

Fourth Edition

NURSING LAW AND ETHICS

Edited by
John Tingle
and Alan Cribb



WILEY Blackwell

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This edition first published 2014

© 2014 by John Wiley & Sons, Ltd

© 1995, 2005, 2007 Blackwell Publishing Ltd

Registered office: John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial offices: 9600 Garsington Road, Oxford, OX4 2DQ, UK
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK
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Library of Congress Cataloging-in-Publication Data

Nursing law and ethics / edited by John Tingle, Reader in Health Law, Head of International Development, Nottingham Law School, Nottingham Trent University, Nottingham, UK and Alan Cribb, Director, Centre for Public Policy Research, King's College London, London, UK. – Fourth Edition.
pages cm

Includes bibliographical references and index.

ISBN 978-0-470-67137-5 (softback : alk. paper) – ISBN 978-1-118-49231-4 (mobi) – ISBN 978-1-118-49232-1 – ISBN 978-1-118-49233-8 1. Nursing–Law and legislation–Great Britain. 2. Nursing ethics–Great Britain. I. Tingle, John. II. Cribb, Alan.

KD2968.N8N87 2013

344.4104'14–dc23

2013007105

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Cover image: Peter Dazeley/Photographer's Choice/Getty Images

Cover design by Cyan Design

Set in 10/12 pt Palatino by Toppan Best-set Premedia Limited, Hong Kong

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Preface to the Fourth Edition

Once again we are very pleased to have been given the chance to update and revise this book into a fourth edition. Health care legal and ethical issues continue to dominate social and political agendas and the courts, as they have done in the periods covered by all the previous editions of our book. Litigation in health care is now a fairly constant feature of the NHS health care environment. Not a week seems to pass without a case being sent to court. The popular media in recent times have abounded with stories of things going wrong in hospitals and elsewhere, where patients have been caused avoidable injury and sometimes death. Nurses feature along with doctors in litigation and claims; and nurses play a key role in making health care safe. Along with lots of other legal and ethical issues and topics covered in this book, we consider the ways the Government and the NHS have tried to grapple with the rising tide of health litigation, and the risk management and patient safety strategies that have been put into place to deal with this.

It is worth highlighting a couple of basic but important truths here:

Errors in health care are inevitable

We are dealing with human beings who sometimes make mistakes. None of us is infallible. Add to this complex medical technology, the busy nature of a health care setting, and you have the recipe for problems. The best we can try to do is to minimise the risk of errors and adverse events occurring, through the proper application of clinical risk management and patient safety strategies. What is more worrying, however, is that the same errors are often repeated and we don't always seem to learn from the errors of the past.

A lot of errors made are simple ones and involve failures of communication

When health care errors are looked at in totality, it seems that a lot could have been easily avoided if doctors, nurses and other health carers properly

communicated with each other and with patients. When surveys and error reports are analysed, many involve simple communication errors such as wrongly noting a patient's name or drug or missing out and failing to convey other key information. Again, this seems to be an area where, sadly, we do not appear to be learning sufficiently from past mistakes. It is easy to feel as an observer that record-keeping is seen as a chore by health carers, when it should be regarded as a key duty and skill.

On the other hand, the NHS has much to be proud about in this area. The NHS is arguably getting better at ensuring good-quality and safe health care. Our patient safety, health quality infrastructure is copied in many parts of the world and is very highly regarded. But it is important to keep the momentum of improvement, and there are considerable challenges to doing so. Since the last edition of this book, the NHS has been in an almost constant state of reform and, as we said in the previous edition's preface, this unstable platform brings about its own problems, as NHS organisations struggle to implement government health quality, risk and patient safety policies and at the same time manage root-and-branch change.

We repeat here the warning about health law changes that we made in previous editions. Health care law is always in a state of flux, and it is simply impossible, for practical reasons, to represent all the legal changes that took place before this book went to press. We have tried to regularly capture the changes to the law as this book's production has progressed, particularly up to September 2012.

For this fourth edition we have been able to retain many of the authors who contributed to earlier editions but a number have now retired. We wish them well in their retirement and extend our deepest gratitude for the contributions they have made. A number of new contributors have joined us for the fourth edition and to them we extend a warm welcome. We, once again, very much hope that this new edition of the book will prove to be of practical benefit – and theoretical interest – to the nursing community.

John Tingle and Alan Cribb
Nottingham and London
January 2013

Preface to the Third Edition

We are pleased to have been given the chance to update and revise this book into a third edition. Health care legal and ethical issues continue to dominate social and political agendas and the courts. Since the last edition a myriad of ethical and legal dilemmas have flowed through the media and the courts, and we have tried to reflect many of these in this new edition. Such dilemmas arise in the context of an NHS that appears to be in a constant state of reform and subject to a number of increasingly contentious and competing political agendas. This unstable platform brings about its own problems, as NHS organisations struggle to implement government health quality, risk and patient safety policies, and at the same time manage root-and-branch change. Nursing law and ethics, as an academic discipline, continues to develop and is now often seen to sit alongside these patient safety, quality and risk topics. The focus now, practically speaking, is the practical and holistic integration of these topics (the Government, for example, currently puts all this under the umbrella of 'Integrated Governance'). We suggest that nursing law and ethics, to be understood properly, should be seen in this broader context, which includes the wider policy context of the NHS. The nursing law and ethics student cannot ignore the work of NHS organisations such as the NPSA, NHSLA and Healthcare Commission and the related governance agendas. An understanding of these broader institutional and policy frameworks is essential for a fully informed discussion, and we hope this book helps to support such a discussion, as well as to properly represent the more focused and disciplinary demands of law and ethics.

The preface to the first edition set out the rationale for, and the structure of, the book. We hold true to this for the third edition as we did for the second. There have been changes, particularly to the law, and we have tried to capture these up to August 2006. That health care law is in a fairly constant state of flux is a self-evident truth, and it is simply impossible, for practical reasons, to represent all the legal changes that took place before the book went to press. We

would note, however, that the NHS Redress Act 2006 was eventually passed into law. Positive changes were made to it as it progressed through Parliament, and it now has the potential to make a real difference to patients who have been harmed through lack of care in the NHS.

We, once again, very much hope that this new edition of the book will prove to be of practical benefit – and theoretical interest – to the nursing community.

Alan Cribb and John Tingle
London and Nottingham

Preface to the Second Edition

We are, of course, pleased that the first edition of this book was so well received; and we are delighted to have had the chance to update and revise it. There is comparatively little to add to the preface produced for the first edition; this set out the rationale for, and the structure of, the book, and these remain the same. But there are many changes to the content of the book. The last six years have seen an extraordinary amount of change in many aspects of health care law and ethics, in the regulation and management of health services, and in conceptions of health professional accountability. The contributors to this new edition have sought to reflect and illuminate these changes and also to provide clear overviews of their subject matter.

There is a new chapter in the first part of the book which summarises the changing policy context and legal environment of nursing; and in the second part there is a new 'pair' of chapters on clinical governance. We are grateful to all the authors who have updated their work and/or written material for the first time in this edition. We very much hope that this new edition will prove to be of practical benefit – and theoretical interest – to the nursing community.

Acknowledgements

We would like to thank Professor Jean McHale, Faculty of Law, University of Leicester and Mr Harry Lesser, Centre for Philosophy, University of Manchester, for acting as editorial advisers.

Alan Cribb and John Tingle

Preface to the First Edition

One of the key indicators of the maturation of nursing as a profession and as a discipline is the growing importance of nursing law and ethics. A profession which seeks not only to maintain, and improve on, high standards but also to hold each of its individual members accountable for an increasing range of responsibilities is inevitably concerned with legal and ethical matters. It is not surprising that these matters have come to prominence in nurse education, and to enjoy a central place along with clinical and social sciences in the disciplinary bases of nursing. There is now a substantial body of literature devoted to nursing law and to nursing ethics.

This book is distinctive because it is about both law *and* ethics. We believe it is of practical benefit, and academic value, to consider these two subjects together. Put simply, we need to be able to discuss 'what the law requires' and 'what is right', and to decide, among other things, whether these two are always the same.

The book is divided into two parts. The first part is designed to be an overview of the whole subject and includes introductions to the legal, ethical and professional dimensions of nursing, as well as a special chapter on patient complaints. The second part looks at a selection of issues in greater depth. These chapters contain two parts or perspectives – one legal and one ethical. The legal perspectives take the lead – the authors were invited to introduce the law relating to the subject at hand. The ethics authors were invited to write a complementary (and typically shorter) piece in which they took up some of the issues but then went on to make any points they wished. Thus the terms of invitation for the ethics authors were different, and more flexible, than those for the lawyers. This difference in treatment of the two perspectives is quite deliberate.

The essential difference is this: it makes good sense to ask lawyers for an authoritative account of the law, but it is not sensible to ask authors for an authoritative account of what is good or right – which is the subject matter of

ethics. An account of the law will not simply be factual; it will inevitably include some discussion of the complexity and uncertainties involved in identifying and interpreting the implications of the law. But it is in the nature of the law that lawyers should be able to give expert guidance about legal judgments. There are no equivalent authorities on ethical judgement. Instead some nurses with an interest in ethics and some philosophers with an interest in nursing ethics were invited to discuss some of the issues and/or cases raised in the first part of the chapter. Clearly, these responses are of different styles and are written from different standpoints. Each author is responsible for his or her piece and any of the views or opinions expressed within them. This difference between the two sets of perspectives is indicated (indeed, rather exaggerated) by giving the former the definite, and the latter an indefinite, article – ‘The Legal Perspective’ but ‘An Ethical Perspective’!

These differences in presentation reflect deeper differences between the two subjects. In short, law and ethics are concerned with two contrasting kinds of ‘finality’ – in principle, ethics is final but, in practice, law is final. It is important to appreciate the need for both open-ended debate and for practical closure. When it comes to making judgements about what is right and wrong, acceptable or unacceptable, the law is not the end of the matter. Although it is reasonable to expect a considerable convergence of the legal and the ethical, it is perfectly possible to criticise laws or legal judgments as unethical (this is the central impetus behind legal reform). On the other hand, society cannot organise itself as if it were a never-ending philosophy seminar. There are many situations in which we need some authoritative system for decision-making, and mechanisms for closing debate and implementing decisions – this is the role of the law. Any such system will be less than perfect, but a society without such a system will be less perfect still.

Of course there are also areas in which there is little or no role for the law. The way in which nurses routinely talk to their patients raises ethical issues, and may also raise legal issues (e.g. informed consent, negligence), but unless some significant harm is involved, these ethical issues can fall outside the scope of the law. For example, it is a reasonable ideal for a nurse to aim to empathise with someone she is advising or counselling; she might even feel guilty for failing to meet this ideal, but she could hardly be held legally guilty. Laws which cannot be enforced, or which are unnecessary, could be harmful in a number of ways. They could detract from respect for the law and its legitimate role, and they could create an oppressive and inflexible climate in which no one benefitted. So even if we are clear that a certain practice is ethically unacceptable, it does not follow that it should be made illegal. However, the opposite can also be true. The overall consequences of legalising something which many people regard as ethically acceptable (e.g. voluntary euthanasia) may be judged, *by these same people*, to be unacceptable – as raising too many serious ethical and legal complications. Both lawyers and ethicists have to consider the proper boundaries of the law.

Even these few examples show that the relationship between the law and ethics is complicated. Professional values, such as those represented in the UKCC Code of Conduct, act as a half-way house between the two. They provide a means of enabling public discussion of public standards. They address the

individual conscience but, where necessary, they are enforceable by disciplinary measures. We hope that this book will illustrate the importance of considering all of these matters together, and will help to provide nurses with insight into what is expected of them, and the skills to reflect on what they expect of themselves.

Alan Cribb and John Tingle

Part One: The Dimensions

1

The Legal Dimension: Legal System and Method

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We live in a society dominated to an increasing – some would say excessive – extent by legal rules and processes. Many of these apply to all of us – for instance, the rules relating to use of the road as driver, passenger, cyclist or pedestrian, while others apply only to specific groups. In this chapter we will concentrate on the law as it affects the provision of health care. It is easier to do this than to look at the law relating to nurses or nursing, since for many purposes there is no legal distinction between different health care professionals and their contributions to the overall health care system. Before we do this, however, it is necessary to look briefly at the main features of the legal systems in which health care operates. There are four distinct legal systems within the United Kingdom. Northern Ireland has had a substantial measure of legislative and executive devolution since the 1920s, although this was often suspended due to civil unrest. A new devolution settlement for Northern Ireland and first-generation ones for Scotland and Wales were enacted in the 1990s.¹ The Welsh initially sought and obtained more restricted powers, but these have since been extended. The devolved legislatures are not sovereign, they exercise defined powers formally delegated by the Westminster Parliament, although any attempt to curtail or modify either the legislative or executive competence of the devolved provinces would be politically hazardous. The provision of health care through the National Health Service (NHS) was originally established throughout the United Kingdom by legislation of general application, but health is now a devolved matter, therefore in Scotland and Northern Ireland it is under the authority of the Scottish and Northern Irish Ministers, and legislative changes are made by the Scottish Parliament and Northern Ireland Assembly. In Wales the Welsh

Assembly Ministers have had executive authority for over a decade, but the Welsh Assembly has only recently acquired legislative competence in relation to primary legislation. The Westminster Government and Parliament now have direct authority only over the NHS in England.

This chapter will concentrate on the English position. It is also possible to draw valuable illustrations and guidance from other countries outside the United Kingdom, particularly in relation to general legal principles, rather than the detail of legislative provisions, although these are influential rather than decisive.

1.1 The law and its interpretation

In this section we will look briefly at the various sources of law operating in England² and at some of the methods used by judges when they have to interpret and apply the law.³

1.1.1 Statute law

Most English law is in the form of statutes. These are made by the Crown in Parliament. Since 1689, by virtue of the Bill of Rights, the Crown in Parliament has been the supreme legislative body in England, and subsequently in the United Kingdom. A statute, or Act of Parliament, results from a bill or proposal for a statute. The bill may be proposed by the Government or by any individual MP or member of the House of Lords. It is debated and approved, with or without amendment, in both Houses.⁴ Once approved in Parliament by both Houses, the bill receives formal Royal Assent. Statutes have been passed on almost every topic imaginable. Among those of direct relevance to the health care professions are the following:

- The series of statutes establishing the NHS and subsequently modifying its structure and organisation. The National Health Service Act 1946 carried through Nye Bevan's project to secure a national, public, health service. Today the principal Act is the National Health Service Act 1977, but this has been amended and supplemented many times – for example, by the National Health Service and Community Care Act 1990, which introduced NHS Trusts and the internal market; the Health Act 1999, which introduced Primary Care Trusts and the Commission for Health Improvement; the Health and Social Care Act 2001, which made numerous changes to community health provision; the Health and Social Care (Community Health and Standards) Act 2003, which among other things created Foundation Trusts; and the Health Act 2009, which among other things introduced the NHS Constitution. The Health and Social Care Act 2012, which among other things extends GP commissioning and restructures NHS management regulation, recently continued this process of amendment and development.

- The Acts regulating the health care professions, such as the Medical Act 1983 for doctors, and the Nurses, Midwives and Health Visitors Act 1997.⁵

Statutes generally provide the broad framework of rules. Thus section 1(1) of the National Health Service Act 1977, in its latest form after amendment, provides:

It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement – (a) in the physical and mental health of the people of those countries, and (b) in the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with this Act.

This is called 'primary legislation' because it sets out the principal foundational rules. More detailed regulations are contained in statutory instruments, which are made by ministers (or in practice by their civil servants) under powers conferred by a relevant statute. This is referred to as 'secondary legislation' because it deals with matters of detail dependent on the general powers given by primary legislation. So, for instance, the provision of general medical services is governed by sections 28C to 34A of the National Health Service Act 1977, which provide for regulations on a variety of topics, including: the manner in which, and standards to which, services are to be provided; the persons who perform services; the persons to whom services are to be provided; and the adjudication of disputes.

In theory the Crown in Parliament can pass a statute on any subject whatever, and may also repeal any existing legislation. So in theory Parliament can accordingly legislate for the execution of people on some arbitrary ground, such as having red hair. This is subject to three very different qualifications, as follows:

- (1) Parliament can only operate within the scope of what is politically and socially acceptable. This not only means that the Red-haired Persons (Compulsory Slaughter) Act will never see the light of day, but more importantly that legislation on such contentious issues as abortion or euthanasia is not undertaken lightly.
- (2) By virtue of the European Communities Act 1972, Parliament has granted supremacy to the legislation of the European Union (EU) in those areas covered by the Treaty of European Union and the Treaty on the Functioning of the European Union. This can mean that existing parliamentary legislation is found to be incompatible with EU law, although the courts will always try to interpret the two pieces of legislation consistently with each other, and it can even mean that new legislation must be disregarded.⁶ In practice EU law does not really have much specific bearing on medico-legal and ethical issues, although since it does deal with recognition of qualifications and many equal-pay and equal-opportunity issues in employment law, it may have an impact on the professional life of many nurses. EU free trade and competition rules apply to drugs and medicines as they do to any other products, and they feature in much of the case law. The EU also regulates the provision of services, and this includes private medical services

with a cross-border element, as well as public medical services to the extent that they are in competition with private provision.

- (3) The Human Rights Act 1998 came into full effect on 2 October 2000. This Act is designed to give effect in English law to the rights conferred by the European Convention on Human Rights and Fundamental Freedoms (ECHR) ('Convention rights'). This has been in effect since 1954, and was originally binding on the United Kingdom internationally through the European Court of Human Rights and the Council of Europe, but not as part of our own legal system. So even if rules of English law, whether in statutes or otherwise, were inconsistent with the Convention, they prevailed, although the United Kingdom might then be held to be in default by the European Court of Human Rights. This has now changed as follows:
- Each new bill must be certified by the Minister responsible to comply with the Convention rights, or an explanation given as to why it is appropriate to legislate incompatibly.
 - English law must be construed so far as possible to be compatible with the Convention rights. The courts have now made it clear that they will exercise this power robustly, as explained later.
 - If an Act is found by the courts to be incompatible with Convention rights, the judges may make a declaration to that effect and it will be up to the Government to invite Parliament to make the necessary changes.
 - The courts will have regard to decisions of the European Court of Human Rights when interpreting English law.
 - All public bodies must act in accordance with the Convention. This includes the various component parts of the health service.

Judges must interpret all statutes to conform to Convention rights 'so far as it is possible to do so'. Although the full implications of this are still being worked through, the approach of the judges is to first consider what the social or other policy purpose of the legislation is, then whether there is a breach of Convention rights if the legislation is interpreted naturally. If there is, but this was clearly intended because of the overall structure of the Act, or the issues are complex and far-reaching, the judges will be reluctant to impose an alternative interpretation. Where they can work 'with the grain' of the legislation, especially where the incompatibility appears accidental and there is no need to address fundamental policy issues, the courts will 'read down' the actual words used and substitute a form of words that secures respect for Convention rights.⁷ The Convention confers a number of rights on people. Some of them are substantive in nature, such as the right to life and the right to freedom of expression, while others are procedural, such as the guarantee of a fair trial. This applies to disciplinary proceedings and requires that there be an independent and impartial tribunal. This may be problematic for bodies such as the Nursing and Midwifery Council (NMC) which have been responsible for the investigation and adjudication of complaints and have had difficulty in developing systems which provide for the necessary degree of independence.

Some areas of medico-legal significance are likely to be affected by the Act. One example is the detention of mentally impaired people. This is permitted in

principle under Article 5, where it is necessary for the protection of the patient or others and there is the safeguard of an appeal to an independent judicial body independent of the executive government.⁸

In 1998 in the case of *R v. Bournewood NHS Trust, ex parte L* the House of Lords approved under the doctrine of necessity the use of informal measures to keep 'compliant' patients who lacked the capacity to consent in hospital without using the powers under the Mental Health Act 1983. In *HL v. United Kingdom* (2004) the European Court of Human Rights ruled that this did not provide adequate safeguards.⁹ In *R (Sessay) v. South London & Maudsley NHS Trust* (2011) any notion of the use of necessity when dealing with a non-compliant incapacitated patient was rejected; the Mental Health Act 1983 and the Mental Capacity Act 2005 together provide a complete statutory framework regulating compulsory detention, assessment and treatment. The acts both of the police and of the hospital, outside the statutory framework, breached the claimant's right to liberty under Article 5 of the Convention.

The right to life would appear to be of direct concern to the health care community, but in practice it focuses on negative aspects (preventing officially sanctioned killing), rather than positive ones (requiring states to provide resources and facilities to cure the sick).¹⁰ In *D v. United Kingdom* (1997) it was held that, while deporting an HIV-positive prisoner to St Kitts, where treatment was not available, amounted to inhuman and degrading treatment, it was not necessary to consider whether the state was failing to ensure the right to life. Indeed recent decisions of the UK courts have held that deportation of HIV-positive patients will not even amount to inhuman or degrading treatment in the absence of extreme circumstances.¹¹ It is also clear as a result of one of the first cases under the Act that withdrawal of hydration and nutrition from a patient in persistent vegetative state (PVS) does not entail a breach of the right to life (*NHS Trust A v. Mrs M., NHS Trust B v. Mrs H.* (2001)).

Both the UK courts and the European Court of Human Rights have held that the refusal of the state to allow assisted suicide is neither an infringement of the right to life (this was a rather convoluted argument that the right to life included a right to terminate one's own life) nor a failure of proper respect for the privacy and autonomy of the patient. In this latter instance it was held that while there was a right to die, safeguards might be necessary against abuse and coercion, and the existing rules were not disproportionate for achieving this.¹² However, doubts persisted, and it was eventually determined that it was appropriate to require the Director of Public Prosecutions to promulgate a policy on prosecution in cases of assisted suicide.¹³

1.1.2 Common law

The rules of the common law pre-date statute. However, there are now so many statutes in so many areas of law that the common law rules are normally of secondary importance. These rules are legal principles laid down over the centuries by the judges in deciding the cases that came before them. In theory the judges were simply isolating the relevant principles from a body of law that

already existed and which represented the common view of the English people as to what was right and lawful, but in practice the judges were really developing a coherent and technical set of rules based on their own understanding of legal principle. We will look at the techniques the judges currently use later. For the moment it is important to recognise that there are some areas where, despite the rise of statute, the common law remains of considerable importance.

The best example is tort, in particular negligence. This is important to nurses, as this branch of the law deals with whether a patient who has suffered harm while being treated will be able to recover compensation because the treatment he received was inadequate.

The judges also have the task of interpreting statutes and statutory instruments and giving effect to them. They have developed their own techniques and principles for this task, which are themselves part of the common law.

An important function of the judges today is controlling the activity of central and local government and other public bodies by means of judicial review. This is now the responsibility of the Administrative Court, which is part of the High Court. Judicial review is essentially a means of ensuring that decisions and policies are made lawfully and by the correct procedures. The judges themselves have developed the rules on which decisions can be challenged and what grounds of challenge are available.¹⁴ In principle, the judges accept that they have not been given responsibility for making the decisions in question, and so do not consider the merits. In *R v. Central Birmingham Health Authority ex parte Walker* (1987) the court had to consider a failure to provide treatment to a particular patient, as a result of decisions not to allocate funds to this particular aspect of the health authority's operations. It was held that the authority was responsible for planning and delivering health care within a given budget and the resulting decisions on priorities. The court could not substitute its own, inexpert, judgment, particularly as it would only hear detailed arguments about the needs of this one patient and not about the whole range of demands. However, in *R (Coughlan) v. North & East Devon HA*¹⁵ the court did address the question of what constituted health care and what constituted social care, as the financial arrangements for these were different. This was a question of statutory interpretation, not of relative priorities. The issue of health care resources is more fully discussed in Chapter 8.

1.1.3 European Union law

Throughout the post-World War II period, the states of western Europe have been engaged in a complex and long-term project of economic cooperation and integration. The first major stage in this was the Treaty of Rome, which established the European Economic Community in the 1950s. The United Kingdom joined this Community in 1974. The initial objective was the establishment of a common market, an area within which there was to be free movement of the various factors of production of goods and provision of services, namely goods, labour, management and professional skills and capital. Initially this meant the removal of obvious barriers, such as customs duties, immigration controls,

exchange controls on money and other restrictions. Subsequently other objectives, such as environmental protection, have been added, and indeed the entity has been renamed the European Union, although the main impact of the Union is still on economic affairs.

Free movement of workers, guaranteed by Article 45 of the Treaty on the Functioning of the EU (TFEU), implied many additional social policies, as workers would not, in practice, move around the EU unless their social security entitlements were ensured and they were allowed to bring their families with them. Genuine freedom of movement also required a common approach to qualifications, with no discrimination on grounds of nationality, and also equal opportunity, at least between men and women. This has resulted in much legislation and many decisions of the European Court of Justice. Article 53 of the TFEU specifically gives power to regulate mutual recognition of diplomas and qualifications. Directives 77/452 and 80/154 made provision for general nurses and midwives, respectively, but there are now general frameworks for the recognition of degree-level and other vocational qualifications in Directive 2005/36, which deals in detail with many medical, nursing and allied qualifications.

The case of *Marshall v. Southampton and SW Hants AHA* (1986) established that UK law permitting differential retirement ages as between men and women in the health service was incompatible with EU law requiring equal treatment, and as a result the UK law had to be disregarded.

The member states of the EU have agreed, in effect, to transfer to the EU institutions their sovereign rights to make and apply laws in those areas for which the EU is to be responsible. As a result EU law prevails over national law in these areas where they are in conflict. However, there are a number of different mechanisms for securing this, and it is not simply a question of ignoring national legal provisions.

The European Council, which comprises an elected president, the heads of government of the member states and the president of the European Commission, is the principal policy-making body for the EU. It meets in regular summits which discuss current economic and international relations issues. The European Council should not be confused with the Council. This is a legislative and administrative body, comprising relevant departmental ministers from each member state. In most cases the legislation is made jointly by the Council and the Parliament, on a proposal from the European Commission. In many cases the Council can act by a majority, and thus legislate against the wishes of one or more member states. The majority is usually a 'qualified' or weighted majority designed to ensure that there is very substantial support for the measure. In practice great efforts are made to ensure a consensus of opinion. The Parliament does not initiate legislation but, as noted above, does have to approve and join in making most important legislation, so it has at least a blocking power and can suggest amendments. The Parliament must also approve the EU budget and the members of the Commission. It may also remove the whole Commission, and although it has never voted to do so, the likelihood of this occurring led to the resignation of the Commission in 1999 as a result of allegations of financial irregularities against one of its members.

The Commission is the administrative arm of the EU. It implements policies and proposes legislation, and can itself make detailed regulations, particularly in relation to the Common Agricultural Policy. It also makes decisions on alleged infringements of EU law – for example, in relation to competition law. It is responsible as ‘guardian of the treaties’ for ensuring that member states comply with their EU obligations.

The European Court of Justice, assisted by the General Court, has the sole responsibility, to the exclusion of the national courts of the member states, for interpreting EU law. It does so by means of rulings on points of law referred by national courts (Article 267 of the TFEU), deciding cases brought against the member states for alleged failure to comply with their obligations under EU law by the Commission (Articles 258 and 260) and by judicial review of the validity of acts of the institutions (decisions on particular cases or secondary legislation) on the application of other institutions, the member states and others directly affected (Article 263).

There are two forms of Act that amount to secondary legislation, namely, Regulations and Directives; both are governed by Article 288 of the TFEU. Regulations, which may be made by the Council, with or without the Parliament, or by the Commission, are directly effective rules of EU law that must be obeyed by all persons and companies within the EU and will be enforced by national courts. Directives, which are normally made by the Council and Parliament, are used where the EU wishes to ensure that national law in all member states achieves the same results, but it is not appropriate to do this by way of regulation. One example is in relation to company law, where the law of the states is very variable in its form and terminology, so regulations would be meaningless.

EU law applies not only to states but also to individuals. This was not clear from the beginning, but the Court of Justice ruled in *van Gend & Loos* (1962) that an individual could rely on a treaty provision which was clear and complete and capable of conferring direct rights (in this case a prohibition on new customs duties) to defeat a claim by a state based on its own incompatible legislation. In *Defrenne v. Sabena* (1976) it was held that a treaty provision meeting these requirements (in this case the right to equal pay for women) could be relied on against a person or company, notwithstanding incompatible national legislation.

The position with regard to directives is more complex. They normally provide for an implementation period; while this is running they have no legal effect (*Pubblico Ministero v. Ratti* (1979)), unless the state passes implementing legislation early, while the period is still running. In that case, the state is bound by the terms of the directive (*Pfeiffer* (2005)).

After the implementation date directives are binding on the state,¹⁶ therefore the state is prevented from relying on its own incompatible law. In addition, the state can be obliged to act in accordance with them (*Marshall v. Southampton and SW Hants AHA* (1986)).

This binding effect applies to the courts, which must interpret national legislation ‘as far as possible’ in accordance with the directive, even in cases involving two private litigants with no state involvement (*Marleasing* (1992)). This applies particularly to rules relating to remedies, which must be effective (*von Colson*

(1986)). However, where the two cannot be reconciled, national law will prevail (*Wagner Miret* (1993)).

A directive cannot be relied on as such against a private individual or company (*Faccini-Dori v. Recreb* (1995)), although the court can be asked to interpret national law, as above.

Where an individual or company suffers loss as the result of the failure of the state to implement a directive properly or at all, as a last resort the state may be held liable in damages (*Francovich* (1993)) provided that the breach is sufficiently grave (*Brasserie du Pêcheur/Factortame* (No. 3) (1996)). In principle this liability extends to a court decision that fails to apply community law (*Köbler* (2004)). Note also that this remedy may be available where the state fails to comply with EU law in other ways, as was the case in *Factortame*.

English courts have been willing to apply very radical interpretative methods to English legislation introduced specifically to give effect to EU requirements, even 'reading them down' to the extent of reversing the apparent meaning of the English legislation. The reasoning behind this is that it was the primary intention of Parliament to comply with the EU requirement, and the words used were believed to achieve this, so any reinterpretation meets that underlying purpose, even if it is not the obvious interpretation of the particular passage (*Pickstone v. Freemans* (1989); *Litster v. Forth Dry Dock* (1990)). After considerable uncertainty it seems that the same will apply to other legislation not passed specifically to meet EC requirements (*R v. Secretary of State for Employment ex parte Equal Opportunities Commission* (1994); *Webb v. EMO Air Cargo* (No. 2) (1995)), although there has been some suggestion that the English courts are happier to see damages claims for non-implementation, rather than radical interpretation (*Kirklees MBC v. Wickes* (1993)).

1.2 The English legal system

The English legal system has developed over many centuries, and although there have been piecemeal reforms, many old procedures and systems remain in place. This applies particularly to titles. Why should the principal judge of the civil side of the Court of Appeal be called the Master of the Rolls? He has nothing to do with either baking or high-end motor cars. What actually happened was that an official responsible for keeping the official records, or rolls, of the Chancery was gradually given a judicial role and by the 19th century, when the Court of Appeal in its modern form was established, he had become a senior judge and was therefore the right person to be appointed to preside over the Court of Appeal.

Effectively there are two court systems in England. The criminal courts concentrate on crime, while the civil courts deal with everything else. There are some exceptions, where specialised tribunals have been set up. The most important of these are probably the Employment Tribunals¹⁷ and the Employment Appeal Tribunal, which deal with most employment-related issues, including equal opportunities, although the various tribunals within the social security system deal with more cases. There are also separate tribunals for income tax and VAT.

1.2.1 Criminal justice system

All cases start with an appearance in the magistrates' court. Usually the case will have been investigated by the police and will be prosecuted by the Crown Prosecution Service, but other government departments and agencies, local authorities and bodies such as the RSPCA also prosecute cases. Private individuals may prosecute, but rarely do. There are a total of some 1,720,000 cases each year,¹⁸ of which 60 per cent are purely summary offences (motoring offences such as speeding, careless driving and defective vehicles, and other minor offences of drunkenness, vandalism, etc.). These must be dealt with in the magistrates' court. The great majority of defendants plead guilty or do not contest the case. The remaining more serious offences fall into two groups. The most serious offences, such as murder, rape and robbery, are actually a small proportion of the total and can only be tried at the Crown court, 'on indictment' – the magistrates' court only deals with bail and legal aid. The others are the middle range of offences (e.g. most assaults, theft, fraud and burglary). These are said to be triable 'either way'. This means that if the defendant admits the charge when it is put to him in the magistrates' court, he is convicted there, although he may be committed to the Crown court for sentence if the magistrates' powers of sentence¹⁹ are inadequate. If the defendant does not admit the offence, the magistrates must decide whether they have power to hear the case, having regard to its seriousness and complexity. If they decline to hear it, the case must go to the Crown court. If they agree to hear the case, the defendant may still elect trial at the Crown court.

Where a case is heard by the magistrates, the defendant may appeal against sentence (and, if he pleaded not guilty, conviction) to the Crown court. These appeals are heard by a judge sitting with magistrates. Although an appeal against conviction is a full rehearing, it will not be before a jury. Both prosecution and defence may appeal to the Queen's Bench Division of the High Court,²⁰ where they consider that the final decision is wrong on a point of law (as opposed to being a wrong decision on the facts). They may also apply to the same court for judicial review of any preliminary decision (e.g. on bail or legal aid).

The Crown court deals with about 130,000 cases a year, of which about 30,000 are contested trials. About 30 per cent of these result in acquittals. These trials are before a judge and jury, with the judge responsible for decisions on matters of law, evidence and procedure, and the jury responsible for matters of fact and the final verdict.

The defendant may appeal to the Court of Appeal (Criminal Division) on the ground that the verdict is unsafe. The Court considers whether the defendant was prejudiced by irregularities at the trial, such as rulings of the judge on law, or the admissibility of evidence, or errors in the judge's summing-up. In effect the Court is asking, 'Can we rely on the jury's verdict, or do we feel that they would have decided otherwise if the irregularity had not occurred?' The prosecution may not appeal against an acquittal, although they may ask the Court of Appeal to consider the point of law involved in an acquittal on a hypothetical basis by an Attorney General's reference. They may also challenge a ruling made by the trial judge which has the effect of terminating the proceedings in favour