

Legal accountability in general practice

Chris Cox

As the roles and responsibilities of healthcare professionals working in primary care continue to change, it is important to consider legal accountability, especially as the number of clinical negligence claims continue to rise. Recent highly publicised events, such as that in the Mid Staffordshire NHS Trust, have brought medico-legal issues to the forefront of many healthcare professionals' minds. However, there is often a great deal of uncertainty about legal accountability. This article aims to clearly describe the "duty of care" that the law imposes on all healthcare professionals, as well as to provide an overview of vicarious liability and indemnity insurance.

Healthcare professionals' roles and responsibilities are constantly changing in response to increasing demands, enhanced educational opportunities and new developments in technology. As these roles and responsibilities alter, issues of risk management and legal accountability inevitably arise. Given the growth in clinical negligence claims, widespread publicity about alleged poor care and new potential criminal offences and civil wrongs in health care, it is natural for practitioners, especially those working in primary care, to ask themselves a number of questions:

- When things go wrong, who will be held responsible by a court?
 - Is it legal for me, a registered nurse or GP, to be doing this?
 - Do I retain any accountability even though I have properly delegated the task to another?
 - Will I need separate insurance or some indemnity arrangement for an expanded role?
- Typically, these are the questions raised

by practitioners, their colleagues and their managers in a perpetually moving healthcare environment. This uncertainty still reflects, in my experience, an educational gap around the legal principles underpinning the delivery of health care. Yet in reality, the answers to the above questions are reasonably straightforward.

First, the law generally does not prescribe who may perform a particular healthcare task, or role. There are, of course, exceptions, but they are limited. Under the mental health legislation, for example, only doctors are empowered to perform certain compulsory mental healthcare procedures. In general, however, the above rule applies to the vast majority of healthcare interventions.

Even if the law is not prescriptive in identifying who may do what in healthcare, it does nevertheless provide a regulatory framework as to how that care should be delivered in practice. This is realised through the ordinary principles of civil (common) law, known as the Law of Tort and, in particular, the Law of Negligence (Mason and Laurie, 2010); in Scotland, this is known

Citation: Cox C (2016) Legal accountability in general practice. *Diabetes & Primary Care* 18: 131–4

Article points

1. Every healthcare professional has a duty of care to the people they treat. This is applicable in circumstances where it is "reasonably foreseeable" that the practitioner may cause harm to an individual, whether through their actions or their failure to act.
2. The law says that all people receiving health care have a right to a similar standard of care, regardless of where, when and by whom the care is delivered.
3. A duty of care may be owed by a number of different individuals or bodies to the same person. When an employee was acting "in connection with" their employment when they caused harm to the person, the employer is vicariously liable for his or her actions.

Key words

- Duty of care
- Indemnity
- Legal issues
- Vicarious liability

Author

Chris Cox is Director of Legal Services, Royal College of Nursing.

Page points

1. The law imposes a “duty of care” on a practitioner, whether healthcare support worker, registered nurse, GP or otherwise.
2. Every individual should be entitled to expect a similar standard of care in relation to a particular healthcare intervention, irrespective of where, when and by whom that care is delivered.
3. The legal standard will be judged by that of the “ordinarily competent practitioner” performing that particular task (or role).

as Delictual Liability (Thompson, 2009). Although both criminal and contract law also have some relevance in this respect, in my view neither plays the same significant role as do the ordinary principles of negligence law, and so will not be considered further in this article.

Duty of care

The law imposes a “duty of care” on a practitioner, whether healthcare support worker, registered nurse, GP or otherwise. Duty of care is applicable in circumstances where it is “reasonably foreseeable” that the practitioner may cause harm to an individual, whether through their actions or their failure to act. “Public policy” may occasionally dictate that no duty should arise, notwithstanding the risk or actuality of harm, but you can guarantee that in healthcare once you assume some responsibility for the care of an individual, you will owe that person a legal duty of care. This applies whether you are performing a relatively straightforward task, such as taking someone’s temperature, through to the most complex forms of surgical intervention. In each instance, it is obvious that if you act carelessly you may cause injury to the person.

Once the law imposes a duty of care, the key question then becomes, what is the appropriate standard of care that is expected of the practitioner performing that task or role? And it is here that I think we find the source of the uncertainty or confusion, about extending “traditional” nursing, GP and other healthcare roles.

Consider this issue from the perspective of the ordinary patient. I suspect that we would all generally accept that every individual should be entitled to expect a similar standard of care in relation to a particular healthcare intervention, irrespective of where, when and by whom that care is delivered (I am only addressing here the situation where it is accepted that a particular investigation or treatment should be undertaken or given, and not where there is a dispute about whether it can be afforded,

or is a clinical priority). After all, by way of analogy, when we are driving on the roads all of us expect that other road users will observe the same legal standard of care (in terms of road safety, observance of the highway code and so on), irrespective of who is driving the other vehicle, and how long they have been sat behind a wheel. Likewise, in the context of healthcare, the law imposes a standard of care in relation to each task, and that standard will apply whether you receive treatment in Cardiff, London, Peterborough or Glasgow, and irrespective of whether your carer is someone with a medical qualification, nursing qualification or otherwise. This means that “inexperience”, for example, will generally be no defence to a claim of negligence.

The legal standard will be judged by that of the “ordinarily competent practitioner” performing that particular task (or role). In other words, the evidence of a practice universally adopted by a responsible, relevant and reasonable body of appropriate practitioners, will usually determine the standard that the courts will accept as appropriate in the circumstances. Fall below that standard and you are in breach of your duty of care. Observe that standard, and you will not be, notwithstanding that the patient sadly experienced harm.

In relation to certain tasks, the courts may simply apply their common sense in determining the relevant standard, and not require expert testimony. So, for example, poor handwriting on a prescription or in a patient’s medical record, or a failure to read the relevant patient notes, will be inexcusable by the standards of any reasonable person. However, other tasks, such as the signs and symptoms that ought to be considered, or the tests or treatments that ought to have been undertaken or given, will be matters of professional judgement, and will necessitate expert advice from responsible practitioners. In other words, the courts generally defer to the relevant healthcare professionals in determining the appropriate standard of care.

To summarise what we have learnt so far:

- The law does not generally prescribe who may perform a particular healthcare task or role.
- It does, however, insist that there is a standard of care in relation to each task or role, that will apply generally irrespective of who is performing it.
- If you are extending or developing your role, then you must be confident that on accepting responsibility for an individual's care, you have the knowledge, skills and experience to perform that task (or the role required of you) to the requisite legal standard. And from a risk management perspective, that is surely the only real issue.

Accordingly, in observing the above, there are, in my view, no unique legal issues presented by the extension or enhancement of traditional nursing or GP roles, and practitioners should have no concerns.

None of the above will be news to many registered nurses, as they will immediately recognise the requirements of the Nursing and Midwifery Council (NMC) in its code of professional conduct (NMC, 2015). Likewise, GPs will be equally familiar with the General Medical Council's (GMC) good medical practice document (GMC, 2013) and the various documents seeking to explain or illustrate individual provisions of the codes.

A duty of care may be owed by a number of different individuals or bodies to the same patient. So the person who actually performs the task in question will owe a direct (or primary) duty of care to the patient. Further, where that task has been delegated to that person by a more experienced practitioner, on whom the overall responsibility for providing the care to that patient initially fell, he or she may also owe a direct duty of care to the patient. Guidance to registered nurses and GPs around delegation is again given by the NMC and GMC respectively in the codes of professional conduct, and this mirrors the advice of other professional bodies to their registrants.

Finally, the organisation employing those individuals may owe a direct duty of care

to the patient concerned and be liable for what are often described as "systemic errors", such as a fault in the system surrounding the training and supervision of staff or the adequacy of staffing levels. Furthermore, the employing organisation (such as a GP, partnership or other legal body in primary care), may also be "vicariously liable" for the actions of its employees. This is known as secondary liability.

Vicarious liability

There is something of a myth circulating in healthcare about the concept of vicarious liability; some people think that it is optional whether the employer accepts or declines its responsibility. The simple fact is that when an employee was acting "in connection with" their employment when they caused harm to the patient, the employer is vicariously liable for the employee's actions. This must be fully understood and appreciated by employers, particularly when they invite staff to change their roles. The onus is clearly on the employer to ensure that those staff are properly trained and supervised until they are able to demonstrate their competence in the new role, working to the appropriate standard of care.

Through the Royal College of Nursing, nurses occasionally ask whether a new task or role must be recorded in their contract of employment or job description before the employer will be held vicariously liable for the nurse's actions (or inaction). So, for example, where a nurse qualifies as an independent prescriber, is the employer only liable for his or her actions in prescribing for patients, once it is written into his or her contractual documentation? The answer is no. In approving the nurse to undertake prescribing, whether expressly or impliedly, the employer is responsible for his or her actions. In practice, however, it obviously makes sense to record in writing the full extent of your extended role, not least because this will be important for evaluating the demands of the job for grading and other purposes.

Page points

1. If you are extending or developing your role, then you must be confident that on accepting responsibility for an individual's care, you have the knowledge, skills and experience to perform that task (or the role required of you) to the requisite legal standard.
2. The onus is clearly on the employer to ensure that those staff are properly trained and supervised until they are able to demonstrate their competence in the new role, working to the appropriate standard of care.

“In my view, it is an unacceptable practice for an employing organisation to expect, or even to insist that an employee, whether doctor, registered nurse or healthcare support worker, who is enhancing his or her role, should take out their own insurance to cover any risks associated with that role.”

Questions over indemnity

Developing or extending roles also appears to give rise to uncertainty about the relevance of indemnity insurance or contractual indemnity arrangements, covering the risks of a claim of clinical negligence or under public liability. Where an employer is vicariously liable for the actions of its staff, it will need to have insurance to cover the risks of a clinical negligence claim arising from the carelessness of its employees. Although the individual practitioner remains legally accountable for his or her actions, it is rare for the injured patient to sue the practitioner as well as the employer. In the NHS, all claims of clinical negligence are handled by the NHS Litigation Authority, under the Clinical Negligence Scheme for Trusts (with equivalent scheme and body in Scotland) and this covers NHS, Acute and Foundation Trusts, and NHS Boards.

Legally, it is possible for an employer to recover from a negligent employee any compensation that the employer has paid out to a patient, through that employee's carelessness. In practice, particularly where the employee is uninsured for this purpose, the insurance companies, on behalf of the employer, do not seek such an indemnity from the employee. Even when the employee is insured, or benefits from a contractual indemnity scheme, it is rare for the employer to press for reimbursement, for at least two reasons. First, it is increasingly recognised that most errors in healthcare are systemic, and responsibility does not just rest with the individual practitioner(s). And second, acquiring a reputation for suing your own staff does not exactly enhance employee relations, nor will it encourage recruitment of the best staff.

In my view, it is an unacceptable practice for an employing organisation to expect, or even to insist that an employee, whether doctor, registered nurse or healthcare support worker, who is enhancing his or her role, should take out their own insurance to cover any risks associated with that role. This is particularly unethical where the new

role is likely to save the employer costs and enhance the quality of service provided for the patients. That is, and should remain, the responsibility of the employer. Given that the employer may be found to be directly (not just vicariously) liable to the injured patient, it would be grossly irresponsible for it to fail to have appropriate insurance cover for all staff, in these circumstances.

I end with a plea. I mentioned at the beginning of this article a continuing gap in the education of many healthcare practitioners (and I include here all healthcare professionals, including medical practitioners, physiotherapists, pharmacists and others) around the legal and ethical implications of their clinical practice. This is particularly apparent in relation to legal accountability, standards of care, consent and confidentiality. Much of the uncertainty and confusion arising from changes in the management of delivery of health care, and the development of expanded healthcare roles, would be eliminated or minimised if employing organisations and relevant educational bodies plugged this gap with appropriate multi-professional training. ■

Acknowledgement

This article has been modified from one previously published in the *Journal of Diabetes Nursing* (2015, **19**: 174–7).

General Medical Council (2013) *Good Medical Practice*. GMC, London. Available at: http://www.gmc-uk.org/Good_medical_practice___English_1215.pdf_51527435.pdf (accessed 18.05.16)

Mason K, Laurie G (2010) *Mason and McCall Smith's Law and Medical Ethics*. Oxford University Press, Oxford

Nursing and Midwifery Council (2015) *The Code: Professional standards of practice and behaviour for nurses and midwives*. NMC, London. Available at: www.nmc-uk.org/The-Code/ (accessed 09.04.15)

Thompson J (2009) *Delictual liability*. Tottel Publishing, Haywards Heath