Nursing and the Law

Patricia Staunton  
President  
Australian Nurses Federation (NSW)

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I was asked to speak on this issue for two reasons I suspect. Firstly, because I am the author of a text book called "Nursing and The Law", which is a recommended text book for nursing and allied health professionals. Secondly, because of the role the New South Wales Nurses Association has played for some time now in defending a particular nurse called Sophie Heathcote. Those of you who are interested in the legal issues arising from rural and remote health, should be aware of the case because it has been widely reported particularly in New South Wales. It has also attracted great attention in other States because of the events that flowed from the particular incident, and in fact the matter has been in court only this week. I will go into the details of that case when I get to the point where I think it is relevant.

The topic of this workshop is Law Reform. When I sat down to consider the comments I was going to make, it didn't seem to me that we should be trying to do is to seek law reform, but rather to address the vulnerability which I believe health professionals in rural and remote areas have, when the question of their legal responsibilities is considered.

What I mean is that the legal principles applying to the delivery of health services, is usually predominantly nurses and doctors. If you want to ask yourself what are the legal principles that apply to us in carrying out our roles in these situations, then the legal principles are no different to those that apply to your colleagues in large metropolitan hospitals or practices. The law does not draw up lists of do and don'ts or legal principles for different situations. The law applies, has legal principles and then says, given that these are the legal principles let us look at the facts and circumstances and apply them in a reasonable way.

So what is invariably different in relation to the question of the standard that the law expects of you and the legal principles that apply, is (that) in coming to look at the standard that is expected of health practitioners in rural and remote areas is that there are clearly individual facts and circumstances that you would have to bring to bear before you could ask yourself whether, what is done or not done, is reasonable or is not reasonable in all of the circumstances.

For those of you that are familiar with the legal principles that are more often than not brought to bear in determining what is the correct legal standard, what are my obligations or as most nurses say to me "how do I stay out of trouble?". I suppose is another way of saying what are my responsibilities at law.

You are really talking about the basic principles of civil negligence or professional negligence if you want to call it that.
I am sure most of you here are well aware that one of the principles you are talking about, is the clear recognition that every health professional in carrying out their job has a duty of care to the patients and clients who come into their care.

What is integral to understanding is that you owe a duty of care and it is not much good in simply saying to people, yes I owe people a duty of care. It really takes you nowhere that statement. What you have to ask yourself and understand is if I owe a duty, at what level do I owe that duty. In other words what is the standard. Because having a duty is one thing. Knowing what the standard is that is expected of you, that is inherent in that duty, is what the whole exercise is all about.

Understanding the standard that the law expects will keep most of us out of trouble. If you understand those legal expectations then you can put in place safe practices, safe clinical practices that will hopefully avoid most of the problems that might come your way.

Clearly a failure to abide by the standard that would be expected of the ordinary reasonable practitioner, in a particular situation, will render you in breach of your duty of care, and obviously if as a result of that, damage follows then somebody is going to be putting their hand out for some dough.

They are the basic legal principles that apply to every doctor, every nurse, every dentist, every lawyer regardless of where you operate. There is a duty, a clear standard that operates, that the law recognises. There is an understanding that if you fall below the standard by doing a particular thing in a particular way, or failing to do something that you clearly should have done; it renders you in breach of that standard that would have been expected. If as a result of that damage it follows, then under the principles prevailing, under the legal system prevailing, people are entitled to be compensated.

Now come back to the question of determination of standards. This is where you get into this arena where you have to accept and understand how do I, how does any lawyer, go about determining the standard of care that a particular doctor or nurse should discharge in carrying out their work.

Let me put to rest, once and for all, the view that the courts somehow set the standards. Judges would have no idea of the standard of clinical expertise that would be expected of a doctor or a nurse or a dentist or whatever. It is not for them to determine the standard. It is for them to ensure that the basic principles are met.

Who do you turn to, to determine standards? Knowing that when the time comes for you to be judged, what the law will do is say look, what we expect of you and what we say that you should have done, is that you should discharged and carried out your work in accordance with the standards that one would have expected of the ordinary reasonable doctor, nurse etc. in that particular situation.

So there is an objective approach but there is also recognition that the particular facts and circumstances of each case must be looked at. This is where the rural and remote areas comes into play. Because the facts and circumstances that prevail in rural and remote areas are clearly quite different, are they not, from the facts and circumstances that prevail in large metropolitan teaching hospitals?

But the basic objective standard is there. Where do you turn? Where would I turn as a lawyer to assume that one of you, a nurse or a doctor – we shall use a doctor to start with – in a remote, (and there is a distinction as I know as already been made in this conference, between rural
and remote). I am not the expert to know where that dividing line is but I do know there are situations where health professionals are clearly in what I call isolated remote situations and those that work in small rural towns, where there are some support services.

Let us assume that we are talking about a doctor in a small rural town and something has occurred. The allegation is that not all that should have been done was done. In other words an allegation of professional negligence. Where do you turn to produce the evidence to show that what you did or failed to do, fell below the standard that would have been expected. Well you turn to your peers don’t you? That is what any good lawyer does. You go and find what is called in the legal jargon the expert witness. You don’t have to be around for too long to know what that means. Anybody who was around during Azaria Chamberlain’s trial – all the in’s and out’s of that would know about expert witnesses. You go and find another doctor or doctors. Find a whole variety of people who will come forward and say, and they are generally considered experts in their field, depending on what the issue is. They will get in the witness box and say yes I have had a look at the facts. I have read all the statements. I have seen the patient records and in my view in this situation X, Y and Z should have been done.

So it is important to understand that it is your peers who judge you. There are a number of other areas that one turns to if you are trying to establish whether somebody has or has not met a particular standard. Not only do you turn to people’s peers and ask them to give their evidence and give their views. You look to obvious other pieces of evidence whether it be patient records. These can be fairly revealing and also fairly damaging in legal situations. Which is all the more reason why it is important that they be very, not only objective, but accurate and complete.

You also go and look at what you might call standard protocols and policies. Whether you like it or not, I have to say to health practitioners and it really doesn’t matter where you are working there has to be accepted standards of practice and protocols in place in certain situations. In other words particularly for nursing staff and I speak with more authority in that area because of my background. There are clearly and should be, written protocols and policies of what to do in certain situations. Whether it be emergency situations or whether there is no other health practitioner available to provide its support or decision making, then certain steps can and should be done.

At the end of the day, and this is where a lot of practitioners in remote areas get into difficulties, is that they push the frontiers, figuratively speaking, in their capacity to make decisions which really in all other circumstances place them in potentially difficult legal situations, which I will highlight for you shortly.

As I have said to nurses particularly. It is all very well to go out there into remote areas and start delivering health care. The day really has come I am afraid where you have to appreciate that there are potential legal liabilities that flow from any mishaps that might occur in the delivery of your services. That goes for doctors as well.

What the courts will more and more turn to is not only the standards of your profession but whether or not there are any written standards so each and every one of you. Whether it is the Royal Australian College of General Practitioners or whether it is the operating theatre nurses, or the remote area nurses. One assumes that they recognise professional standards. Most of those standards, should be, sooner or later, reduced to writing somewhere. We don’t all operate these days with it all in the top of our heads. That sort of documentation also becomes relevant.
You also have to address the question of statutory provisions. You are all aware of course now increasingly that State and Federal Governments, particularly State Governments are very keen at passing inordinate amounts of legislation that effects your work. Whether it be something as trite as your Registration Acts which is very important. Whether it be things like the Poisons Act which makes certain provisions in relation to the dealing with everything from Schedule 1 to Schedule 8 medications and how they can be dealt with or whether you deal with other extraneous pieces of legislation from the Human Tissue Acts to the Medical Practitioners Emergency Medical Treatment Act and so on. This is not trivia time but bear in mind that you cannot sit in ignorance any longer from the suggestion that you are not aware of the plethora of legislation that applies to your work as nurses or doctors. Therefore that brings you of course to the question of how do you address these issues that I am raising from a legitimate professional standing and legitimate professional concern knowing that if you are not aware of the problems that can flow how do you deal with them, knowing the potential legal difficulties that can follow.

It seems to me not so much that we require law reform but what is needed particularly in the rural and remote area situations is a greater recognition on the part of the employers and if you are doctors who are independent contractors that is you're self employed but particularly for those of you who are in situations and it is largely as nurses whether it is clearly an employer. It might be the Department of Health of that particular state, it might be a particular hospital, or a particular community health service. If as doctors you are in some sort of contractual arrangement to provide services then clearly of course there is an employer in that scenario whether you like it or not. In fact you should be grateful for that, because when you have an employer situation at law they, the employers become vicariously liable do they not. In other words they are going to pick up the tab for any monetary amount of damages that might be awarded for negligent acts that are carried out by employees in the course and scope of employment. Whilst that might sound like an ideal way to not pay out the bottom line about all of that is that the employers more than ever before who have a clear responsibility to put in place safe practices for the people they employ. What happens almost invariably in rural and remote areas is that those obligations of the employer to put safe practices and safe standards in place are not there. They are not there for a variety of reasons. Departmental bureaucracies are not prepared to put the money into it. I heard the Minister this morning say, that the only thing that sort of fetters us is our imagination. I will say that the next time I go along to talk to the Department about spending some money. That the only thing that fetters me is my imagination.

The other thing of course that the Minister made reference to as though it was in some way a criticism that sectional groups and their efforts to attract a percentage of the health dollar was in some way distorting this holistic approach to make decisions that were in the best interest of all. Of course the only way in which money is ever going to be diverted into any particular area is that sectional groups such as yourselves clearly lobby for that and lobby actively for your share. I see nothing wrong with that. I think that anybody to suggest that sectional interest groups are going to disappear is obviously living in fantasy land.

Rural and remote area issues are obviously the flavour of the month at the moment. Not only do we have some evidence of Commonwealth interest in this conference but the New South Wales government themselves has now decided it is going to have a conference about rural health in April of this year. My argument is that people, if they want to, as a result of these conferences, stuff money into rural health services who am I to put my hands in the pockets to say that some how or other there is a greater public good, because we want to build a heart transplant unit at Royal North Shore Hospital. Because you have no doubt that your colleagues in the metropolitan areas lobby very vigorously for those things too.
Sectional interest groups are a fact of life and really the only way that any Minister can deal with them is try and balance the competing interests feeling, that is part and parcel of the system.

I shall now outline an incident which some of you would be aware of some may not. If nothing else it highlights the problems that health practitioners in remote and isolated situations encounter. This incident occurred at Wilcannia in 1987. It has had some publicity but not very much because we have been at pains not to have a lot of publicity while it has been going through a whole sporiaty of legal hearings.

It involves a nurse who was on duty at Wilcannia Hospital on night duty. At around 2.10 am on night duty by herself with one other additional untrained wards person. The reason why I am taking the time to go through this is because there has been a lot said and written about this matter and some of it is factually incorrect. It is better that the true facts are being made clear.

This young man was brought to the accident and emergency – well you don’t have an Accident and Emergency Department at Wilcannia Hospital, you just have a hospital. For those who have been to Wilcannia you will know what I am talking about. This young man was brought in by two relatives, certainly a brother and another person. When they arrived at the hospital, the registered nurse who was on alone, they asked once they brought the young man in, if they could then leave. She said yes if you want to leave you can leave, which they did. They were in the Hospital for some two to three minutes. She didn’t question that particular request and she certainly did not suggest that they remain. They seemed anxious to go and she agreed that they could.

The young man was confused, disorientated, wondering around and conscious but very confused and disorientated. They gave a brief history when they brought the young man in that he had been off alcohol for the past two to three days and was clearly suffering some withdrawal effects. He had a previous history of alcohol abuse from which he had been treated some three years prior at an earlier treatment. That was the history they gave and then left.

When they left the young registered nurse, and I might add an English registered nurse, who in her enthusiasm to work in the outback had applied for a job from the paper in the England to work at Wilcannia Hospital. Obviously she had either read *A Town Like Alice* or something like that and it seemed a good idea. Nobody of course bothered to explain to her the difficulties that arise in working in such isolated communities. Her employer did not spend any amount of time by way of orientation at all to introduce that young registered nurse to all of the difficulties inherent in working in such communities, of the problems that she would encounter. Particularly the individual cultural issues and social issues that arise from the large aboriginal community in Wilcannia and she was therefore simply rostered on night duty not long after she arrived to work at Wilcannia Hospital.

There is where I say the system lets you down. There is simply no point in asking people to work in rural and remote situations unless the employer is prepared to spend the money to put in place proper support services, proper orientation and education services and then follow that up with obvious and necessary support at crucial times.

The relatives having left the Hospital the young man was wondering around and he was proving very difficult to try and manage because Wilcannia Hospital being what it is there were a couple of other patients in the Hospital, young babies, children. One of the things the nurse then did, is she went in to make the man a cup of coffee. She left the immediate room
they were in and went to make a cup of coffee with lots of sugar in it. When she came back out, he had disappeared. He had left the hospital grounds.

She was concerned, because as you may know, the Darling River runs not far from the back of the hospital. She rang the local police station and asked could they find him and bring him back to the hospital, which they said they would do.

In the meantime having made that telephone call the young man turned up of his own volition and had in his hand a piece of wood. She said “would you mind leaving that outside” which he did. She then rang the police again to say don’t bother to look for him, he has come back, so it is all right. One of the police officer’s wife answered the phone and said “well they have already left to look for him so you will have to wait until they return.”

The young man then asked the nurse where the toilet was and she directed him to the toilet in the hospital. He took no notice of that. As I said at this time he was still very confused, very disorientated and unable to give any coherent story or history as to why he was there. It was obvious and apparent that he was suffering from the effects of alcohol withdrawal, given the very brief history that the relatives had given, given his previous history. To all intense purposes he was to use the expression that was then used in the telephone conversation with the Royal Flying Doctor “in the dings”.

Instead of going to the toilet, he went outside again and wandered off and didn’t say where he was going. The nurse then rang the Director of Nursing of the hospital and sort of advised her that if anything, she was having a management problem. She was there by herself, she had some sick children, the hospital is not very big and she was worried about him. She didn’t really know what to do.

After she had the conversation with the Director of Nursing the police officers arrived and they had found the young man wondering up the street. They had put him in the back of the van and they brought him back to the hospital. They left him in the back of the van. They didn’t bring him into the hospital. They came in and said “we have found him, we have him in the back of the van”. What do you want us to do? She said “well I am not sure, I’ll ring the Royal Flying Doctor in Broken Hill”, which she did. She spoke to the doctor over the telephone and advised him that she had this young man and the expression “in the dings” was used and it was obviously understood, at least that seems to be the suggestion, understood as to what that expression meant. She wanted to know what to do with him as she was worried about the other patients particularly the young children, as he was wondering around the hospital and was concerned he might wonder off and come to some harm permanently.

The doctor at the other end of the phone said “check his blood sugar and see if it is all right”. The police had then raised the suggestion that if it was a management problem as to what to do with the young man, that they could take him down to the police station and let him sleep down there.

The registered nurse advised the Royal Flying Doctor, that this is what had been suggested and asked him what he thought. He said “well if his blood sugar is all right, you may let him go with the police and he can sleep at the police station”.

She took the young man’s blood sugar which was normal and the police then took him off and put him to bed at one of the cells at the police station. They rang her as she had asked them to do from the police station at about 3.00 am. I might add all these events took place in about 20 minutes. They said they had put him to bed, he was in the cell and he was asleep.
That was the end of the situation until the next morning at 8.30 when she was going off duty she called in at the police station to see how he was and she was told that in the interval between 3.00 am and 8.30 am he had hung himself in his cell. That is a tragic situation, a tragic end and a tragic story.

The point of course is it is important to look at the consequences that flowed from that for that particular nurse. If nothing else it highlights what I have already said, that it is not law reform you need in relation to rural and remote areas as far as your legal responsibilities. It is a recognition of the authorities who are responsible for delivering rural and remote health services to recognise the very difficult situations that they put health professionals in and provide absolutely no support services by way of orientation, ongoing education, peer support and so on.

What happened following that. Naturally of course, given the circumstances of the young man’s death it was necessary to have a coroner’s inquest. I might add, every man and his dog came out of the woodwork for that coroner’s inquest. It is hard to imagine that there were 8 barristers in Wilcannia Court House for a coroner’s inquest. There is the barrister representing the hospital, barrister representing the nurse, barrister representing the doctor, barrister representing the aboriginal legal aid, barrister representing a whole variety of vested interests and barrister representing the crown.

The end result of that coroner’s inquest, which was really to determine the manner and cause of death and there was no dispute about the manner of cause of death, but certain allegations flowed. There were allegations that the nurse had not properly diagnosed the man’s problem and therefore in not properly diagnosing she should not have allowed the young man to be taken off by the police and put in the situation that led to his death.

There were certainly allegations from the aboriginal legal aid that this would not have happened if the young man had been european and it was only as a result of his aboriginality that he was treated this way.

There were allegations of course in relation to the police and allegations in relation to the doctor.

I will concentrate on the question in relation to the doctor and the nurse. The outcome of the coroner’s hearing was that the so called papers in the matter were referred to both the Medical Registration Board and the Nurses Registration Board for disciplinary proceedings to be instituted against the nurse and the doctor. There were no other steps taken I might add to in any way criticise the hospital, to criticise the authorities, to look at the whole system in some objective way and say it was really the system that let people down.

I don’t point the bone at any particular aspect of it. I am simply saying, trying to get people to put money into rural and remote health services is very difficult. The people who make decisions about where to spend money in our health services see more cutous into heart transplant units, IVF programs and so on. There is no kudos in putting money into preventive health services in this country because the people who are making the decisions and the politicians who go along, they get much greater joy about opening a cardiac heart transplant unit then they do about putting ongoing education programs into rural and remote centres.

What happened to both of those health practitioners. The doctor appeared before the disciplinary committee of the Medical Registration Board. He was reprimanded and as I understand is now probably for his own sake and others, moved to another state to practice.
The nurse appeared before the disciplinary committee of the Nurses Registration Board and was struck off the Register for professional misconduct. That decision might I say has opened enormous outcry and continues to do so. Because of all of the people involved whether it be the hospital, hospital administrators, the Department of Health responsible for administering the hospital, the police and so on. Only one of those people was singled out. Two in a way, but one got off, one could say, more lightly then the other. The doctor was reprimanded, the nurse de-registered.

What has happened, I might add, that particular death also became the subject of hearings before the Royal Commission into Aboriginal Deaths in Custody.

You can see the legal consequences that are flowing from this one incident that took place in a space of 20 minutes at Wilcannia Hospital. What was brought into play was the professional sort of standards that you would expect from a nurse working in remote areas.

Naturally of course the Nurses Registration Board took heed of nurse academics who quite happily leapt into the witness box and said yes of course there were a variety of rather extraneous measures that should have been taken that would have avoided the situation. No account was taken, and this is what I said to you earlier of the very difficult circumstances, the very special and particular circumstances that people working in these situations have encountered.

I might add since that time, the NSW Nurses Association appealed against the decision of the Nurses Registration Board. In the meantime we had to injunct the Nurses Registration Board to prevent them from cancelling the registration of that young nurse and the matter is now being heard on appeal in the Supreme Court in Sydney for the past week.

If you wanted to tote up the legal expenses that have flowed from that one incident you are probably looking at over $2 million. You are talking about the initial coroner's inquest, the Royal Commission, the appearances before the various registration authorities, the appeal proceedings and all the interlocutory matters that have flowed. All the expert witnesses that were flown from all over Australia as far afield as Broome to talk about remote and isolated areas and so on.

That will give you some idea, and I can't do it any more graphically, to demonstrate to you just how legally vulnerable you can be in these situations. It is of great concern certainly from my perspective that what you have to do is learn to be smart about how you go about your job. Do not put yourself in potentially difficult, legally dangerous situations.

Particularly in relation to nurses, very often they diagnose, they treat and are often surrogate doctors in some situations and I have said to them it is potentially legally dangerous position to put themselves in. It might be a great idea. It might be the very best they can do but legally it is very dangerous. I can assure you when something goes wrong and you ask the employer to support the stand and the role of the nurses discharging there is no support. As I have said if you are going to go out into these remote and rural areas and work you have to go out sure to the extent that your employer, that there are written protocols and written guidelines. There is one clear thing that you must lobby for out of this conference is education and with education will come a better understanding, better appreciation and better protection for each and everyone of you legally. You don't need to change the law you need to change the attitudes and you need to get money spent where it is important to be spent to protect yourselves in these very vulnerable situations.

I might add that quite apart from those sorts of situations there have also been and it is just
As well that I state my position here, that in relation to New South Wales there has been ongoing discussions between the Rural Doctors Association and the NSW Department of Health about the utilisation of Accident and Emergency Centres by patients in small rural communities after hours. It has been the view of the Department of Health that the local community who generally tend to use Accident and Emergency Centres as GP dropping clinics that they should be as it were "encouraged not to do so". In other words they should go down to see their local GP in their local waiting rooms and the reason for that is because every time they come up to the accident and emergency centre there is a cost involved to the Department because, if the doctor then comes there is a charge made.

The doctors of course, some of them are not unhappy for that to occur, for patients in the community to use Accident and Emergency Centres as GP dropping clinics. From a financial perspective they see it as not a bad thing, some of them. From a convenience point of point it is also not a bad thing. The problem of course arises is to who gets caught as the ham in the sandwich as to having to make the difficult decisions of who to keep and who to turn away. Oh "we let the nurses do that" they say. The doctors say that and the Department says that. Well that is not good enough. Once again you are asking nursing staff to be the ones to make the initial clinical assessment of which ones to keep and which ones to send away. My advice to nurses and to hospitals who ask as to what policy they should put in place, as I said you keep the lot and you ring the doctor. You say "come up here mate" right, "we have a room full of people just begging to see you" right and I'm not going to go into the position of saying "you, you've only got a headache, you can go home. You can go see your doctor tomorrow". You "you've got a sore toe, you can stay". You "know". Because you can be sure of one thing, the person with the headache that you send home, or be it the one with the bleeding cerebral aneurism that probably drops dead about 500 metres down the road. Where does that leave people. There is absolutely nothing put in place to protect that sort of decision making that nurses are being asked to discharge. As I say to nurses "don't do it". I don't give a stuff if there is a bun fight between the Rural Doctors and the Department. It is not your bun fight. If they want to have a bun fight about how much money they get paid or whether they should or should not come to the hospital, that's one issue but don't you be expected to take the spin off of that which is you be the one to decide who shall and shall not get treated. It is an irony you know that it is the level of responsibility that nurses are expected to discharge one would think that they are autonomous health practitioners. They are of course but they are never given the cuteos for that when something goes wrong. They are then expected to "why didn't you follow the doctor's directions?" "why didn't you consult with somebody if you made that decision". So on one hand there is this autonomous health practitioner role and on the other there is the recognition that they must always follow somebody else's directions and you can't have it both ways. There is no doubt there is a role for independent health practitioners and some of you maybe aware that in the 1970's indeed in Wilcannia for those of you familiar with Ian Webster the Professor of Community Health at the University of New South Wales and some of his work in the area of drug and alcohol will know that, I think it was in 1977, a project known as the Arid Zone Project commenced in Wilcannia and that was designed to study the quality and effectiveness of community health services delivered to the aboriginal communities. There was a lot of money going to be spent and the town was going to get a doctor. There was going to be a very good program put in place because what was said is that the primary objective of the project was to devise a training program for nurse practitioners and to evaluate the effectiveness of such program. The study that had been done said that there is no doubt whatever in my mind that an appropriately educated and experienced nurse practitioner or more family practised nurse with the backing of understanding medical practitioners and aboriginal health workers could offer a far more effective health service to the people of Wilcannia then they have at the present time. You may be interested to know that in 1979 the dough ran out. This great idea that got off the ground in 1977, the plug got pulled on it in 1979 on a funding basis and nothing
has changed, nothing has occurred. Therefore the tragic situation that occurred in 1987 with that young man, these sorts of incidents will continue to occur until, and all the legal consequences that flow, until the question, the proper issue is addressed and that is proper education, proper training, proper understanding of the issues relating to rural and remote health services and I mean everybody, doctors, nurses the lot. The proper ongoing backup services are provided and that means the money has got to be found and the support has got to be there. Because if that is not done then each and every one of you who work in rural and remote situations are going to be placed in ever increasing difficult positions because you can be sure of one thing medico-legal litigation is not declining. Medico-legal litigation is on the increase and more and more people will question, more and more people will challenge and more and more people, as it were take you on and if you are found wanting then unfortunately you have to rely on your own resources to get yourself out of that.

As I said it is not law reform you want here, it is a recognition by the authorities that you are all in potentially vulnerable legal situations and that has to be addressed in a positive way.