Nurses taking on junior doctors' work: a confusion of accountability

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The number of hospital based posts in which nurses take over clinical work previously done by junior doctors is growing. Accountability for the scope of such new roles and the standards of practice which apply to them are still unclear. When analysed together and compared, the regulations arising from the professional bodies (GMC and UKCC), civil law concerning certain wrongs to patients, and employment law are sometimes contradictory and hard to interpret. The resulting uncertainties about appropriate management for clinical roles evolving *between* the professions, coupled with an increasingly litigious public, put the nurses and consultants involved at risk of complaints and of disciplinary and legal action. Drawing on our current research into changing clinical roles at the medical-nursing interface, we suggest strategies to reduce risk. Doctors and nurses should be equal partners in planning and managing these new posts, patients should be informed adequately about the nature of the postholder's role and training, significant changes in the work of such postholders should be formally acknowledged by the employer and relevant insurers, individuals taking up new roles should have access to legal advice and support to cover legal risk, and national regulatory bodies need to work together to harmonise their codes of practice in relation to changing clinical roles between the professions.

A quiet revolution is occurring in the division of labour between the professions of medicine and nursing,[1,2] created partly by requirements to reduce junior hospital doctors' work[3,4] and to compensate for their shortage in some specialties.[5] Nurses in particular are taking on clinical work that has traditionally been done by doctors. Our research into the resulting new roles in hospitals has made us aware of the confusion surrounding the management of accountability for the scope of these new roles and the standards that apply to them.[2,6] Certain clinicians—experienced nurses and consultants—may be at risk of complaints or disciplinary or legal action as a result of the innovatory nature of their work and the lack of clear guidance on accountability if things go wrong. We explore here some of the regulations that currently apply to doctors and nurses and illustrate, by means of a case report, some of the sources of confusion.

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Accountability

In this paper accountability refers to obligations and liabilities arising from:

- Professional regulations of the General Medical Council (GMC) and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC);
- The law on civil wrongs (torts) to patients;
- Employment law covering the relationship between employers and their employees.

These three areas of regulation have each developed independently, are driven by different concerns, and are uncoordinated. Yet for doctors and nurses working with patients these divisions in the requirements of external regulators make little sense; they have to practise within them all, all the time.

Case report

Although the following story of a consultant led development to reduce junior doctors' hours of work is fictional, every detail has been recorded in one or more of the eight posts studied in our recent research[2,6] and consultancy work.

Trust X created a new consultant surgeon's post without an associated preregistration house officer post. The consultants suggested that a nurse should be employed to do much of the routine work normally done by house officers. The postholder would be part of the consultant firm, clinically and managerially accountable to the consultant, and through him to the clinical director. The trust approved the plan, ignoring their senior nurses' advice that nurses should be equal partners in the planning and management of the post. They conceded there should be regular meetings for supervision with a senior nurse and the consultant.

An experienced nurse, Ms Gilbert, was appointed to work with the senior consultant, Mr James. He arranged for her to "shadow" a house officer for three weeks and learn specific skills from anaesthetists. For some weeks Ms Gilbert felt unsure about clerking routine admissions and refused to do them on her own. The house officers complained: she should "learn on the job" as doctors did.

Ms Gilbert was uneasy about her title "surgical practice manager," which gave no hint of her identity as a nurse. She stopped using it and left off her name badge. Although she wore a sister's uniform and introduced herself to patients as a nurse with special training to do parts of junior doctors' work, they sometimes called her "Doctor." She did not join in ward nursing activities but behaved like the doctors, attending ward rounds, going to theatre, etc.

At the end of six months the tasks listed in Ms Gilbert's job description did not match her expanded role. For instance, she became skilled at a new technical procedure and, at Mr James's request (but unknown to the clinical director), took this over from the registrar. A senior nurse's comments that this was "a step too far" were dismissed by Mr James as professional rivalry; he would "carry the can" if anything went wrong.

After some months Ms Gilbert felt isolated and unsupported. If it hadn't been for the challenge of new work she might have left. The promised regular meetings with the consultant and senior nurse had not taken place.

Ms Gilbert thought that if she required legal advice or representation she would be covered by her union's

indemnity insurance. Neither she nor Mr James had given their respective insurance agencies details of this post.

Accountability for scope and standards of professional practice

The GMC and UKCC are required by statute to regulate the nature and standards of practice of doctors and nurses respectively. The GMC's guidance, *Good Medical Practice*[7] allows doctors to delegate medical care to nurses if they are sure the nurse is competent to undertake the work. The doctor remains responsible for managing the patient's care (para 28).

In our case it is unclear whether Ms Gilbert's work would be considered "delegated," given its inclusion in a job description for a qualified nurse. The consultant might, however, argue that he was delegating in some sense as the post operated within the framework of a surgical firm, substituting for juniors' work. For reasons of his professional regulations alone, therefore, he might ensure Ms Gilbert's accountability to him for her competence.

The UKCC's *Scope of Professional Practice*[8] describes principles to guide nurses' professional practice when taking on new roles, as in Ms Gilbert's job. These principles arise from the UKCC's *Code of Professional Conduct*[9] and associated advice[10] on accountability. The following are relevant here:

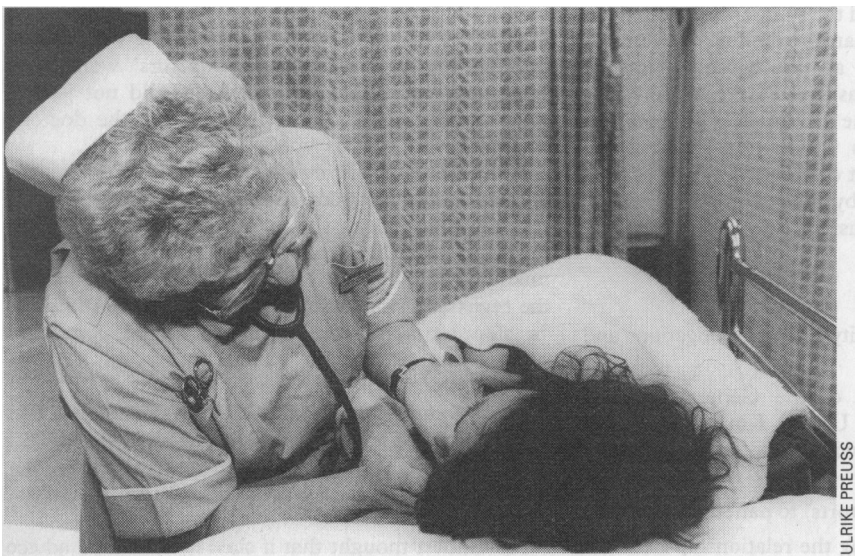
- Regardless of employment circumstances, registered nurses are subject to UKCC regulations and accountable, personally, to the council (para 5).[8]
- In taking on new work registered nurses must acknowledge any limits in their competence and decline duties unless able to perform them in a safe and skilled manner (para 4).[9]
- Nursing managers must ensure local policies are based on UKCC principles and that nurses are assisted to fulfil suitable adjustments to their practice (para 25).[8]

Nurses may interpret these regulations as a major change in their relationship with doctors, removing their dependence on them for assessing nurses' competence to do work previously done by doctors.[11]

At the start of the job Ms Gilbert followed UKCC principles and refused to clerk patients on her own because she did not feel competent. If Mr James disagreed with her he should be sensitive to UKCC regulations concerning the locus of responsibility for competence when extending nurses' roles. Ms Gilbert, in turn, should appreciate that the UKCC's emphasis on nurses' personal responsibility does not exclude her being accountable also to Mr James for her competence.

Such dual accountability could be difficult to manage if there was disagreement. Finding an operational way to cope with the difficulties would, however, be in the spirit of both councils' emphasis on promoting good relationships and constructive working with other professions in health care.[7,9,10] Unfortunately neither council in its advice on multiprofessional teamwork deals specifically with respect for other professions' binding codes of conduct or the difficulties that may arise if they differ from their own.

The consultants' reluctance jointly to plan and manage this post with nurses made it difficult for the nurse leaders of the trust to fulfil their professional responsibility to ensure Ms Gilbert had the necessary professional support (para 25).[8] In such a situation the spirit of UKCC advice[8-10] suggests these nurses should do everything possible to keep open their one avenue for professional support to Ms Gilbert through joint nurse-consultant supervision.



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Who is responsible when things go wrong?

Legal accountability for civil wrongs to patients

The two main areas of civil law relevant to the changing roles of doctors and nurses are negligence and battery.[12-14] Generally civil legal action is directed against the NHS employer (trust or health authority) rather than the individual nurse or doctor, and it is the trust which bears financial responsibility for paying any damages.[15] The trust is entitled to try to recover damages from individuals at fault, but this has never occurred in practice. Nevertheless, a finding of negligence or battery against any professional is harmful personally and professionally.

NEGLIGENCE AND THE NURSE

To give rise to a negligence action Ms Gilbert must make an error which results in the patient suffering injury. In such a situation Ms Gilbert owes a duty of care to the patient—that is, she has a duty to use reasonable care and skill in the treatment. The more difficult question is to what standard of care will Ms Gilbert be held for the purposes of determining whether that duty has been breached. It cannot be assumed that because Ms Gilbert was trained as a nurse and calls herself a nurse she would be held in law to the standard of the competent nurse according to accepted standards of that profession.

In determining Ms Gilbert's standard of care, a court will look at a range of criteria including the nature of the task, the way she "holds herself out" to patients (dress, name badge, language, socialisation), and the way she is perceived by patients. If the task is traditionally performed by a doctor, and if the patient expects it to be performed by a doctor, then unless Ms Gilbert has explained her status to the patient she could, for the purposes of legal negligence, be held to the standard of the doctor in the performance of that task. This standard will pertain to all aspects of the task, including any circumstances which might arise incidental to the treatment and for which she had not been trained.

Ms Gilbert has been specifically trained in certain tasks previously performed by house officers and will probably in practice meet the standard of the doctor in the performance of those tasks. She is required to learn other jobs as house officers do, "on the job," without the rigorous process of teaching and supervised practice and assessment to which nurses are accustomed. Inexperience will not excuse Ms Gilbert from liability. A beginner is always held to the standard of a competent performer of the task[16,17] With respect to these tasks she will be held to that standard regardless of the innovative nature of the post.

BATTERY AND THE NURSE

When a patient is touched without consent a battery has been committed.[18] When Ms Gilbert has carefully explained her identity to the patient the patient can fully consent, knowing that the treatment will be performed by a nurse. Consent to touching by a specific person or profession will not act as consent to touching by any other. Without careful explanation from Ms Gilbert, a patient's consent may be invalid if, as had sometimes happened, the patient assumed from the nature of the task and the way she "held herself out" that she was a doctor. Unlike the situation in cases of negligence, a patient need not show harm to be entitled to bring legal action; also unlike in negligence,[19] an action in battery raises the possibility of an award of aggravated damages if the patient has suffered excessive distress or if the defendant has behaved in a particularly high handed manner.[20]

WHO ELSE COULD BE LIABLE?

The consultant or trust may also be found liable in relation to Ms Gilbert's negligence or battery.

The consultant

The consultant owes a duty of care to his patients to see that Ms Gilbert does not perform any task for which she is not trained and competent. The consultant could then be found liable in negligence for allowing her to act beyond the scope of her competence or responsibility. The courts still appear to regard the relationship between doctor and nurse as one of professional and handmaiden,[21] where the doctor gives the orders and the nurse carries out the instructions.[22] Such attitudes might influence a court to conclude that, irrespective of the UKCC's professional nursing regulations, the consultant is ultimately responsible for determining Ms Gilbert's competence and ensuring that she does not exceed it.

The trust

The trust can become legally responsible for the negligence of the nurse or the consultant in either of two ways: through the concept of vicarious liability, or as a result of the hospital's non-delegable duty to its patients.[23]

Vicarious liability applies in relation to employees of the trust but not to self employed or agency staff. The trust will be liable for any negligence or battery committed by an employee so long as the employee was acting within the course of employment. The definition of "course of employment" is the subject of some legal debate but allows the employer to place limits on the range of tasks within the domain of employment.[24] If, as suggested by the senior nurse, Ms Gilbert's performance of a procedure previously done by the registrar was considered well beyond her expected and authorised responsibilities, she might be taken to have acted outside her course of employment,[25] which would relieve the trust of legal liability for her practice of this procedure.

The trust also has a personal and non-delegable duty to see that each patient is competently treated. Should a patient suffer from Ms Gilbert's practice it can be argued that the trust was negligent in assigning her to tasks for which she had not been properly trained and which were normally done by someone more qualified.

Accountability of employers and employees to each other

THE TRUST AS EMPLOYER

The courts emphasise that the modern employment relationship is one built on "mutual trust and confidence"[26]: while employees must be prepared to adapt to new practices, an employer should provide the means for this, including the necessary training and professional and management support. Here, where Ms Gilbert was unsatisfied with aspects of the training provided, and the organisation of regular meetings for clinical supervision had broken down, it might be claimed that the trust had not provided the necessary support and was in breach of contract. If Ms Gilbert resigned as a result she could have grounds for a claim of unfair dismissal because of this breach.

THE CONSULTANT AND NURSE AS EMPLOYEES

Even when employees (here, the consultant) have not infringed their professional code and their action has not resulted in any commencement of legal proceedings, they may still be in breach of their employer's disciplinary rules and therefore in breach of contract. The behaviour of the consultant in relation to Ms Gilbert's work would be subject to the trust's policies, protocols, and other rules of behaviour. By agreeing that Ms Gilbert should take over the new technical procedure from his registrar before there was agreement by the trust, and in the absence of agreed protocols, the consultant might be in breach of trust policies and thus liable to disciplinary action.

Ms Gilbert refused to clerk routine admissions because she felt she lacked the necessary skills and knowledge. This was correct in terms of her professional UKCC regulations. However, her job specification required her to work on a surgical firm on a similar basis to a house officer. By refusing to carry out the work Ms Gilbert might be considered to be in breach of contract and liable to be disciplined.

Suppose Ms Gilbert was dismissed as a result of her stand on this issue and subsequently brought a case of unfair dismissal to an industrial tribunal. In determining fairness one of the issues for the tribunal would be to consider the adequacy of Ms Gilbert's training and supervision. This could highlight differences between the medical and nursing approaches to these, and clinicians' difficulties when developing roles between two professions with such different educational cultures.[27,28]

Conclusions and recommendations

Ms Gilbert's role might be characterised as that of a "watered down doctor,"[2] one of several emerging at the nursing-medical interface to meet problems in the organisation of doctors' hospital work. Despite criticisms that such medically dominated posts are inappropriate for experienced nurses,[2,29] they appear to be increasing. Other types of expanded nursing roles exist, many located more clearly within nursing and operating within nursing management structures. We suggest that the principles raised in this paper are relevant to all such nursing expansions, although details may differ.

WAYS OF REDUCING THE RISKS

Doctors and nurses have to allow their roles to evolve to meet the rapid changes in health service delivery, technology, and patient needs.[30] Such innovations, however, occur in an era of escalating medical litigation,[31,32] subtle changes in the power relationship between patients and carers,[33] and policies which reinforce patients' rights to complain if adequate services are not provided.[34] It may be some comfort that there is no evidence that nurses in these new roles are more likely to make mistakes than doctors doing the same work. The introduction of crown indemnity for doctors[15] means that if a consultant or nurse in such a development were found legally negligent they would be unlikely to be financially liable for damages. Nevertheless, the stress of an official complaint can be enormous, whatever its outcome.

The dual demands of innovation and safe practice require educational and management strategies designed to make innovation as safe as possible for clinicians and employers. When addressing any ambiguities and apparent contradictions between the three areas of regulation discussed in this paper, we must not forget that the raison d'etre, common to them all, is the protection of patients. Our analyses suggest certain recommendations to minimise risk which complement other more general advice for managing such developments (see box).[35-37]

NURSES AND DOCTORS SHOULD BE EQUAL PARTNERS IN PLANNING AND MANAGING THE NEW ROLES

Because these posts bring together aspects of two very different professions both professions should be involved in the planning and management of such developments. Doctors and nurses developing such new roles should be aware that there may be different demands on each profession for accountability for the scope and standard of their practice. They require support to negotiate appropriate operational arrangements which accommodate the relevant professional regulations; clarify the nature and limits of the post; and provide means of training, supervision, and competence assessment which are mutually agreed.

PATIENTS SHOULD BE INFORMED

There should be an agreed way of explaining the new role to patients, indicating the profession the postholder comes from and relevant training and experience for this job. The nurse's dress and job title require careful consideration to be consistent with these explanations.

APPROVAL BY EMPLOYER AND INSURERS

These posts are innovative and the work required may change within a postholder's appointment. Important changes should be communicated to and agreed by (*a*) all key staff concerned with the post, (*b*) the chief executive of the trust (or delegate) through clearly defined procedures, and (*c*) the insurers of the employer and those of the consultants and nurses directly concerned. Job descriptions should be updated as necessary.

STAFF NEED ACCESS TO LEGAL ADVICE

However carefully these posts are planned and supported, the nurses and doctors involved are potentially vulnerable to the challenge that their practice contravenes professional regulations or aspects of the law. These staff should be advised to join an organisation which can provide independent professional and legal advice and indemnity.

NEED FOR CENTRAL ACTION

Such strategies at trust level are only a partial solution for safe innovation in clinical roles. Urgent action is also needed by the GMC, the UKCC, and the NHS Executive, working together, to clarify relevant regulations, influence legal processes, and educate the public about changing professional roles.

Recommendations to minimise risk

- Nurses and doctors should be equal partners in the planning, management, and training for these new clinical roles
- Patients should be informed adequately of the postholder's role and relevant training
- Changes in the work of such postholders should be formally acknowledged by the employer and relevant insurers
- Staff should have access to legal advice and support
- The GMC, UKCC, and NHS Executive should work together to ensure relevant regulations of the scope and standards of new professional roles

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