

Legal and Ethical Principles

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INTRODUCTION

Legal and ethical issues/dilemmas are abundant in healthcare practice and it is therefore important that nurses understand the law, ethical theory and professional guidance in order to be able to account for their practice. The law and ethical principles underpin all aspects of health care; therefore, as a member of the healthcare team, one needs to have an awareness of the legal and ethical issues that impact on healthcare professionals when undertaking and recording patients' vital signs. The legal, professional and ethical principles discussed throughout this chapter relate to adult patients only. All healthcare professionals taking responsibility for treating a patient thereby owe that patient a duty of care (Fullbrook, 2007a; NMC, 2008). The concept of 'duty of care' was introduced in *Donoghue v Stevenson* (1932) AC562 and Lord Atkin introduced the 'neighbour principle'.

You must take reasonable care to avoid acts or omissions that you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question

(Dimond, 2008, p. 40).

LEARNING OUTCOMES

By the end of this chapter, you will be able to discuss the following:

- ☐ The legal system in England and Wales
- ☐ Ethical principles

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Joyce Smith and Rachel Roberts.

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- ☐ Professional regulation
- ☐ Consent
- ☐ Dignity and respect
- ☐ Equality and diversity

THE LEGAL SYSTEM IN ENGLAND AND WALES

The law, ethical principles and regulation by professional bodies underpin all aspects of health care. As a result of devolution in 1998, Scotland and Northern Ireland have their own healthcare legislation. The English and Welsh legal system is separated into three individual elements – the legislature, the executive and the judiciary. Legislation is the law passed by Parliament, which consists of the House of Commons, the House of Lords and the Sovereign (Queen). The laws made by the parliament cannot be changed by the executive or the judiciary. The executive consists of the police and local authorities; you may have read about cases that challenge local authorities when patients are unable to obtain the specialist drugs that they need. For example, women living in Wales who were diagnosed with early stages of breast cancer received Herceptin, but women in England had to pay for the drug because their primary care trust would not fund the treatment. Thus a 'post code lottery' that was dependent on which part of the country you lived in had consequences for women with early-stage breast cancer (Hendrick, 2004). The judiciary consists of judges who are independent from the government and parliament; however, they direct the interpretation of the law and must abide by the laws introduced by the parliament. All three systems work closely together to protect the public and ensure that the law is enforced (Boylan-Kemp, 2009).

There are two main sources of law that relate to England and Wales. They are Statute Law (Acts of Parliament), also European Law that is an integral part of the law in the United Kingdom, and Common Law (decisions made by judges based on previous cases) (Dimond, 2008, Montgomery 2003).

Statute Law (Acts of Parliament). The government, through the parliament, introduces a statute (Bill) or Act that is debated in both houses and approved by the sovereign. Examples of an Act passed by the parliament include the National Health Service



Act of (1946) that came into effect from the 5 July 1948, Data Protection Act (1998) and the Mental Capacity Act (2005).

Criminal law (criminal proceedings). These are usually brought by the state – for example in 1993, nurse Beverley Allitt was charged for murder and attempted murder on a children's ward; in January 2000, Dr. Harold Shipman, a general practitioner, was convicted on 15 counts of murder and the majority of his patients were aged over 65; and in 2008 Nurse Colin Norris was convicted of murdering four orthopaedic patients – all three were convicted in the Criminal Court (Ford, 2008).

Common law. Principles have been laid down by judges based on the doctrine of judicial precedent. Therefore, where a decision has been made, the principles of the decision shall be followed in later cases. In health care, a lawsuit regarding negligence will be judged under common law (Tingle and Cribb, 2007). For negligence to occur, the practitioner would have to deviate from a duty of care and so cause harm to the patient.

Civil law. A *civil action* is brought by an individual who sues another individual to obtain redress, usually in the form of damages and therefore may not be a crime. Any patient who is touched without their consent may pursue their action in the civil court as a tort of battery. The burden of proof in civil law is on the balance of probability with three conditions being satisfied. The first is that the practitioner was under a duty of care to the patient, a breach of that duty has occurred and as a result of this breach, harm has been caused to the patient (Pattinson, 2009).

ETHICAL PRINCIPLES

Throughout our lives, we not only abide by the law but we are also influenced by our morals, beliefs and attitudes. 'The word "ethics" comes from the Greek *ethos*, meaning character. "Morals" come from the Latin word *moralis*, meaning custom or manner – both words mean custom' and may be used interchangeably (Tschudin, 2003, p. 45). One definition suggests, 'Ethics is concerned with the study and practice of what is good and right for human being' (Thompson et al., 2000, p. 5).

Our morals may be influenced by our culture, religion or our upbringing. In health care, you may experience situations or decisions that you feel are morally right or wrong. Morals are based



on our own beliefs and values; however, we have to respect that not everyone will have the same beliefs or values. To try to address the issues that may arise in health care, two philosophers, Beauchamp and Childress (2008), introduced a framework of four moral principles.

- **Respect for autonomy.** Respect for the right of individuals to make their own decisions according to their own values and goals. Therefore, we must respect our patients' rights to make their own decisions regarding any treatment or care.
- **Non-maleficence.** Obligation to do no harm. In all aspects of our care delivery, we must not intentionally cause our patients harm.
- **Beneficence.** Act in ways that promote the well-being of others. Always act in the best interest of our patients when delivering care.
- **Justice.** Treat others fairly. We must not be judgemental or discriminate our patients in relation to race, culture or disability. Every patient is treated equally with compassion, respect and dignity. Societal expectations are that everyone has an equal status in the allocation of healthcare resources. However, increasing costs and limited resources raise ethical issues and dilemmas related to health care.

In all aspects of our daily activities in practice, we may encounter ethical dilemmas when caring for our patients. An understanding of the law, ethical principles and professional regulation is necessary as it underpins our clinical decision making, including any actions taken. If you fail to deliver appropriate care for a patient, the legal and ethical principles are the same. Legally, if you are negligent you are responsible; ethically, you are also morally to blame for failing to take the necessary precautions to protect the patient when delivering care (Tingle and Cribb, 2007). In 2004–2005, there was more than '£500 million paid out by the NHS in clinical negligence claims' (Coombes, 2006, p. 18). As healthcare professionals, we have a legal, ethical and professional duty – not to cause harm to our patients who trust that we are competent practitioners (NMC, 2008).



PROFESSIONAL REGULATION

The Nursing and Midwifery Council (NMC) is responsible for the regulation of all registered nurses within the United Kingdom but ultimately its aim is to protect the public (NMC, 2008). To protect the public and ensure that registered nurses are fit to practise, the NMC has introduced mandatory policies, standards and professional guidelines for all registered nurses. *The Code* (2008) outlines the legal and ethical responsibilities and accountability of the registered nurse. If a registered nurse delegates to a member of the team who is not on the NMC register, he or she is held accountable for that delegation. Therefore, a registered nurse must ensure that the person to whom they delegate the task (e.g. taking and recording the patient's vital signs) has undertaken relevant training and been assessed as competent. The regulation of healthcare support workers has not yet been decided (DH, 2004). However, healthcare workers employed within primary and secondary trusts have been included within the Knowledge and Skills Framework and undergo mandatory training including the opportunity to access further education through National and Vocational Qualifications (NVQ) (RCN, 2007).

Equally, if the person undertaking the task fails to perform the task to the level at which they have been assessed as competent, then they are personally accountable in law (Storey, 2002). Consequently, the unqualified healthcare worker who delivers care to the patient is also responsible and accountable for his or her actions, while the registered nurse retains professional accountability. The NMC has a statutory obligation to regulate and monitor registered nurses and any complaints regarding a nurse's fitness to practise are investigated. The NMC Fitness to Practise Panel has the power to apply a caution order for 1–5 years, conditions of practice order for 1–3 years, suspension order for up to 1 year and to remove registered nurses from the register with no application to restore their registration before 5 years from when the order became effective (NMC, 2009).

Responsibility and accountability

Responsibility is a term that is used when you are responsible for your day-to-day actions and role responsibility is related to your



contract of employment. It is important that you are aware of your responsibilities and accountability when you are delivering patient care. All healthcare professionals who are responsible for patients have a duty of care. A breach of duty is judged on whether an action or inaction has resulted in negligence. In *Bolam v Friern Hospital Management Committee* (1957) 1WLR 562, a doctor failed to inform a patient of all the risks associated with undergoing electroconvulsive therapy. The patient allegedly claimed that the doctor had not informed him of the risk of a fracture; also, he had not received relaxant drugs or been physically restrained during the procedure and therefore he stated that the doctor's management was negligent. Medical opinion was divided and there was no clear consensus on the treatment of patients undergoing electroconvulsive therapy. A decision was made by the judge to direct the jury 'that a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art'. The doctor was, therefore, not guilty of negligence as he had acted in accordance with accepted practice by the medical profession. The judgement indicates that a healthcare professional is judged on what is agreed as an acceptable level based on current practice, guidelines and policies.

All healthcare professionals are held accountable in both the criminal and civil courts and by their professional body. Therefore, healthcare professionals may be found guilty of a criminal offence against a patient in the same way as any member of the general public. If a healthcare professional is charged with gross negligence leading to a patient's death, they will be held accountable in a criminal court. For example, in *Misra and Srivastava* (2005) 1CRAPP R21, two senior house officers were charged with gross negligence and convicted of manslaughter over the mismanagement of a man aged 31 who died of toxic shock syndrome following a routine knee operation (McHale and Fox, 2007; Huxley-Binns, 2009). The Court of Appeal held that the jury had been correctly directed that the negligent breach of duty had exposed the deceased to the risk of death. It was also highlighted during the court case that both doctors failed to recognise the significance of the patient's deteriorating vital signs.



As an employee, you have a contract of employment, and your employer is vicariously liable for your acts or omissions under common law. The legal principle of vicarious liability holds one person (the employer) liable for the actions of another (the employee) (Griffith and Tengnah, 2008). All healthcare professionals are therefore accountable to their employer and must abide by their contract of employment. If you do not practise within the employer's policies and guidelines, you will be held accountable for your actions. The employer is not legally liable if the employee has not adhered to their policies and clinical guidelines (Tingle and McHale, 2009).

Competence

How do you know that you are competent to perform a skill? To be considered in law as competent, you must have undertaken a training programme provided by your employer or higher education institution as part of your nurse training and been assessed as competent. Huxley-Binns (2009) cautions that nurses are at risk if they treat a patient and know that they have not been trained to carry out the treatment; this will result in a breach of their NMC 'Code'. In 1999, the government imposed a legal duty on NHS organisations to ensure that standards of quality patient care and best practice are evident within the trust (DH, 1999; DH, 2000). Clinical Governance was implemented to provide a framework within all acute NHS trusts to minimise risks and monitor clinical quality. In October 2008, the Department of Health carried out a national consultation on safeguarding adults from abuse and harm; 'Safeguarding Adults', a review of the 'No secrets' guidance was introduced in 2000. A key finding was that there was no adult safeguarding system in place within the NHS. From 2010 Safeguarding Adults is to be an integral part of Clinical Governance systems within the NHS (DH, 2010b).

An essential component of Clinical Governance is to ensure that policies, guidelines and training are available for all healthcare workers, thereby reiterating that education and training are integral in the development of a competent workforce. However, if following a training programme, you still feel you need further supervision and do not consider that you are competent, you have a legal and professional responsibility to inform the person who has delegated the task.



1 Vital Signs for Nurses

Practice point 1.1

It is a very busy morning on the ward and two members of the nursing team have telephoned the ward to say that they are sick. The staff nurse is trying to prepare for the consultant's ward round and telephones the on-call manager to request more staff. The staff nurse asks you to take blood from a patient who has just been admitted from outpatient's clinic. Although you have attended a venepuncture course, you have not completed the supervised number of blood samples that the Trust policy has stated you must complete to be signed off as competent.

- Q1. What would you do in this situation?
- Q2. Who is responsible and who is accountable for your actions?

Mental Capacity Act 2005

Within your area of practice, you may meet vulnerable adults who do not have the capacity to make their own decisions. Demographic studies predict that there will be 870 000 people with dementia by 2010 and this is expected to rise to 1.8 million by the year 2050 (Alzheimer's Society, 2006). Any patient who has been diagnosed with dementia may vary in his or her ability to consent to treatment. Patients who have had a cerebral vascular accident (CVA) or have suffered a traumatic brain injury may also be vulnerable. Patients may find it difficult to understand the information that you are providing and therefore unable to give informed consent. A lack of capacity to consent may be permanent or temporary – for example, a patient may be confused because of an infection or unconscious following surgery and therefore unable to consent (Nazarko, 2008). To protect vulnerable adults, the government has introduced the Mental Capacity Act (2005) for England and Wales that came into force in 2007. The aim of the Act is to ensure best practice, based on the principles of common law, and it consists of five key principles (Mental Capacity Act, 2005):

1. **A presumption of capacity.** Every adult has the right to make his or her own decisions and must be assumed to have the capacity to do so unless it is proved otherwise.



2. **Individuals being supported to make their own decisions.** Persons must be given all practicable help before anyone treats them as not being able to make their own decisions.
3. **Unwise decisions.** Just because individuals make what might be seen as an unwise decision, they should not be treated as lacking the capacity to make that decision.
4. **Best interests.** An act done or decision made under the Act for or on behalf of a person who lacks the capacity must be done in his or her best interests.
5. **Less restrictive option.** Anything done for or on behalf of a person who lacks the capacity should consider options that are less restrictive of his or her basic rights and freedoms if the options are as effective as the proposed option.

The Mental Capacity Act enables a patient to appoint another person who may be a relative, friend or colleague to be his or her lasting power of attorney (LPA) and have the power to act on his or her behalf in relation to care and treatment decisions (Dimond 2007c). The patient must have the mental capacity to set up the LPA, which only comes into effect once the patient no longer has the mental capacity to make his or her own decisions. A new development outlined in the Act is the office of Public Guardian that has been created to keep a register of LPA. Equally, if the patient has no relatives and does not have the mental capacity to make a decision in special situations, an advocate must be contacted. The special situations that apply include *serious medical treatment, accommodation arrangements by the NHS and accommodation arrangements by the local authorities*. NHS organisations and local authorities are required to appoint an Independent Mental Capacity Advocate (IMCA) to be available when special situations occur, to make decisions on behalf of those who do not have the mental capacity (Mental Capacity Act, 2005). The government has also produced a Code of Practice (DH, 2007) in line with the Mental Capacity Act that explains how to identify when a person is at risk of being deprived of his or her liberty. It is a legal duty to have due regard for the Code of Practice and any decisions by healthcare professionals regarding the patient's mental capacity and the appropriate steps involved in



the decision-making process must be clearly documented in the patient's records.

CONSENT

It is a legal and ethical principle that valid consent must be obtained before treating, investigating or providing personal care for patients (DH, 2001). The Mental Capacity Act (2005) assumes that a person over 16 years of age has the capacity to make his or her own decisions regarding his or her care and treatment. For consent to be valid, it must be given by a patient who is mentally competent (Dimond, 2007a). There are three requirements for valid consent, that the patient has the capacity to consent, voluntarily consents and has the relevant information prior to consenting. Valid consent must be obtained without pressure or deception (DH, 2009). In *Freeman v Home Office* (1984), Mr Freeman was a prisoner who alleged that he had forcibly been given drugs against his will, thus claiming that he had not given valid consent because the prison medical officer administering the drug had disciplinary authority over him and consequently he could not make a free choice. According to the law, the burden of proving absence of consent is on the claimant (patient). The Court of Appeal refused to accept his claim agreeing with the original verdict by the High Court judge: that the claim of coercion was rejected and ruled that the plaintiff had consented because he had been informed of the purpose of the treatment (Dimond, 2008; Pattinson, 2009).

According to the law, patients who are mentally competent have the right to refuse treatment. Equally, a patient must be able to decide to either consent or refuse treatment without pressure. To determine capacity, principles of common law provide legal direction – for example, in *Re T* (adult: refusal of medical treatment) (1993), T was rushed to hospital because of a road traffic accident, and following a discussion with her mother who was a Jehovah's Witness, T stated that she did not wish to have a blood transfusion. Following a Caesarean section, T was unconscious and haemorrhaged; although the medical profession felt they could not lawfully disregard her wishes, an appeal to the courts was initiated by her father and boyfriend. The court ruled that T should



receive a blood transfusion (Whitcher, 2008; Pattinson, 2009). Lord Donaldson, the judge, noted that a special problem may arise if at the time of the decision the patient has been influenced by a close relationship. In his judgement, the patient's refusal was not therefore valid because of the influence of her mother. All healthcare professionals have a legal and ethical duty to respect patient autonomy; however, the cases presented highlight that consent may at times be a complex process (Dimond, 2007b, 2008; NMC, 2008). If a patient refuses the care you offer, the refusal must be clearly documented in the patient's care plan. The law also states that a person under mental health legislation is not necessarily unable to make a judgement in relation to his or her capacity to consent. In *Re C* [adult: refusal of treatment] (1994), a man in Broadmoor Hospital refused to have his gangrenous left leg removed. The doctors assumed that he was incapable of making a decision as he had been detained under the mental health legislation. However, the court took an alternative view as the judge was satisfied that he had passed a three-stage test – *firstly*, that he had comprehended and retained the information, *secondly*, believed the information and *thirdly*, made a clear decision after weighing his choices (Dimond, 2008). The law also states that the patient's previous wishes and feelings, if known, must also be taken into consideration including any written information. The patient's age, behaviour or appearance must not influence the decisions made in acting in the patient's best interest. The Department of Health (2009) recognises that partial consent may be given by the patient – for example, a patient may consent to a procedure but withdraw consent for certain aspects of that procedure. Therefore, a patient may give consent to undertake any tests that may confirm a diagnosis; however, he or she may, when advised of the treatment, decide to withhold consent to the treatment.

It is important that you gain the consent of the patient before you commence any procedures; an explanation of what you are going to do and the reasons must be discussed with the patient before you continue. There are several ways that a patient may give consent – patients may put consent in writing or consent verbally. Implied consent (non-verbal) may be expressed by visual observation of the patient's facial expressions or body language;



for example, this may involve the patient extending an arm for you to take their blood pressure or to provide a blood sample (Bourne, 2008; Dimond, 2008). The law recognises that consent for treatment can be in different formats and all are equally valid. However, the Department of Health (2005) recommends that consent for any major investigations should be in writing. This demonstrates that consent has been given and mitigates against a case of trespass.

Any procedure or any aspect of care that is delivered without consent has ethical and legal implications for healthcare professionals as patients have a right in law to take action in the civil court. Touching a patient without consent is called *trespass*, and *assault* is when the patient fears they will be touched against their wishes. Every patient who is mentally competent has a right in law to give consent to anyone touching his or her person (Dimond, 2007a, 2008).

Written consent is judged by the law to be the best and is the preferred method for patients who are having procedures undertaken that may carry any kind of risks – for example, prior to an operation. The Department of Health in 2001 has produced guidance on consent to examination and treatment that you can access from the website: www.doh.gov.uk.

Word of mouth is valid but may be more difficult to prove in a court of law and may result in one person's word against another. On a day-to-day basis, word of mouth will possibly be an important part of how you gain consent from the patient as part of his or her daily care.

Implied consent is when the patient does not verbally give consent. A patient may roll up the sleeve or put the arm out, ready for the blood pressure check and it is clear that the patient is giving consent to proceed (Bourne, 2008). Often, we care for patients who do not speak English and are from multicultural backgrounds. Therefore, it is very important that they are fully informed of any procedures in order to give consent. Several trusts now employ interpreters who translate for the patient; if there are no interpreters based at the trust, there is often a list of interpreters who can be telephoned to provide support for the patient and healthcare staff.

Practice point 1.2

Take time out to consider how a patient gives consent to any intervention or procedure. Make notes in the box below.

Consent	Verbal	Implied	Written
Vital signs			
Bed bath			
Venepuncture			
Medication			
Urine sample			
Operation/procedure			
Discuss treatment with a relative			
Discuss information over the telephone			

DIGNITY AND RESPECT

Every patient, especially one who is potentially vulnerable, has the right to be treated with respect and dignity (DH, 2001; NMC, 2008). Therefore, all healthcare professionals must treat patients with respect, dignity, listen to their concerns and act on their behalf. The Human Rights Act (HRA, 1998) clearly outlines under articles 3 and 14 respectively that no one shall be subjected to inhuman or degrading treatment or discrimination on the grounds of age,

disability, race, gender, sexual orientation, religion or beliefs. In 2001, the Department of Health introduced the National Service Framework for Older People that emphasised that treating patients with dignity and respect was central to care delivery. At the same time, the government also established the Social Care Institute for Excellence (SCIE) that introduced a guide that respects people's dignity in health care.

The Dignity Challenge

High quality care services that respect people's dignity should:

1. Have a zero tolerance of all forms of abuse.
2. Support people with the same respect you would want for yourself or a member of your family.
3. Treat each person as an individual by offering a personalised service.
4. Enable people to maintain the maximum possible level of independence, choice and control.
5. Listen and support people to express their needs and wants.
6. Respect people's right to privacy.
7. Ensure people feel able to complain without fear of retribution.
8. Engage with family members and carers as care partners.
9. Assist people to maintain confidence and a positive self-esteem.
10. Act to alleviate people's loneliness and isolation.

(SCIE, 2008)

The Essence of Care benchmarks devised by the Modernisation Agency (2003) and updated in 2010 are benchmarks that compare and develop practice that is patient focused in line with best practice (DH, 2003a; DH, 2010a). Treating patients with dignity and respect is included as an essential benchmark. The Royal College of Nursing (RCN) initiated a national campaign for dignity in health care and advocated that all nurses should display respect, compassion and sensitivity; these represent the three characteristics of dignity when caring for patients (Waters, 2008). The NMC has provided guidance on patient dignity and care that relates to both hospital and community settings. Although the guidance is intended for nurses and midwives, the principles are applicable to anyone receiving health care irrespective of their age and should be utilised as a benchmark for principles of care delivery by all members of the multidisciplinary team (NMC, 2009).

**Equality and diversity**

On the 8 April 2010, the Equality Bill became the Equality Act (2010), addressing key areas in regard to socio-economic inequalities. The Act outlines seven protected characteristics that include age, disability, race, gender reassignment, religion or belief, sex or sexual orientation. All seven characteristics are integral to healthcare practice. Equality and diversity is an ethical principle of treating patients equally and respecting the diversity of their culture and beliefs. The NMC (2009) outlines equality and diversity principles as a personal commitment to provide care in a non-discriminatory, non-judgemental and respectful way. Equality is about valuing each individual and recognising that we all come from different cultures and backgrounds.

Practice point 1.3

John is 18 years old and has been admitted from the Accident and Emergency (A&E) department to your ward following a suspected drug overdose. The staff nurse from A&E informs you that they have contacted John's parents. You are taking John's blood pressure when he confides in you that he was at his cousin's party and has taken drugs, but that he does not wish his mum and dad to know. He asks you not to mention to his parents that he has taken drugs or that his cousin was involved when they visit.

- Q1. What are your legal and professional obligations to John?
Q2. What ethical issues do you think may emerge from this situation?

Confidentiality

Confidentiality is a legal and ethical principle as the personal data of patients must remain confidential. However, there are exceptions to breach of confidentiality – for example, in *W v Egdell* (1990), Dr Egdell was instructed by solicitors representing a patient detained in a special hospital to provide a report for the patient's application to a mental health review tribunal. The doctor disagreed with the patient's resident medical officer and felt the patient represented a risk to the public. The patient's lawyers withdrew



his report and it was not disclosed. However, Dr EgdeU had grave concerns and made the report available for the hospital authority without the patient's consent. The patient's lawyers tried to restrain the report but the judge decided that the public interest in disclosure overrode the patient's right to confidentiality. The NMC 'Code' clearly states that you must only disclose information if you consider that someone may be at risk or harm and in accordance with the law (NMC, 2008).

As technology evolves and the number of patients requiring health care increases, there is a move away from the traditional method of paper case notes to electronic records. As a direct result of concerns regarding electronic data and maintaining patient confidentiality, the Government in 1997 appointed Dame Fiona Caldicott to review how confidential information is stored within the NHS. The Caldicott committee recommended the establishment of a network of Caldicott Guardians throughout the NHS. A senior person within the Health Organisation should be nominated as a Caldicott Guardian and the role was implemented in 1999 (DH, 1998; Fullbrook, 2007b). In 2003, following public consultation, the Department of Health (2003b) produced the NHS Code of Practice that relates to the consent and confidentiality of health records and includes the principles of the Caldicott report, the Data Protection Act and Human Rights Legislation. In 2006, the Department of Health published the 'Caldicott Guardian Manual'; the manual includes a set of principles and the fourth principle states that access to a patient's personal data should be on a strict need-to-know basis (DH, 2006). Confidentiality, therefore, comes under the umbrella of common law; there is a legal and also ethical obligation for everyone employed in health care to protect the patient's confidentiality (DH, 2003b).

CONCLUSION

In this chapter, the legal system that applies to England and Wales has been briefly discussed; thus it is important that you gain an understanding of the legal system in whichever country you practice (NMC, 2008). Ethical and professional issues related to patient care including the responsibility and accountability of healthcare workers in gaining the patient's consent have been



identified as essential. It is also an important legal and professional requirement that you are competent in all aspects of the care you provide. Every patient has a legal and ethical right to be treated with respect and dignity including the right to refuse or consent to any procedure or treatment. Dimond (2008) succinctly states that nurses have a personal responsibility to stay updated on legal principles. An understanding of the legal, professional and ethical principles will therefore be invaluable throughout your career as the patient must always be at the centre of our decision making and care delivery.

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