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NURSES AND THE LAW

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I Introduction

IT WAS in 1854 that Florence Nightingale was asked by the British Secretary of War to go to the main theatre of war, where the absence of sewers and laundering facilities, lack of supplies, poor food, disorganised medical services and absence of nursing, led to a death rate of more than 50 per cent among wounded soldiers. Her work and that of the nurses whom she recruited, brought sufficient improvement so as to lower the death rate to 2.2 per cent.

Florence Nightingale was a firm believer in the need to train nurses and was of the view that nursing services should be administered by nurses with special training. In Florence Nightingale's thinking, we find the beginnings of so many modern concepts, such as:

(*i*) the relationships between physicians and nurses should be professional;

(*ii*) nurses were to be prepared for hospital nursing as well as for care of the ill in homes;

(*iii*) nurses were expected to teach good health practices to patients and families; and

(*iv*) there was a substantial body of knowledge to be learnt in nursing.

II Post-war developments

The Second World War further enhanced the importance of nursing as a profession. This is a development of peculiar importance to India, because it was soon after the war that the Indian Nursing Council Act 1947 was passed. In UK also, in 1949, the legislation relating to registration of nurses was revised. The revision enlarged the strength of the Nursing Council to 34 members (of whom half are nurses elected by nurses) and educational interests—both nursing and general—were given greater representation. At least the intellectuals have come

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to realise that nursing is not a mere adjunct to the profession of the physician and surgeon, but has an independent status in its own right. Sir William Osler, the Canadian doctor who is regarded by many as the greatest physician of the present era, expressed the view that the evolution of the profession of nursing is one of the greatest human blessings and that a nurse occupies a position not inferior in any manner to that of the physician or the priest.

III Legal scenario

Coming to the legal scenario, one should mention at the outset, that like the law relating to many other subjects, the law relating to nurses is not to be found in one consolidating enactment. One must collect it from several sources. The Indian legal system recognises several sources of law. This is a fact which needs to be mentioned in order to correct the impression that prevails amongst non-legal persons who assume that all the law in India is based on statute and has the shape of enacted law. This is not correct. Laws enacted by the legislature are only one part of the entire legal picture. Besides statutory law, there is what is known as the uncodified law, consisting of principles laid down in judicial decisions rendered by the higher judiciary. A person belonging to skilled and learned professions may become liable to pay damages for harm caused by his negligence, and this liability arises, not from statute, but by reason of case law. To come to concrete details, one can say that anyone who wants to study the law relating to nurses in depth will have to explore at least three important sources of law, namely, (*i*) central legislation on the subject; (*ii*) state enactments on the subject; and (*iii*) the uncodified law of India, in so far as it is relevant to the legal rights and duties of nurses.

IV Central Act

Legislation contained in the Indian Nursing Council Act 1947 does not lay down the duties and responsibilities of nurses. It is mainly intended to introduce uniformity in the standards of education, training and examination of nurses and to eliminate lack of interstate reciprocity in such matters. It appears that the present Act replaces an Ordinance promulgated in 1947 for the purpose. The central Act, as mentioned above, is mainly concerned with recognition of the qualifications. Though section 15*A* of the Act contemplates the Indian Nurses Register, provisions of the Act do not go beyond the formality of registration. They do not deal with disciplinary proceedings for misconduct. Primary object of the Act is to establish a council for the recognition of educational qualifications. It does not go beyond this narrow academic object. In particular, it does not prohibit the practice of nursing by unregistered persons, nor does it purport to lay down any code of ethics for nurses.

The statement of objects and reasons annexed to the Bill which became the Act of 1947 will be found in the *Gazette of India*.[1] The Act of 1947 was amended

1. Pt. V, p. 456 (1947).

in 1957—to mention the principal amendment. But this amendment does not substantially expand the scope of the Act.

V State Acts

In India, it is really state legislation that is more important, for professional conduct of nurses. *E.g.*, Bengal Nurses Act of 1934 contains provisions, not only regarding the State Nursing Council to be established for the state, but also regarding registration of nurses, removal of names from the register, disciplinary proceedings against nurses and the like. Section 29 of the Bengal Nurses Act prohibits non-registered nurses from unlawfully assuming the title of "registered nurses", *etc.* Section 27 of the same Act prohibits unregistered persons from being employed as nurses, *etc.*, in a dispensary, hospital, *etc.*, supported by public or local funds. Section 20 empowers the Nursing Council of the State to remove registered nurses from the roll. Such removal can be ordered for criminal conviction of certain offences or for defects in the character of a person which (in the council's opinion) would render the retention of that person's name in the register undesirable. An enquiry must be held, before this is ordered.

Bengal and Maharashtra Acts

Thus, in order to ascertain the position regarding permission to practise as a nurse, registration of nurses, removal of names from the register and the like, one has to go to the state Acts on the subject. Examples of such Acts are the Bengal Nurses Act 1934, Maharashtra Nurses Act 1964, Mysore Nurses, Midwives and Health Visitors Act 1962 and similar Acts of other states. There is want of uniformity on several matters from state to state. Take for example, the position regarding removal of a registered nurse from the register on the ground of misconduct, *etc.* The Bengal Nurses Act 1934[2] empowers the Bengal Nurses Council to remove the name of a person from the register on the following grounds:

(*i*) that he has been sentenced by any court *for any non-bailable offence*, the sentence not having been subsequently reversed or quashed, and his disqualification on account of such sentence not having been removed by an order which the state government is hereby empowered to make, if it thinks fit, in this behalf;

(*ii*) that he has been guilty of any offence which, in the opinion of the council, indicates professional incompetence, negligence or contravention of regulations ordinarily included in the performance of the duties of nurses, midwives or health visitors;

(*iii*) that there are defects in his character which, in the opinion of the council, would render the entry or retention of his name on the register undesirable.

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2. S. 20(1), main para.

When one has a look at the Maharashtra Nurses Act 1966, one finds that the language employed is different. Under section 23 (1) of that Act, if a registered nurse is, after due inquiry, found by the Nurses Council of the State to be guilty of any misconduct, the name of that nurse may be removed from the register. The Explanation to section 23(1) provides as under:

> For the purposes of this section, 'misconduct' shall mean—
>
> (*i*) the conviction of a registered nurse by a criminal court for an offence which involves *moral turpitude, and which is cognizable* within the meaning of the Code of Criminal Procedure, 1898; or
>
> (*ii*) any conduct which, in the opinion of the Council, is infamous in relation to the nursing profession, and particularly under any code of ethics prescribed by the Council in this behalf.

It would be of interest to note that section 10(*c*) of the Maharashtra Act empowers the State Nursing Council, *inter alia*, to prescribe a Code of Ethics for regulating the professional conduct of nurses.

It would be seen from the above analysis that while the Maharashtra Act sets a limit to the kind of offences by requiring that the offence must be cognisable and must also involve moral turpitude, the Bengal Act puts the requirement as that of a non-bailable offence.

VI Want of uniformity[3]

Local variations and conditions, while they may justify differences in administrative machinery, do not explain why the standards of judging misconduct should vary from state to state. For some obscure reasons, India does not, as yet, have one law in this regard. It may be that as the central Act of 1947 was passed during troubled times, the legislature did not consider it appropriate at that time to look into these matters. Another possibility is that all concerned probably assumed that legislation of this nature falls within the topics of public health and sanitation, hospitals and dispensaries which were provincial subjects. But there does not appear to be any justification for taking such a narrow view because the Centre can legislate under the Concurrent List, entry 28, which is concerned with "legal, medical and other professions". Without expressing any final opinion in this regard, it is suggested that with the 21st century fast approaching, it will not be too much to assert that nursing is a profession.

VII Need for reform of Nursing Act

It is therefore appropriate that central legislation on the subject of registration of nurses and prohibiting unregistered nurses from practising, should be thought of, as the ultimate goal. If that is not possible in the near future, uniformity on the

3. This is only one example of differences between state Acts relating to nursing. There is no reason why the law should lack uniformity.

basis of a model law is definitely the need of the hour. Of course, preparing even a rough draft of a Model Bill would involve expenditure of money and also some labour. But, if the guidelines for nurses, so beautifully set up by the International Council of Nursing, are to find their concrete reflection in the legal framework of India, this will have to be done.

VIII Common law liability

So much as regards the statute law. As stated above, we must also look to the uncodified law of India, for understanding and appreciating how a nurse, as a member of the profession, may become liable for professional negligence. This is a branch of the law of torts or civil wrongs. Liability to pay damages for negligence is not peculiar to nurses or doctors. The principle of the law is that a person who holds himself out as ready to give professional advice or treatment, impliedly undertakes that he is possessed of the skill and knowledge requisite for the purpose. This is not a duty arising from contract, but is based on the general principles of the law of torts. A breach of the duty will support a suit for damages for negligence for the harm caused to the patient. Halsbury,[4] tells us that the general principles set out above are applicable not only to physicians and surgeons, but also to dentists, veterinary surgeons, nurses and midwives and to all others who give medical advice or treatment.

IX Liability for negligence

The law relating to liability of nurses for negligence is really a vast and somewhat uncharted topic. The standard of care is an abstract one. Its application to a particular case must depend on the facts of that case; and opinion is likely to differ from person to person. However, for the sake of convenience, one can set out the legal position as to liability for negligence as under, taking care to remember, that what follows, is only a very broad statement of the main principles.

(*i*) Like any other person, a nurse is personally liable for negligence in the performance of her duties.[5] In an English case—*Strangway*,[6] two nurses had misread their written instructions and administered (to a female patient) a dose of 6 ounces of paraldehyde (a sedative), instead of six drachms, with the result that the patient died. On the bottle containing the paraldehyde, the ordinary dose was stated to be half to two drachms by the mouth and the nurse who administered the medicine stated, that she knew that the dose by the rectum would be at the most three times as much. The dose was not checked by the sister-in-charge or her deputy, though this was the practice in the hospital. No notice to the nurses for such checking was exhibited in the hospital The husband of the patient

4. 30 *Laws of England* 31, para 34 (4th ed.).
5. *Id.* at 224, para 371.
6. [1936] 1 All E.R. 494 (per Justice Horridge).

sued the nurses and the hospital authorities by whom the nurses were engaged. It was held that the nurses were negligent and were liable to pay damages. They were bound to use professional skill in administering the medicine.

(*ii*) A hospital authority or nursing home is responsible (besides the nurse herself) for negligence of nurses employed by the hospital authority or nursing home where the negligence arises in the course of her employment.

(*iii*) Where an association or body of persons supplies the nurses to the hospital, *etc.*, then the liability of the association, *etc.*, for the negligence of the nurse depends on the relationship between the agencies concerned and the terms of the contract under which the nurse is supplied. In an English case, *Hall* v. *Lees*,[7] a nursing association was held not to be liable for the negligence of a nurse supplied by the association on the facts of the case.

(*iv*) Nurses will not normally be guilty of negligence, if the act or omission complained of as a negligence, was a faithful and careful compliance with the orders of a surgeon, physician or anaesthetist concerned.[8]

Of course, the last mentioned proposition (as regards following the instructions of the doctor) is subject to qualification in certain cases.[9]

X Nurse, doctor and patient

Very often, a delicate question arises in nursing practice. It is delicate, because it involves the question of relationship between the nurse on the one hand and physician or surgeon on the other hand. Generally, nurses are not allowed to diagnose or prescribe, the primary responsibility for the patient's care is supposed to rest with the physician, while the nurses are supposed to carry out the instructions of the physician or make the instructions known to those responsible for carrying them out. But the question that often arises is this. Should the nurse act totally in submission to the physician? Or, can it be conceived that at least on some occasions, she can ask the physician to re-think about the matter? In a learned article,[10] it has been pointed out that in the interaction amongst physicians, nurses and patients in a hospital setting, some ethical dilemmas may arise if and when a nurse questions the order. If the order is a result of incompetence, the physician is not likely to be grateful. Whatever the reason for the medically unsound order,

7. (1904) 2 K.B. 1024 (C.A.).

8. *Gold* v. *Gold*, [1942] 2 All E.R. 237 at 241, 244 (C.A.) (per Lord Greene M.R. and Mackinnon L.J.).

9. See the case of *Strangway*, *supra* note 6.

10. E.Joy Kroegar Mappes, "Ethical Dilemmas for Nurses: Physicians' Orders Versus Patients' Rights", in T.A. Mappes and J.S. Zembaty (ed.), *Biomedical Ethics* 95-102.

the nurse is obligated to question an order if it is clearly medically unsound. The nurse must refuse to carry out the order if it is not changed, and to press the matter through proper channels in order to protect the medical interest of the patient. It is further pointed out that such an ethical dilemma tends to arise when the nurse (blindly) follows the orders of the physician, as this would mean acting against the medical interests of the patient. The article is written by a lady professor of philosophy and not by a person specialising in nursing, medicine or law. Nevertheless, it raises important questions of ethics; and it is not an uncommon experience, that what is a question of mere ethics today, can become tomorrow a question of legal liability. In fact, it appears that the aspect mentioned above has already been attended to, in some states in USA. Nurse Practice Acts, which regulate the practice of nursing, in many states of USA reflect the change towards an expanded and more independent role for nurses. For example, a definition of a nursing diagnosis, as distinct from a medical diagnosis, is a part of some Nurse Practice Acts in USA.[11]

XI Conclusion

A great English scholar once said, that it is always an excitement to cross the frontiers of one's country and to enter the territory of another nation. One can adapt this proposition and say, that it is equally exciting to cross the intellectual frontiers of one's own discipline and to stay, even as a guest, in the region of another discipline. The frontiers of knowledge are receding; and the excitement and thrill of inter-disciplinary discussion can be made available to all of us. The lamp-lighting ceremony, which is the most beautiful tradition of the profession of nursing, is not a mere ceremony. The light that emanates from the lamps is a light that brings pleasure to millions of patients and to their families. It is a light that not merely restores health, but also enlightens the soul.

11. Rothman and Rothman, *The Professional Nurse and the Law* 65-81 (1977).