only narrowly escaped dismissal, meanwhile a disciplinary inquiry exonerated the consultant of professional misconduct.<sup>46</sup>

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<sup>43</sup> Op. Cit., n.16

<sup>44</sup> G Cooper, 'Appendix nurse to keep surgery job' *The Independent* (London, January 27 1995)

<sup>45</sup> Anon., 'British surgeon in appendix row keeps his job' (1995) 310 *British Medical Journal* 6976, 348.

<sup>46</sup> J Kellett, 'An Ethical Dilemma: A Nurse is suspended' (1996) 313 *British Medical Journal* 7067, 1249-50.

The disciplinary penalties for both nurses were the same, implying that the counsels were at fault in their arguments that obeying doctor's orders is a credible defence – yet I suggest in the next section that their comment was well founded in case law, an assertion reinforced by the judgment the Lords delivered in *RCN v DHSS*<sup>47</sup> after hearing the counsel's arguments.<sup>48</sup> Furthermore, in both the cases above it is notable that no illegal act was alleged. In the light of this, the legal and regulatory context of these cases deserves explanation. In the case of a theatre nurse undertaking an operation while supervised by a surgeon, it is unclear precisely what regulation may have been transgressed, as the disciplinary proceedings were not a matter of public record, but instead took place between Sister Tomlinson and her managers. No law prevents any competent individual from undertaking an operation, yet in the words of the trust, such actions went “beyond what would normally be expected of a theatre nurse”.<sup>49</sup> National guidelines were not transgressed,<sup>50</sup> and as the patient did not complain and Tomlinson practiced the operation competently, no action was taken by the nursing regulator.<sup>51</sup> In the case of disciplinary proceedings for covert administration of medication, once again the closed doors nature of the tribunal means it is unclear what local protocol was breached. Yet managerial action does not accord with the national guidelines available at the time for covert administration of medicines,<sup>52,53</sup> which, while suggesting that covert administration is far from ideal practice, accept that in a patient lacking capacity it may be undertaken if it is in their best interests.

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<sup>47</sup> *Op. Cit.*, n.16

<sup>48</sup> Which, as stated in the previous section, suggested that references to doctors in the Abortion Act recognised a team effort. I will return to the case later.

<sup>49</sup> L Hunt, ‘For doctor, read nurse’ *The Independent* (London, January 27 1995).

<sup>50</sup> While the National Association of Theatre Nurses produced guidelines that emphasised the importance of training for nurses who are to act as first assistants to surgeons in the operating theatre, this role was constructed for specific procedures and did not include activities such as Sister Tomlinson’s in its scope. See: National Association of Theatre Nurses. ‘The Role of the Nurse as First Assistant in the Operating Department’ (1993); also see: The Perioperative Care Collaborative, ‘Position statement - The Role and Responsibilities of Advanced Scrub Practitioner’ (2007) <<http://www.afpp.org.uk/filegrab/theroleandresponsibilitiesoftheadvancedscrubpractitioner.pdf?ref=36>> accessed on: 12 October 2011. Dimond considers Tomlinson’s activities would fall under the general auspices of the nursing regulator’s *Scope of Professional Practice* (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, ‘The Scope of Professional Practice’ (1992) which merely specifies that an individual must be satisfied they possess the necessary skills to practice competently: as no harm came to the patient in this case, such a loose definition of competence seems satisfied. See: B Dimond ‘When the nurse wields the scalpel...’ (1995) 4 *British Journal of Nursing* 2, 65-66.

<sup>51</sup> Dimond. *Ibid.*

<sup>52</sup> United Kingdom Central Council for Nursing and Midwifery, ‘Code Of Professional conduct’ (1992)

<sup>53</sup> United Kingdom Central Council for Nursing and Midwifery, ‘Position Statement on the Covert administration of medicines---Disguising medicine in food and drink.’ (2001)

More than anything else, these cases highlight the vulnerability of nurses to local protocols which create a further level of potentially conflicting regulatory demands on their practice. The capriciousness of such protocol may be fuelled by the poorly defined nature of nursing duties which in practice lack clear demarcation between the roles of doctor and nurse in the everyday delivery of healthcare. The divergence between legal, managerial and regulatory responses is not trivial. While nurses may be spared legal penalties due to the blunt principles of vicarious liability, they may find their career impaired, or indeed being debarred from practising it altogether for complying with those same principles. Patient care is also likely to suffer if the law holds that a nurse has a primary duty to the doctors' instructions rather than the patient – and what of the much touted protection for whistle-blowers who expose bad practice? As we shall see, the environment created by the conflict between legal and professional responsibilities is chaotic indeed.

### *Nurses in the law*

There are few cases where the judiciary specifically addresses the role of nurses, and even more rarely does the role of the nurse form the *ratio decidendi*. The position of nursing as an ancillary profession to medicine means that many judgments simply do not address nurses at all, even when they are central to the case at hand.<sup>54</sup> Chiarella suggests this invisibility is partly based on judicial ignorance of the work nurses perform, which is characterised as mundane, domestic, and, when not directly replacing a medical role, unskilled.<sup>55</sup> Certainly in the three cases examined, all of which concern nurses' liability for their actions, the law advances a view that nurses' primary duties are to doctors, rather than patients, a standpoint that is at variance to the nursing code of professional practice.<sup>56</sup>

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<sup>54</sup> M Chiarella, 'Searching for the 'true' status the nurse' in *The Legal and Professional Status of Nursing* (2002), 3-36.

<sup>55</sup> M Chiarella, 'Living in a legal and professional shadow land' in *The Legal and Professional Status of Nursing*, *idem.*, 227-262.

<sup>56</sup> Nurses' professional responsibilities are set out in "The code: Standards of conduct, performance and ethics for nurses and midwives", published by the The Nursing and Midwifery Council. The code contains 61 points, the first 20 of which explicitly detail nurses' duties toward those in their care, while points 21-34 detail duties toward colleagues. The code apparently envisages interprofessional relationships within healthcare as collegial rather than hierarchical in form. As shall be explained in more detail later, the statement that particularly seems to contradict the legal position is found on the opening page of the code: "As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions." See: Nursing & Midwifery Council, 'The code: Standards of conduct, performance and ethics for nurses and midwives'

Although it now carries little authority in the determination of vicarious liability,<sup>57</sup> the place of nurses suggested within Farwell LJ's speech in *Hillyer*<sup>58</sup> seems to begin an unbroken line of reasoning most recently aired in *RCN v DHSS*<sup>59</sup>. *Hillyer*<sup>60</sup> was a negligence case brought by a patient who, following surgery, had been burned by the hot bricks that were routinely used by nurses to warm post-operative patients at that time. In that case, the hospital was judged not to have vicarious liability for the negligence of the nurses. The appeal court judges disagreed on the reason and advanced two views of a nurses' professional standing. Kennedy LJ suggested that, within the boundaries of the operating theatre, the nurses were professionals and thus were liable for their own actions. Meanwhile, Farwell LJ proposed that they were under the control of the surgeon at the time, so the surgeon was vicariously liable for their actions. Outside the operating theatre both agreed that the hospital assumed vicarious liability as nurses' roles in that environment were domestic rather than professional.

The vicarious liability question was settled in *Gold v Essex*<sup>61</sup>, a negligence case brought on behalf of a child who suffered facial burns due to the actions of a radiographer, that explicitly overturned *Hillyer*<sup>62</sup> when it was held that the hospital's vicarious liability extended to *any* negligent employee. Despite the fact the hearing was about a radiographer, the judgment refers almost exclusively to nurses, which Greene MR explains is because legally they represent the type of skilled hospital employee apart from doctors.<sup>63</sup> Although delivering a judgment that the hospital was vicariously liable for nurses' actions, the judgment also seems to side with the principle advanced by Farwell LJ in *Hillyer*;<sup>64</sup> both Greene MR and Goddard LJ voice similar opinions that a nurse *cannot* be negligent when carrying out a doctors' orders:

*I should myself have thought that the true ground on which the hospital escapes liability for the act of a nurse who, whether in the operating theatre or elsewhere, is acting under the instructions of the surgeon or doctor is, not that*

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(2008) <<http://www.nmc-uk.org/Nurses-and-midwives/The-code/The-code-in-full/>> accessed on 16 December 2011

<sup>57</sup> My understanding from its distinguishing in *Cassidy v Ministry of Health* [1951] 2 KB 343 (at 361) is that it may still exempt a hospital of vicarious liability for a surgeon whom the patient personally selects and employs.

<sup>58</sup> *Hillyer v Governors of St. Bartholomew's Hospital* [1909] 2 KB 820, at 826

<sup>59</sup> *Op. cit.*, n. 16

<sup>60</sup> *Supra*, n. 58

<sup>61</sup> *Op. cit.*, n. 38

<sup>62</sup> *Supra*, n. 58

<sup>63</sup> As I commented earlier, this may be evidence of an intent to differentiate by choosing to name "doctors" in Lord Goff's speech in *Bland*.

<sup>64</sup> *Ibid.*



*pro hac vice she ceases to be the servant of the hospital, but that she is not guilty of negligence if she carries out the orders of the surgeon or doctor, however negligent those orders may be.*<sup>65</sup>

In the light of this statement it is perhaps unsurprising that a generation later in *RCN v DHSS*,<sup>66</sup> the question of the degree to which nurses' actions could be called their own was again answered with a ruling that suggested nurses' actions might be those of the doctors under whose instruction they worked. The case concerned the extra-amniotic method of termination of pregnancy, where a catheter is inserted via the cervix into the uterus into which an abortifacient infusion is administered, causing the miscarriage of the fetus. A Department of Health and Social Security circular advised that nurses should be able to connect and administer the abortifacient infusions used to terminate the pregnancy, provided a doctor had decided on the treatment and inserted the catheter. The Royal College of Nursing contended that this advice was not correct in law, as the Abortion Act 1967 states:

*"...a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner"* ...and therefore abortifacient administration by a nurse was in contravention of the law. The Lords found in the department's favour by a 3-2 majority, suggesting aspects of the Abortion Act implied a team effort, and thus its protection must extend to the team at large, not just the Doctor concerned. Lord Diplock suggested this was manifest in the requirement for terminations to take place in hospital. Meanwhile both Lords Keith of Kinkel and Roskill find their evidence in the wording of the clause in Section 4 paragraph 1 of the *Abortion Act* providing a right of conscientious objection to participation, which they felt implied a wider process. Again, other comments imply that a nurse's actions are not her own, but rather an extension of a doctors':

*I think that the successive steps taken by a nurse in carrying out the extra-amniotic process are fully protected provided that the entirety of the treatment for the termination of the pregnancy and her participation in it is at all times under the control of the doctor even though the doctor is not present throughout the entirety of the treatment.*<sup>67</sup>

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<sup>65</sup> *Op. cit.*, n. 38 at 299 per Greene MR. Even more bluntly, Goddard LJ comments: "*If the surgeon gives a direction to the nurse and she carries it out, she is not guilty of negligence even if the direction is improper*" *Ibid.* at 310.

<sup>66</sup> *Op. Cit.*, n. 16

<sup>67</sup> *Ibid.* at 838 per Lord Roskill.

The law in this area seems to leave the question of nurses' actions to the supervising doctor, perhaps even to the extent of mitigating a negligent act that the nurse performs on the doctor's behalf. Here we have a solid basis on which to suggest the law would defend nurse actioned withdrawal. There is further reason to suspect this when we consider that judges (with an eye to public policy) may surmise it is not in the public interest to criminalise nurses, and therefore extend the special treatment allowed to doctors to nurses actions as well. Yet there are important caveats to this conclusion; vicarious liability does not operate in criminal law, and so could not form a specific defence against criminal charges, only civil ones. Furthermore, this argument is based largely on *obiter dicta* and therefore does not have binding authority on future cases. As I shall argue below, it is not rational to say that nurses have no responsibility to patients except through a doctor, indeed, such judicial assumptions apparently contradict statutory moves to promote whistle-blowing under the Public Interest Disclosure Act 1998, opening these judgments to accusations of irrational law. Even within civil law the defence of vicarious liability is questionable. Past tendencies to permit medical practice to operate in a rarefied, self referential atmosphere, exemplified by the use of the *Bolam*<sup>68</sup> test to justify apparently irrational practices have given way to a less deferential approach to medical conduct.<sup>69,70</sup> Judgments such as *Bolitho*<sup>71</sup> (where the Lords ruled that medical opinion must have a logical basis) show an increasing desire among the judiciary to root out irrational assumptions that underlie medical law, and nurses would be well advised to arm themselves with more justification than the law provides before defending nurse actioned withdrawal in a court, and it is to ethical and practical justifications that I suggest they turn.<sup>72</sup>

### *Negligence and complications in end of life care*

Having raised the spectre of *Bolitho*<sup>73</sup>, I wish to end this section by considering how claims of negligence might arise in a terminal care scenario, as it may not be

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<sup>68</sup> *Op. cit.*, n. 22

<sup>69</sup> M Brazier, J Miola, 'Bye-Bye Bolam: A Medical Litigation Revolution?' (2000) *Med.L.Rev.* 8, 85-114

<sup>70</sup> Lord Woolf 'Are The Courts Excessively Deferential to the Medical Profession?' (2001) *Med.L.Rev.* 9, 1-16

<sup>71</sup> *Bolitho v City and Hackney Health Authority* [1998] AC 232

<sup>72</sup> Although it is beyond the scope of this paper to explore these.

<sup>73</sup> *Ibid.*

immediately apparent how this might take place given the usual close involvement of the family in agreeing withdrawal of treatment (especially from incompetent patients).

While agreement is generally sought between relatives and the healthcare team before withdrawal, it is possible that withdrawal of treatment might still be subject to post hoc accusations of negligence by a family. There are clear circumstances where such accusations may occur when ventilatory support is withdrawn: Agonal breathing, an apparently distressing, pre-terminal gasping caused by very high levels of carbon dioxide in the blood has been noted to last up to 40 minutes in adults,<sup>74</sup> while in infants it can last considerably longer: 31 hours in one study.<sup>75</sup> Relatives may be unprepared for such events and may feel their loved one has been robbed of the dignity that withdrawal was intended to preserve, so that while the death itself may be agreed upon, the actual management might form the source of considerable dissatisfaction to a significant minority (as was the case with 8% of interviewees in the study above).<sup>76</sup> A further complexity is introduced by the differentiation of such breathing from dyspnoea, an acute and agonising inability to breathe adequately, that, unlike agonal breathing, is associated with conscious suffering in the patient, and is treatable (in the context of terminal care) with increased doses of sedation. The existence of such a differential diagnosis at least opens the door for queries of negligence. Should such claims be advanced against a nurse it is questionable if the courts would accept a bald defence of 'doctors' orders' without comment.

Such risks also raise pressing questions of a fracture between law and clinical practice suggested by legal arguments that the nurse may perform a negligent act at the behest of the doctor and escape responsibility. This seems to indicate a limitation in the duty of care owed to the patient, creating a fundamental inconsistency with nursing's code of professional practice, which declares: "*As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions*".<sup>77</sup>

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<sup>74</sup> R Perkin, D Resnik, 'The agony of agonal respiration: is the last gasp necessary?' (2002) *Journal of Medical Ethics* 28, 164-169.

<sup>75</sup> H McHaffie, A Lyon, P Fowlie, 'Lingering death after treatment withdrawal in the neonatal intensive care unit' . (2001) 85 *Archives of Disease in Childhood - Fetal and Neonatal Edition* 1, F8-F12.

<sup>76</sup> A quote from one interviewee sharply illustrates the degree of ongoing distress relatives may suffer: "He was coughing, spluttering, gasping . . .the minute he (the doctor) was coming over (to check that his heart had stopped) he started again. I was just not looking . . .My arm was numb. They were saying, 'Go and have a lie down, this could go on for hours.' But I couldn't even move. I was just so damned scared. I think it was more his noises that haunt me than the colour of his blue hand. It was going on forever . . .It was two and a half hours." (P20: mother of severely asphyxiated baby)' *Ibid.* at F10.

<sup>77</sup> *Op. cit.*, n. 56

In turn this creates potentially disastrous consequences for nurses who, due to formal complaints or civil actions, are called on by their registering body to justify their actions, scrutiny that will take place regardless of any legal outcome. The inherently unpredictable nature of dying, and the highly charged atmosphere of the death of a loved one, makes such situations a possibility and one has only to look the complications of terminal care to see how such complaints might arise. It is to these considerations we shall now turn.

*A regulator with teeth – The Nursing and Midwifery Council*

Blurred roles and ambiguous distinctions between spheres of practice are a fact of nursing life, particularly in areas such as hospital nursing where doctors and nurses work closely together. As the law correctly observes, such healthcare is a team activity, and a loyalty to that team will often lead a nurse to set aside feelings of professional vulnerability if doing so will expedite the process of care and deliver perceived benefits to the patient. In so doing they may assume their activities will be vouched for by the doctor in charge, and that, provided they acted in good faith, they might be shown understanding in giving an account of their actions. There seems then, to be a tension between the perception of a nurse as a member of a team (as reflected in the law) and the nurse as a responsible individual within the Nursing and Midwifery Council's (NMC) Code of Professional Conduct<sup>78</sup> and managerial protocols. This emphasis on the individual has been criticised as mistaken given the intrinsically communal nature of healthcare work,<sup>79</sup> yet this personalisation of responsibility has to some extent been the result of attempts to bolster the professional autonomy of nursing. Chiarella<sup>80</sup> argues that these may have missed the mark, inasmuch as they sought to alter the status of nursing without altering the fundamental structures of wider healthcare decision making, and nursing's subordinate status within these. Such analysis is evidence of deeper tensions within nursing as it seeks to both incorporate medical responsibilities and distinguish itself from medicine. Yet professional regulation of nurses is now tougher than ever, and the tensions between the practicalities of teamworking and the idealisation of practitioner autonomy place nurses under significant professional risks.

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<sup>78</sup> *Ibid.*

<sup>79</sup> S Pattison, P Wainwright 'Is the 2008 NMC Code Ethical' (2010) 17 *Nursing Ethics* 1, 9-18.

<sup>80</sup> *Op. cit.*, n. 55

The widespread loss of confidence in the ability of the medical profession to self regulate, underpinned by ideological drives to improve standards by increasing the power of health consumers, and fuelled by the successive scandals highlighted in the *Bristol Royal Infirmary Inquiry*<sup>81</sup> and the *Shipman Inquiry*<sup>82</sup> also resulted in dramatic changes to the regulation of other health professionals. The Nurses and Midwifery Order 2001 convened a new regulator to oversee nursing, the NMC, which differed in important respects from the former regulator, the UKCC, with the emphasis shifting from professional regulation to public protection. Lay membership of the regulator was increased and half of the council are now non-nurses, paragraphs of UKCC guidelines reflecting the impact of deregistration upon practitioners were removed and there was a reduction in the standards of proof needed to find nurses guilty of misconduct from the criminal (beyond reasonable doubt) to the civil (balance of probabilities) standard<sup>83</sup>. Finally the Council for Regulation of Healthcare Excellence (CHRE) was given the power to refer any 'unduly lenient' ruling by the NMC to the High Court<sup>84</sup>. The overall effect was to create a regulator more zealous than ever in rooting out nurses whose practice does not meet their standards.

Changes to the burden of proof in malpractice cases mean that nurses who escape the courts may nevertheless find themselves stripped of a right to practice by their regulator. Given the volatile nature of public opinion and the ability of "right to life" groups to motivate it, nurses may be called upon to justify their activities in the terminal care environment (consider for instance the recent equating of the Mental Capacity Act with "backdoor euthanasia";<sup>85,86</sup> consider too the momentous changes to the treatment of disabled children after the trial of paediatrician Leonard Arthur in 1981 and that this trial was instigated by the anti-abortion pressure group *Life*).<sup>87</sup> This is against a background of regulatory decisions that have often been criticised for excessive zeal rather than undue leniency. Only two cases were referred by the CHRE

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<sup>81</sup> Bristol Royal Infirmary Enquiry. 'Learning from Bristol: the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary, 1984-1985' (2001).

<sup>82</sup> The Shipman Enquiry. 'Safeguarding Patients: Lessons from the Past, Proposals for the Future' (2004).

<sup>83</sup> S Fullbrook, 'Professional regulation. Part 6: transition of regulatory bodies' (2008) 17 *British Journal of Nursing* 16, 1042-1044.

<sup>84</sup> S Fullbrook, 'Professional regulation. Part 5: Bristol Inquiry and the Kennedy Report' (2008) 17 *British Journal of Nursing* 15, 978-979.

<sup>85</sup> Society for the Protection of Unborn Children, 'Euthanasia,' (no date)

<<http://www.spuc.org.uk/ethics/euthanasia/mca/euthandsuic>> accessed on 4 June 2010

<sup>86</sup> S Doughty, 'We'll fight backdoor euthanasia and risk jail say doctors' *Daily Mail* (London, 30 March 2007)

<sup>87</sup> J Read, L Clements, 'Demonstrably awful: The right to life and the selective non-treatment of disabled babies and young children' (2004) 31 *Journal of Law and Society* 4, 482-509.

to the High Court in 2008/9 and one of these was later withdrawn<sup>88</sup>. Meanwhile, court appeals by nurses against NMC decisions have resulted in criticism of the regulator for disproportionately reflecting on past misdemeanours rather than future patient safety,<sup>89,90</sup> undue severity<sup>91</sup> and lack of due process.<sup>92</sup> Some judgements seem particularly harsh; for instance, *Sarkodie-Gyan*<sup>93</sup> concerned a nurse who, having recovered from depression was not allowed to return to practice as she could not demonstrate that the stresses of work might not induce a relapse. The recent case of Margaret Haywood threw the severe nature of NMC discipline into the public consciousness.<sup>94</sup> Haywood, an experienced nurse, tried unsuccessfully to raise concerns about patient maltreatment within the ward where she worked. In frustration she contacted a television company and secretly filmed this maltreatment, which was then broadcast in a television documentary. After a complaint to the NMC from the hospital trust where the abuse took place, Haywood was removed from the nursing register for breaching patient confidentiality (on the basis that consent for filming had been obtained from patients after footage had been scrutinised by the production team). There was outcry and her punishment was eventually downgraded after a public campaign<sup>95</sup>. Naturally the NMC may defend such decisions as necessarily firm on the basis of upholding the trustworthiness of the profession or protecting patient safety, yet such sentiments seem significantly at odds with their conduct in this case. But would the NMC remove a nurse from the register for following doctor's orders? Cases of deregistration for following doctors' orders are rare – perhaps because it is rarely advanced as a defence given the explicit advice of influential commentators such as Dimond.<sup>96</sup> However, such cases do exist. Rosser<sup>97</sup> reports a case where a senior midwife was held responsible for a stillbirth that resulted from the administration of medication to speed up a slow labour. As the medication had

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<sup>88</sup> Commission for Regulation of Healthcare Excellence, Section 29: Statistical return. Financial year 2008-2009 (no date)  
<[http://www.chre.org.uk/\\_img/pics/library/090722\\_s29\\_Statistical\\_summary\\_2008-2009\\_1.pdf](http://www.chre.org.uk/_img/pics/library/090722_s29_Statistical_summary_2008-2009_1.pdf)>  
accessed on 4 June 2010

<sup>89</sup> *Balamoody v Nursing and Midwifery Council* [2009] EWHC 3235 (Admin)

<sup>90</sup> *Sarkodie-Gyan v Nursing and Midwifery Council* [2009] EWHC 2131 (Admin)

<sup>91</sup> *R (on the application of James) v Nursing and Midwifery Council* [2008] EWHC 365

<sup>92</sup> *R (on the application of Marshall) v Nursing and Midwifery Council* [2008] EWHC 2931

<sup>93</sup> *Supra*, n. 91

<sup>94</sup> P Grant, 'Ethical lessons from the 'undercover nurse': implications for practice and leadership' (2010) *Journal of Medical Ethics* 36, 469-472.

<sup>95</sup> L Smith, 'High Court reinstates nurse who exposed neglect' *The Independent* (London, 13 October 2009)

<sup>96</sup> B Dimond 'Doing the right thing' (1987) 83 *Nursing Times* 5, 61.

<sup>97</sup> J Rosser 'Struck off – The midwife who obeyed doctor's orders' (1999) 2 *The Practising Midwife* 4, 4-5.

recognised risks to the fetus, the midwife followed protocol and summoned the registrar when the fetal heartbeat showed signs of distress. When the registrar made no instruction to change the management, the midwife continued with the medication and the baby was subsequently delivered stillborn. The professional conduct committee of the UKCC, ruled that following doctors orders was not a defence as the midwife was personally accountable for the care she gave and removed her from the register. Of course, such examples do not exactly match the circumstances of nurse actioned withdrawal, however, even without such concrete examples, the existence of differing legal and professional expectations represents a disquieting paradox for practicing nurses, especially given that nurse actioned withdrawal of treatment results in the death of a patient and may cause significant distress to the patient's family. Whilst it is important to maintain perspective on the risks of deregistration – only 0.2% of nurses ever have contact with the NMC over fitness to practice issues<sup>98</sup> and many cases of deregistration are for infractions that are clearly unacceptable – the lack of clear guidelines from a regulator known for their strict attitudes, whose judgement of nursing practice may be coloured by its proportion of lay members, suggests nurses may risk their careers by undertaking legitimate activities. Of course, the legal system makes it share of mistakes and has shameful and disproportionate verdicts in its history, yet as judges are loath to overturn the verdicts of professional bodies<sup>99,100</sup> faulty verdicts are simply referred back to the NMC for reconsideration; the lack oversight may create a concerning lack of responsiveness to the very real privations deregistration creates.<sup>101</sup>

The disjuncture between legal and professional attitudes appears to make the risk of professional censure a real possibility for nurses who get caught up in disputes around end of life care. The position of nurses is highly nuanced, and both the regulator and the judiciary seem to have part, but not all, of the story. Ultimately, the legal position is the fallout from the patchwork of judicial manoeuvres to ensure that properly

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<sup>98</sup>Nursing and Midwifery Council, 'Hearings | Nursing and Midwifery Council,' (no date) <<http://www.nmc-uk.org/hearings/>> accessed on 1 June 2010.

<sup>99</sup> *Op. cit.*, n. 90

<sup>100</sup> *Op. cit.*, n. 92

<sup>101</sup> My point is that the process is slow and unresponsive and may involve multiple appeals to correct it; indeed, the glacial pace of NMC procedure was among the many criticisms of the organisation in the Council for Healthcare Regulatory Excellence 'Special Report to the Minister of State for Health Services on the NMC' (2008)

<[http://www.chre.org.uk/\\_img/pics/library/080611\\_NMC\\_Final\\_Report\\_1.pdf](http://www.chre.org.uk/_img/pics/library/080611_NMC_Final_Report_1.pdf)> accessed on 23 October 2011. See: S Fullbrook, 'Professional regulation. Part 7b: CHRE Report and the NMC response' (2008) 17 *British Journal of Nursing* 18, 1074-1075. For a discussion of the punitive nature of nursing self-regulation see: M Chiarella, 'The authority of disciplinary bodies' in *The legal and professional status of nursing. Op. cit.*, n. 54, 182-184.

conducted medicine does not fall foul of the law. Meanwhile professional expectations come from both nursings' ambitions for autonomy and a regulatory desire to promote patient safety; a critique of the organisation and status of the healthcare professions is beyond the scope of this paper. However, in the case of the topic at hand there are several courses of action that would remedy the current situation. First and foremost would be a recommendation for the professional code to recognise the nature of teamworking within the healthcare environment, and to undertake that no disciplinary action should take place against a nurse who carries out express instructions that are themselves accordance with the law.<sup>102</sup> Nurses themselves must also construct a body of evidence that both documents and defends their practice in terminal care settings, and such evidence used to inform guidelines from professional bodies that can act as quasi-law in the event of scrutiny. Ultimately there is a wider need for parliament to produce properly considered statute that can replace the current patchwork of common law in order to provide coherent guidance for both judiciary and practitioners in end of life care settings, and nurses must join with other healthcare professionals to press for this and recognition of their own role within it.

### III. CONCLUSION

In English law, doctors have been granted special dispensation to end life in certain, very specific, circumstances. In termination of pregnancy these circumstances are detailed in the Abortion Act; similar dispensations exist in the withdrawal of life sustaining treatment. Each of these activities has their corollary in criminal or civil law. The mechanisms by which these dispensations are achieved are highly subjective and, in the case of withdrawal of life sustaining treatment, considerable weight is attached to the opinions of the judiciary over what constitutes an act or omission and in what circumstances a duty of care may entail withholding rather than providing treatment. Whether this judicial subjectivity can be relied on to grant a dispensation to nurses similar to that enjoyed by doctors is unlikely. The deliberate way that the actions of doctors have been distinguished from those of other interested parties means that judicial sympathy cannot be relied upon, particularly as there exists an, albeit slim, body of law that considers the activities of non-medical professionals in

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<sup>102</sup> Further force would be given to such a relinquishing of simplistic notions of professional autonomy by robust judicial assertion that negligent care by doctors should be challenged by the ancillary professions, and that firm action be taken against doctors who resist such challenge.



hospitals. These cases contain competing versions of the status of nurses: *Hillyer*<sup>103</sup> first advances the idea that nurses could be professionals in their own right, yet also characterises their activities as under the control of a doctor. While *Gold v Essex*<sup>104</sup> establishes that vicarious liability rests with the employer, it contains significant obiter dicta which seem to indicate their *de facto* status as instruments of medical will, a status eventually confirmed by *RCN v DHSS*.<sup>105</sup>

Nurses' professional status as clinical subordinates to doctors is a fact; nursing careers climb into education and healthcare management, but never into ultimate executive power in the clinical workplace. It is from this subordinate status that the judicial attitude to nursing may arise, yet the characterisation of nurses as simple tools of doctors is not only inaccurate, but clearly at odds with the requirements of nurses' professional registration, which in turn misses the essentially collaborative nature of much healthcare work. It may make irrational law to suggest nurses have a primary duty to doctors, rather than patients; it certainly suggests a failure to engage with the realities of healthcare practice to treat doctors as a breed apart from their colleagues in the ancillary professions despite the identical nature of their workplace and client group, and the overlap in their professional duties. It is irrational to suggest nurses who comply with an order which they know to be negligent may be spared legal penalties due to the blunt principles of vicarious liability, and does nothing to bolster the position of a nurse, who, knowing the *professional* risks to nurses who comply unquestioningly with doctors' orders, is caught in the horns of such a dilemma. The case of John Lovell<sup>106</sup> and the significant dissatisfaction experienced by relatives who witness protracted complications of a dying loved one<sup>107</sup> suggests a likelihood that in the highly charged environment of end of life care, nurses will at some stage be called upon to justify their actions, if not to the courts, then to their professional regulator. I hope that such actions would be viewed sympathetically, but fear nurses may have to assert robust reasons for their activities to avoid censure. Medical law is seen by some as noteworthy for imaginative interpretations of the law by a judiciary seeking to protect the good of medicine, interpretations that have sought to divide medical acts from non-medical acts despite flagrant similarities. The unusual legal status of nurses' activities in end of life care, as well as other areas, appears to have been an almost

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<sup>103</sup> *Op. cit.*, n. 58

<sup>104</sup> *Op. cit.*, n. 38

<sup>105</sup> *Op. cit.*, n. 16

<sup>106</sup> *Op. cit.*, n. 40

<sup>107</sup> *Op. cit.*, n. 75

accidental creation of such behaviour, and like much of the law at the end of life, the ultimate answer to the current predicament is the creation of well reasoned statute. Meanwhile nursing leaders have sought to define nurses as autonomous agents with scant regard to the actualities of healthcare delivery. These professional and legal half truths have built a fragile edifice that creaks uncomfortably under the weight of everyday reality. Should the price of these contradictions be an injustice done to the legitimate activities of nurses?