LAW for Nurses and Midwives

9th edition

Patricia Staunton & Mary Chiarella

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Table of contents

Dedication

To my parents with love and affection. Patricia Staunton

For my beloved family and my grandchildren, at home and abroad. Mary Chiarella

Preface

It has always been our goal to provide nursing students and practising nurses with an introduction to the legal issues relevant to the provision of healthcare in Australia, and to do so in a practical and readily understandable text with a clear, concise and readable exposition of the law.

With the recent updates to regulation for nurses and midwives under national registration, we have updated the ninth edition of *Law for Nurses and Midwives* with the aim of reflecting these standards, and incorporated legislation relevant to midwifery practice.

All chapters have been revised and updated to reflect recent changes in legislation and regulations relating to nursing and midwifery practice, as have references to relevant court decisions. Special attention has been given to areas where legislative provisions apply, such as professional standard of care, workplace health and safety, coroners' jurisdiction and mental health, to ensure that a nationwide perspective is provided.

Chapter 8 'Professional regulation of nurses and midwives' has undergone a complete rewrite to incorporate the new standards and regulations established by the Nursing and Midwifery Board of Australia for national registration, and includes a specific section on maternity services law to address the new standards and guidelines for eligible midwives. In light of the NMBA's adoption of two international Codes of Ethics for Midwives and Nurses respectively, we have introduced a new chapter that looks specifically at these Codes and explores how they might influence the practices of midwives and nurses by their introduction.

As always, we are extremely grateful for the comments and feedback we have received from readers and professional critics of our text to ensure it remains relevant to those who use it.

Again, we thank our own staff who have provided us with assistance in undertaking our task as well as our publishers for their support and patience during the writing of the ninth edition. Specific recognition must go to Anthony Lark for his assistance with research and to Skye Blackwell, Summer Scholar to Mary Chiarella, for her background work on the Codes of Ethics.

We trust this most recent edition of our text continues to provide assistance to all who use it and we thank them for their encouragement and interest in the ongoing editions of this text.

About the authors

Hon Patricia J Staunton AM, RN, CM, LLB, MCrim;
Barrister-at-Law of the Inner Temple, London

Patricia Staunton has had a professional career encompassing both the health and legal systems. She has qualified and worked as a registered nurse and midwife both in Australia and overseas. She is legally qualified and has practised as a barrister in Australia, during which time she represented nurses and midwives in matters relating to their professional activities as well as industrial matters relating to their professional career structure, wage rates and conditions of employment.

Patricia was the elected General Secretary of the NSW Nurses and Midwives Association for eight years and was instrumental in introducing the professional career structure and wage rates into industrial awards for nurses and midwives in both the public and private sector. She was also the elected Federal President of the Australian Nursing and Midwifery Federation.

Subsequently Patricia was appointed a Magistrate of the Local Courts of NSW and ultimately the Chief Magistrate of NSW. She was then appointed a Judge and Deputy President of the Industrial Court of NSW. Since retiring from that position, Patricia is presently a part-time Deputy President of the NSW Mental Health Review Tribunal.

Patricia has lectured extensively for many years to nurses and midwives throughout Australia addressing legal issues relating to their professional practice. She continues to do so.

In 1995, Patricia was appointed a Member of the Order of Australia for her services to nursing.

Professor Mary Chiarella AM, RN, RM, LLB (Hons), PhD (UNSW), FACN, FRSM

Mary's career spans 40 years both in the United Kingdom and Australia across a variety of nursing services. Mary is Professor of Nursing, Susan Wakil School of Nursing at the University of Sydney. In 2003/04 she was the Chief Nursing Officer, NSW Health Department and prior to that was the Foundation Professor of Nursing in Corrections Health, with the University of Technology, Sydney.

Mary has provided her professional expertise to health services, organisations and governments over the years. She is a Board member of Northern Sydney LHD and currently chairs its Health Care Quality Committee. She also serves on the Clinical Ethics Advisory Panel to the NSW Minister for Health and the Clinical Governance Advisory Committee to *healthdirect* Australia.

Mary's particular research interests focus on legal, policy and ethical issues in nursing, midwifery and healthcare delivery. She publishes and speaks nationally and internationally on her work. She has recently completed an ARC-funded study of a comparative analysis of health professional complaints processes between the

new Australian national regulation scheme and the NSW scheme, and has just completed a study with a grant from the US National Council of State Boards of Nursing exploring insight and continuing competence in clinical practice performance.

She was awarded an AM for significant contributions to nursing and midwifery education and healthcare standards in June 2019.

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Table of abbreviations

A

AC	appeal cases
ACAT	ACT Civil and Administrative Tribunal
ACFI	Aged Care Funding Instrument
ACM	Australian College of Midwives
ACMI	Australian College of Midwives Inc
ACN	Australian College of Nursing
ACORN	Australian College of Operating Room Nurses
ACSQHC	Australian Commission on Safety and Quality in Health Care
ADHA	Australian Digital Health Agency
AHEC	Australian Health Ethics Committee
AHMAC	Australian Health Ministers' Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AIMS	Advanced Incident Management System
AIN	assistant in nursing
AIRC	Australian Industrial Relations Commission
ALJ	Australian Law Journal
All ER	All England Law Reports
ALR	Australian Law Reports
ALRC	Australian Law Reform Commission
ANCI	Australian Nursing Council Inc.
ANF	Australian Nursing Federation
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANMC	Australian Nursing and Midwifery Council
ANMF	Australian Nursing and Midwifery Federation
APAC	Australian Pharmaceutical Advisory Council
APSF	Australian Patient Safety Foundation
ART	assisted reproductive technology
AVM	arterio-venous malformation

C

CCO	continuing care order
CCP	Chief Civil Psychiatrist
CFP	Chief Forensic Psychiatrist
CHF	Consumer Health Forum
CHRE	Council for Healthcare Regulatory Excellence
CLR	Commonwealth Law Reports
CMO	community management order
COAG	Council of Australian Governments
CPD	continuing professional development
CRM	crew resource management
CRPD	Convention on the Rights of Persons with Disabilities
CTO	community treatment order

D

DET	Department of Education and Training
DPP	Director of Public Prosecutions
DST	deep sleep therapy

E

ECT	electroconvulsive therapy
ECV	external cephalic version
EHR	electronic health record
ELS	English language skills
EM	eligible midwife
EMM	electronic medication management
EN	enrolled nurse
ETP	electronic transfer of prescriptions

F

FAQ	frequently asked questions
FCTO	forensic community treatment order

G

GIFT	gamete intrafallopian transfer

H

HCCC	Health Care Complaints Commission
HCE	health complaints entity
HDU	high-dependency unit
HIM	health information management
HPCA	Health Professional Councils Authority
HSR	health and safety representative

I

ICM	International Council of Midwives
ICN	International Council of Nurses
ICSI	intracytoplasmic sperm injection
IDRS	Intellectual Disability Rights Service
IELTS	international English language testing system
IIMS	Incident Information Management System
IPO	involuntary patient order
IQNM	internationally qualified nurses and midwives
ISR	Incident Severity Rating
ITO	involuntary treatment order
IV	intravenous
IVF	in vitro fertilisation

J

J	Judge

L

LQR	The Law Quarterly Review
LRC	Law Reform Commission

M

MBS	Medicare Benefits Scheme
MHIPU	Mental Health Inpatient Unit
MHR	My Health Record

N

NEHTA	National E-Health Transition Authority
NGMI	not guilty on the grounds of mental illness
NHMRC	National Health and Medical Research Council
NMBA	Nursing and Midwifery Board of Australia
NP	nurse practitioner
NRAS	National Registration and Accreditation Scheme
NSQHS	National Safety and Quality Health Service
NSWLRC	New South Wales Law Reform Commission
NSWR	New South Wales Reports

O

OAIC	Office of the Australian Information Commissioner
OD	open disclosure
OH&S	occupational health and safety
OTA	Organ and Tissue Authority

P

P	President
PBS	Pharmaceutical Benefits Scheme
PCA	patient-controlled analgesia
PCBU	person conducting a business or undertaking
PCEHR	Personally Controlled Electronic Health Record
PEP	Professional Education Package
PII	professional indemnity insurance
PIN	Provisional Improvement Notice
PPM	privately practising midwife
PPTP	Prescribed Psychiatric Treatment Panel

Q

QAHCS	Quality in Australian Health Care Study
QB	Queen's Bench
QC	Queen's Counsel
QPD	Queensland parliamentary debates

R

RCA	root cause analysis
RCNA	Royal College of Nursing Australia
RIPN	rural and isolated practice nurses
RM	registered midwife
RN	registered nurse
RoP	recency of practice
RTAC	Reproductive Technology Accreditation Committee

S

SAC	severity assessment code
SASR	South Australian State Reports
SAU	sub-acute unit
SMHU	secure mental health unit
SOP	standard of practice
SQF	Safety and Quality Framework
SQGs	safety and quality guidelines
SUSMP	Standard for the Uniform Scheduling of Medicines and Poisons

T

TEN	trainee enrolled nurse
TO	treatment order
TTO	temporary treatment order

V

VCAT	Victorian Civil and Administrative Tribunal
VHIMS	Victorian Health Incident Management System

W

WHS	Work Health and Safety
WLR	Weekly Law Reports

Z

ZIFT	zygote intrafallopian transfer

CHAPTER 1

An introduction to the law and Australia's legal system

LEARNING OBJECTIVES

In this chapter, you will:

- learn about the philosophies that underpin the development of our legal system
- examine the development of Australia's legal system including common law and parliamentary-made law
- understand the difference between civil and criminal law, and the application of criminal and civil law to your work as a nurse or midwife
- examine the administrative structure of Australia's legal and court systems encompassing the Commonwealth and the states and territories.

INTRODUCTION

Registration as a nurse or midwife in Australia incorporates a *Code of conduct*[1] and a *Code of ethics*[2] as well as a *Standards for practice*[3] that sets out in broad principle-based terms the professional, ethical and legal responsibilities expected in the delivery of healthcare and health services.

A requirement within the *Standards for practice* (at 1.4) states that, when practising, a registered nurse or midwife should comply 'with legislation, common law, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions'.

For a nurse or midwife to attain that standard requires, in the first instance, a rudimentary understanding of what the law is, where it comes from and how it operates. Such an understanding is essential to enable you to extract from a seemingly complex system sufficient practical information to be of benefit to you in your professional life.

The Development of the Law and Its Role in Society

Rather than seek to precisely define what the law is, it is more important to understand the rationale behind the development of the law and its role in society.

The sophisticated and complex legal system that exists in Australia today represents the development of many centuries of Western civilisation. The discovery and colonisation of Australia by England over 200 years ago saw the adoption in this country of the legal system and principles that existed in England at that time. The English legal system, as it then was, originated in primitive community or village systems and its historical development can be traced back over centuries of invasions. These primitive communities recognised the need for rules of behaviour which encompassed respect for each other and each other's property to ensure a degree of order in the community.

Hand in hand with such recognition was the inevitable desire for dominance and power of man over man, which has played such a major role in the development and subsequent decline of civilisations over the centuries.

Inevitably, what started as a crude system for rules of behaviour, operating on an individual community or village basis, was forced to develop and change over the centuries with the growth of the population and the diversity and sophistication of community systems, as well as the rapid growth of industry and technology.

As earlier stated, the laws of a community essentially comprise rules of behaviour as well the recognition of personal and property rights. Within that process, certain philosophies have influenced, and continue to influence, the development of such rules. Primarily these are referred to as natural law and positive law philosophies.

Natural law philosophies, as a general rule, saw the origins of law as arising from a higher or divine being, which encompassed the notion of divine retribution operating in human affairs. Such a philosophy embraced the concept of sin as a transgression against the divine will, or contrary to certain principles of morality.

The development of the Greek civilisation, and to a lesser extent the Roman civilisation, was influenced by such natural law philosophies (in the shape of their gods), which stressed individual worth, moral duty and universal brotherhood. Such philosophies were developed further during the medieval period in Europe by the increasing influence of the Catholic Church, which set the tone and pattern of all speculative thought. The Catholic Church pursued this natural law view as law derived from God with one faith, one church, one empire — not man-made but conceived as part of the universe.

In summary, natural law philosophies view situations as they might or ought to be, as opposed to how they are. It is an idealist notion with strong moral overtones. As an example, the United Nations Declaration of Human Rights is essentially a natural law document.

Positive law philosophies view law in a totally secular cast without regard for divine prescriptions or intervention. Such views emerged during the Renaissance period of European history (fourteenth to sixteenth centuries), which saw the rise of independent national states and emphasis on the individual. Further development occurred during the nineteenth century, when states were established with absolute sovereignty not subject to an external natural law. The industrial revolution and the

development of science supported this imperative theory of law, which saw the key concepts of law as being:

1. the command;
2. of a sovereign (used in this context, sovereign means the government of the state or country);
3. backed by a sanction (i.e. the penalty imposed for non-compliance with the command of the sovereign).

Such a view of the law takes no account of morality, and indeed positive law is most evidenced in the rigid separation of law and morals.

The Influence of Natural and Positive Law Philosophies on the Development of Legal Systems

Natural law philosophies have had their greatest impact on the development of the legal systems of Western civilisation in shaping statements of ideal intent. As an example, the United States Constitution states that the individual has the right to certain fundamental freedoms — two of which are the freedom of speech and freedom of the press. Although such rights are guaranteed in the Constitution, such rights are not absolute in practice, as they are subject to constraints that prohibit that freedom in certain circumstances. As an example, the freedom of the press is subject to the laws of defamation, which will prevent the publication of material in particular circumstances and provide for the courts to award monetary compensation if defamatory material is disseminated. Nevertheless, it is the *intent* of the United States Constitution to guarantee absolute freedom of speech and of the press, so that every citizen and the press should be able to speak their mind and state their views freely, without fear of reprisal.

Natural law philosophies have also been responsible for the continuing influence of morality in shaping some of our present laws, much to the disapproval of positivist lawyers who believe morality should play no part in such an activity. As an example, areas of law-making where morality and/or religious influences have played a significant role in influencing our present laws have been the contentious areas of abortion, same-sex marriage and voluntary euthanasia.[4]

The positive law view that law is a command of a sovereign backed by a sanction means that no regard should be paid as to whether the command of the sovereign may be considered immoral by general community standards or a particular group in the community. The mere fact that the sovereign (the parliament) has the power to command and impose a sanction for non-compliance legitimises such a command. An example of such a situation is the international legal recognition that is given to governments of various countries whose government regimes would be considered by any moral standards to be odious and repressive. At a more local level, an example would be where parliament has approved voluntary euthanasia laws that some sectors of the community would not support because of their religious or moral beliefs.

Both philosophies have had an impact on the laws that we have today and will have in the future.

WHERE DOES OUR LAW COME FROM?

As a legacy of our colonisation by England, Australia as a nation inherited many of England's laws — certainly its legal principles — and in doing so the historical

development of its legal system. Therefore, let's examine briefly the history of the English legal system in order to understand ours.

The development of the English legal system saw the emergence of two major sources of law:

1. common law;
2. parliamentary or statute law.

The Development of the Common Law

To understand how the common law principles developed, appreciate that the land mass known to us as England and Wales[5] was not always the densely populated modern community that it now is. The development of English common law principles that were established on a central unified basis goes back to the time of Henry II, who ruled England from 1154 to 1189.

At that time Henry's kingdom consisted of a large number of feudal villages, each presided over by the feudal lord or chief of the village. Communication as we know it today did not exist, battles between warring factions were not uncommon, and Henry was having the usual problem of maintaining power and control over his kingdom that English monarchs were wont to have in those times.

The law, as then understood and applied, consisted of the rules of the individual villages, generally based on custom and practice, which were administered and interpreted by the feudal lord of the village. Such rules were generally arbitrary and subjective, were changed frequently and varied from village to village.

In an attempt to unify his kingdom and as an alternative to the capricious and variable nature of the individual village laws, Henry offered his subjects access to his law, known as the King's law. This law was also based on custom but had the great advantage of universal application. Henry arranged for his knights to visit each village in his kingdom on a regular basis to deal with disputes that had arisen. The villagers had the choice of being dealt with by the feudal lord according to the laws of the village, or they could wait and be dealt with by the King's knight according to the King's law. The King's emissary was usually fairer, as he was able to be more objective and his decisions were more certain and predictable. In due course more and more people chose to have disputes dealt with in this way and gradually the King's law supplanted the village law system completely.

In offering an alternative system of development and administration of law to his subjects, Henry II was also responsible for commencing the first central unified system of law reporting. In travelling from village to village, not only did his knights attempt to administer the law fairly and objectively but, having applied certain principles to a particular set of facts in one village, they would do so in all future situations where the same facts arose. To be able to do that, they kept notes of the cases they had dealt with and referred to them as required. The recording of previous decisions and the facts on which they were based saw the emergence of certain principles concerning personal and property rights, which became established and were known as **common law principles**.

The writing down of facts and decisions of decided cases also saw the development of what became known as the doctrine of precedent. That is, when a similar case came before the King's judges (knights) they would refer to the notes of previously decided cases based on similar facts to use as a precedent in determining the matter before them. Over the centuries this convenient practice became well established and

developed into a rule of law known as the doctrine of precedent where a previous judgment of a court is used as an authority for determining a case based on similar facts. By the early twentieth century the doctrine of binding precedent had been established.

As communities developed and society became more complex and sophisticated, the common law principles as well as the doctrine of precedent were expanded and developed by the courts and judges who had long replaced Henry's knights of old.

It is interesting to consider that the present-day court structure, where magistrates or judges preside in our cities and towns in each state and territory to administer the law, owes its origins to the primitive system of the King's knights travelling on horseback from village to village administering the King's law.

Clearly, the centuries that have passed since Henry II's time have seen the continued development by the courts of the common law principles. Such principles are well enunciated and recorded in the present sophisticated system of law reporting, which represents the history of such development through decisions of the courts. The principles enunciated in the recording of cases in the law reports are the authorities relied on by lawyers to support a legal argument based on common law principles. This is sometimes referred to as **case law**.

As the court system applied the common law principles and recorded them, certain power struggles were developing, centred on the perceived divine right of the monarchy and the right of the people to have a say in the affairs of government. This struggle culminated in the establishment of the second major source of our law — parliament.

Parliamentary Law or Legislation

The institution of parliament as we know it today, with the power to make and unmake laws, was the result of many years of turmoil and struggle in English history. The long-established divine right of the monarchy, with the power to make and unmake laws and to tax the people at will without accountability, was gradually eroded by increasing demands for representation and participation in government. Out of the demands for representation and participation came the early beginnings of a parliament representative of the people. One of the powers that the early parliaments soon took upon themselves and away from the monarchy was the power to make laws. Although parliaments have also changed in complexity and sophistication, their fundamental right to make laws has remained unchallenged. In the last century particularly, parliaments have increased their law-making role significantly, to keep pace with social, industrial and technological changes in the community. Today many of the well-established common law principles have been extended or replaced by parliamentary-made law to take account of such changes.

Laws created by a parliament are embodied in documents known as **Acts** of that parliament and commonly referred to as **legislation**. When a document concerning a particular matter is placed before a parliament with the intention of creating legislation, it is known as a **Bill**. Once it has been passed by both houses of parliament (with the exception of Queensland, which has only a lower house) and subject to any amendments on the way, it then receives the Royal Assent from the Queen's representative and is formally proclaimed an Act of parliament. The provisions of an Act are known as **legislation** or **statutory law** (or statutory authority).

Acts of parliament often have a separate document known as **Regulations**, which accompany the Act and should be read in conjunction with it. The Regulations generally give precise directions that must be followed to comply with the intent of the Act; for example, the Regulations relating to the New South Wales (NSW) *Poisons and Therapeutic Goods Act 1966* provide considerable detail as to how drugs of addiction are to be stored and the steps that must be observed by registered nurses and midwives in administering such substances. This topic is covered in detail in **Chapter 6**.

Apart from their role in expounding and applying the common law principles, the courts are now increasingly occupied in interpreting the legislation passed by the relevant parliaments.

The Application of English Legal Principles to Australia's Laws and Legal System

The inheritance of the principles and sources of law arising from our colonisation by England laid the groundwork for the development of our legal system.

The English common law principles have been universally adopted throughout the states and territories of the Commonwealth as the basis for future development of the law.

Prior to Federation, the land mass known as Australia consisted of a number of self-governing and independent colonies of the United Kingdom. However, the creation of the Federation in 1901, with concurrent parliamentary systems in each state, and their inherent law-making powers, posed significant problems.

The creation of the Federation pursuant to the *Commonwealth of Australia Constitution Act* (Cth) established a Commonwealth Parliament, and the former self-governing colonies became states of the Commonwealth of Australia. In the same Act, exclusive powers to make laws in relation to certain areas were given to the Commonwealth Parliament. Those areas are set out in section 51 of the Act, and include such common policy matters as customs, currency, overseas trade, defence, and divorce and matrimonial causes. At the same time, section 51 allowed certain powers to be shared between the Commonwealth and the states and territories. Such powers are known as **concurrent powers**. By implication, matters not mentioned in section 51 or elsewhere in the Constitution comprise the powers that can be exercised exclusively by the state or territory parliaments.

The outcome of such a sharing of powers with the right to make laws in relation to them means that all Australian citizens are subject to the laws of two parliaments — the Commonwealth Parliament and the parliament of the state or territory in which they reside. Understandably it can sometimes be confusing.

The power to make laws in relation to health is a concurrent power shared between the Commonwealth and the states and territories. For example, the Commonwealth is responsible for the legislation underpinning the funding of Medicare and general health insurance. Consequently, the Commonwealth has control over the level and extent of financial rebate that is paid by Medicare for general practice fees and medical specialist consultation fees. It also controls the level of fees able to be charged by health insurance companies, and administers and subsidises the Pharmaceutical Benefits Scheme available to all Australians in relation to the cost of approved and prescribed medications. However, it is the state and territory governments that have control of and responsibility for the delivery of hospital and public health services

as well as a broad range of community-based services. In 2012, the Commonwealth introduced a number of sweeping changes to the funding arrangements for the public hospital system in Australia that saw the Commonwealth have a much more direct say in the delivery of public hospital services.

Since 2010, Australia has had a national registration scheme for healthcare professionals, including nurses and midwives. The system is known as the National Registration and Accreditation Scheme (NRAS). Under the *Health Practitioner Regulation (Consequential Amendments) Act 2010* (Cth), nurses and midwives now need to hold only one licence to practise as a nurse or midwife in any state or territory.

The national Nursing and Midwifery Board of Australia (NMBA) is charged with overseeing national registration provisions for nurses and midwives. See **Chapter 8** for full details of those provisions and the implications for nurses and midwives in relation to their professional responsibilities.

Apart from Commonwealth legislation regarding the regulation and registration of health professionals, there are also specific provisions of individual state or territory legislation regarding the delivery of health services that can, and do, vary. For example, although generally consistent in their respective approaches, each state and territory has its own version of a *Mental Health Act*. The same applies to the legislation relating to the control and supply of poisons and prohibited substances which governs the administration of dangerous drugs and drugs of addiction in each state and territory.

Nurses and midwives quite often move freely between the states and territories seeking employment. Accordingly, when such a shift is made, it is important that differences in legislative provisions which are relevant to a nurse's or midwife's employment are known and emphasised.

THE DIFFERENCE BETWEEN CRIMINAL LAW AND CIVIL LAW

The law is divided into two distinct areas:

1. criminal law;
2. civil law.

It is essential that such a distinction is grasped from the very beginning, as otherwise it makes it difficult to understand and follow the legal process.

Criminal Law

The best way to think of the criminal law is that it is essentially rules of behaviour (laws), backed by the sanction of punishment, that govern our conduct in the community, particularly in relation to other people and their property. Most of us are aware of the more common rules of behaviour — for example, not taking another person's property without their consent, not assaulting another person, or not exceeding the speed limit when driving a motor vehicle. The parliament's power enables it to set the rules by passing legislation (laws) stating what actions are deemed unlawful and generally determining the punishment (sanction) that will apply if a person is found to have committed the particular unlawful act.

The government monitors our behaviour in the community to ensure we obey the laws or face the sanction of punishment, by way of delegated authority to the police force. Their task, in the first instance, is to adopt a preventive role and, in the second instance, to 'catch' us when we do break the law. Having done that, the police must, via the relevant prosecuting authority, charge the person (the accused) with a breach of the law (a criminal offence) and then the prosecuting authority must prove that the accused committed the offence charged.

The task of having to prove an offence has been committed is known as having the **burden of proof** or **onus of proof**. In satisfying the burden of proof, the prosecution must prove the offence according to the criminal law **standard of proof** — that is, beyond reasonable doubt — by producing evidence from a number of different sources, for example:

- evidence of identification and relevant events from the victim (if possible);
- direct evidence of eyewitnesses who saw the offence being committed;
- medical or scientific evidence by experts;
- written or verbal admissions made by the accused.

A criminal charge will be dealt with before a judge and jury or before a magistrate sitting alone. More serious matters are generally always dealt with by a judge and jury, with the jury having the task of deciding the guilt or innocence of the accused based on the evidence presented. In some states, it is possible for the accused to elect to be tried by a judge alone without a jury. The role of the judge in such trials is to determine points of law and ultimately sentence the accused if he or she is found guilty. In less serious criminal matters a magistrate will hear and determine the matter without a jury and sentence the accused. The degree of the punishment will depend on the nature and seriousness of the offence and can range from fines, bonds, community-based supervision or intensive correction orders, periodic detention and home detention, to imprisonment.

In addition to the criminal offences that most people think of when they think of the criminal law — that is, murder, assault, robbery, theft, fraud and so on — there are other categories of criminal offences that individuals or companies can commit. For example, companies and/or individuals can be prosecuted for environmental, occupational health and safety, or corporate law offences.

Unless the accused is acquitted of the offence, the outcome of the criminal law process is punishment.

WHAT CONSTITUTES A CRIME?

If a person is charged with a criminal offence, the prosecution must prove that two essential elements existed at the time the offence was committed:

1. the activity that constitutes the offence; and
2. the intention to carry out the particular activity or a high degree of reckless indifference as to the probable outcome of a particular activity.

The first element is often referred to as the *actus reus* of the offence. For example, in a charge of theft, the 'activity' of the offence would be the dishonest appropriation of property belonging to another person without that person's consent.

The second element is often referred to as the *mens rea* of the offence — that is, the guilty mind, where there is the intention to carry out the offence, or in some instances a high degree of reckless indifference as to the probable outcome of a particular activity.

As a general rule, if the activity is carried out without intention there can be no crime. So, using the example of the offence of theft again, the 'activity' and 'intent' elements of that offence, when expressed together, would be the taking of property belonging to another without their consent with the intention of permanently depriving them of the property. The presence or otherwise of an intention to harm is particularly relevant in the healthcare environment. That is, a health professional may, by their actions or a failure to act, cause harm to a patient but almost invariably they do not intend to harm the patient.

NURSES AND MIDWIVES AND THE CRIMINAL LAW

It is hoped that a detailed knowledge of the criminal law does not arise for consideration in your day-to-day working activities. However, regrettably, there have been instances where registered nurses have been charged with serious criminal offences relating to their professional activities.[6]

Remember, for the actions of a nurse or midwife to constitute a criminal offence it is necessary for the prosecution to prove not only that the nurse or midwife did the act that constitutes the crime but also that he or she intended to do the act. Most actions of a nurse or midwife that do cause harm to a patient are never intended to do so. They are almost invariably a negligent act without any intent to harm. However, the negligent act may create a civil liability on the part of the nurse or midwife or his or her employer.

CRIMINAL NEGLIGENCE AND THE SIGNIFICANCE OF INTENT

On occasions, incidents may occur in hospitals or healthcare centres that, at first glance, suggest a criminal offence has been committed. For example, if a patient died as a result of the administration of a wrong drug, it might be thought that whoever administered the drug was guilty of murder or manslaughter. However, as far as the criminal law is concerned, the most significant factor to be established would be the presence or otherwise of any intent to cause harm or a high degree of recklessness or inadvertence such as to amount to criminal negligence. If the wrong drug were administered intentionally, with the deliberate intent to kill the patient, this would amount to murder. If the drug were given believing it to be the right drug but with an attitude or degree of recklessness as to the amount to be given or the contraindications to be observed in the administration of the drug and the patient died as a result, this may amount to the offence of manslaughter on the basis of criminal negligence.

In most situations in hospitals where mistakes are made, a degree of carelessness or error of judgment is usually present such as to amount to civil negligence. For a nurse or midwife to be found guilty of criminal negligence as a result of their activities at work, there has to be a much higher degree of negligence, which would demonstrate an attitude of recklessness or inadvertence to the possibility of harm occurring.

It follows that it is important to distinguish between civil negligence and criminal negligence. One of the earliest cases that clearly made that distinction concerned the actions of a doctor in attending a woman during delivery. **Case example 1.1** sets out the relevant facts; then consider **Clinical study 1.1**, which follows.

CASE EXAMPLE 1.1

R v Bateman[7]

Dr Bateman attended a woman at home during labour. The labour was prolonged, and the child's presentation was unusual and difficult. The doctor attempted to turn the child by the procedure known as 'version'. In doing so, he used considerable force over a period of an hour and delivered the child, which was dead. In delivering the placenta he also removed, by mistake, a portion of the patient's uterus. After the delivery the doctor left the patient at home. Five days later the patient was so ill that the doctor then transferred her to hospital where she died 2 days later. The post-mortem examination revealed the following:

> **... the bladder was found to be ruptured, the colon was crushed against the sacral promontory, there was a rupture of the rectum and the uterus was almost entirely gone.**[8]

Comment and Relevant Considerations Relating to *R v Bateman*

Dr Bateman was charged with manslaughter on the grounds of criminal negligence in that he had:

- caused the internal ruptures in performing the operation of version;
- removed part of the uterus along with the placenta;
- delayed sending the patient to hospital.

Dr Bateman was initially found guilty of the charge, but successfully appealed that decision. His conviction was quashed. In handing down their decision the appeal court judges said:

> To support an indictment for manslaughter the prosecution ... must satisfy the jury that the negligence or incompetence of the accused went beyond a mere matter of compensation and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving of punishment ... *there is a difference in kind between negligence which gives a right to compensation and the negligence which is a crime*.[9] [emphasis added]

While the appeal court judges may have considered Dr Bateman had been less than professionally competent in carrying out the surgery, they did not accept that his actions amounted to a 'disregard for the life and safety' of his patient such as to amount to criminal negligence.

Although Dr Bateman's case is some considerable time ago, the test to be applied when considering manslaughter by criminal negligence has remained fundamentally unchanged. In 1992, the High Court of Australia approved the following formulation of the elements of manslaughter by criminal negligence in the following terms:

> In order to establish manslaughter by criminal negligence, it is sufficient if the prosecution shows that the act which caused the death was done by the accused consciously and voluntarily, without any intention of causing death or grievous bodily harm but in circumstances which involved such a great falling short of the standard of care

> which a reasonable man would have exercised and which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment.[10]

Where, as in the case of Dr Bateman, a specific duty of care is owed to the victim, the elements of the offence that must be established beyond reasonable doubt are slightly modified and have been expressed in 2019 in the South Australian Supreme Court decision[11] involving a registered midwife charged with two counts of manslaughter by criminal negligence as follows:

- The accused owed the victim a duty of care.
- The objective standard of conduct required of her was that of a reasonably competent midwife.
- The accused's act and omissions caused the death of the victim (in the sense of being a substantial cause of death).
- The accused's acts and omissions were deliberate.
- The accused's acts and omissions fell so far short of the applicable standard as to amount to gross or criminal negligence and thereby to warrant criminal punishment.

In the above case, after considering all the evidence and after considering the elements required to be established, the Court determined the midwife not guilty on both charges.

Having regard to the above test, consider the hypothetical example set out in **Clinical study 1.1**.

CLINICAL STUDY 1.1

A patient, Mr Smith, was ordered to have a number of units of blood following major surgery. The appropriate cross-matching had been done and the cross-match slip was received in the ward. When one of Mr Smith's units was complete, Ms Jones, a registered nurse, went out to the refrigerator where cross-matched blood for all of the patients in the hospital was kept. Ms Jones picked up the first bag of blood she saw and did not bother to check it against any slip or with any other person. She came back to the ward and then proceeded to administer it to Mr Smith. The blood was incompatible; Mr Smith had an extremely adverse reaction to the incompatible blood; he nearly died and was extremely ill for many months. When questioned about her actions, Ms Jones admitted that she was aware of the dangers of incompatible blood transfusions and the need for checking but thought that on this one occasion it would be 'all right', and that nothing would happen. She also said she was sorry about what had happened and had not really meant to hurt Mr Smith.

Comment and Relevant Considerations Relating to Clinical Study 1.1

Ask yourself these questions:

- Did Nurse Jones owe Mr Smith a duty of care?
- What was the standard of care expected of Nurse Jones in administering the blood transfusion?
- Did Nurse Jones's acts and omissions cause the injury and damage to Mr Jones?
- Were Nurse Jones's act and omissions deliberate?
- Did Nurse Jones's acts and omissions fall so far short of the applicable standard as to amount to gross or criminal negligence and thereby warrant criminal punishment?
- If so, in what way?
- What should Nurse Jones have done?

On the facts provided, it is highly likely the prosecuting authorities would consider Nurse Jones' actions did warrant charging her with criminal negligence. Obviously the example is extreme, but it illustrates the degree of negligence that must be present to constitute the requisite intent in a charge of criminal negligence occasioning grievous bodily harm. If Mr Smith had died as a result of the incorrect blood transfusion, again on the basis of the facts given, Nurse Jones would probably face a charge of manslaughter by criminal negligence.

In considering what Nurse Jones should have done, it would be said that as a registered nurse, Nurse Jones owed Mr Smith a duty of care. Further, Nurse Jones was well aware of the significant dangers of administering incompatible blood to a patient. As well, there would be a clear policy and checking procedure required to be followed when administering a blood transfusion to a patient. Knowing that, the actions of Nurse Jones would, we submit, be considered as showing a reckless disregard for, or indifference towards, the safety of Mr Smith.

As a general rule (thankfully) the type of professional activity that would constitute criminal behaviour falls outside the scope of practice of most nurses and midwives. However, it is the element of either direct intent or 'reckless indifference' to the possible outcomes of one's actions that can render a harmful act a crime, and it is important to bear this in mind in going about your day-to-day work as a nurse or midwife.

How does the above process differ from the civil law?

Civil Law

The first thing to remember about civil law is that, generally speaking, it has nothing whatsoever to do with the police force and punishment. The best way to think of civil law is that it exists to enable us, individually and collectively, to resolve the disputes and differences of a personal and property nature that arise between us as members of the community and which we are unable or unwilling to resolve ourselves. Usually in resolving such disputes, monetary compensation (damages) will be sought by the person or party alleging personal and / or property loss and damage. There are many divisions of the civil law — for example, family, industrial, land and environment, and workers compensation, to name just a few. There is also what is known in civil law as a common law division and into that division are allocated those matters whose origins are the well-established common law principles, such as contract law, negligence, defamation or nuisance.

The person who initiates an action in civil law is known as the **plaintiff** and the person against whom the action is taken is known as the **defendant**. There are exceptions to this; for example, in family law the person seeking a divorce is the **applicant** and the spouse from whom the divorce is sought is the **respondent**.

Similar to the requirement in criminal law, the person who brings an action in one of the areas of civil law (the plaintiff) bears the burden of proving the matter in dispute. The significant difference here is that, although the plaintiff has that onus, the standard of proof in civil matters is not the same as in criminal matters. In a civil action the plaintiff has to prove his or her case only on the balance of probabilities. What this means is that the evidence would disclose that, on balance, the allegation made by the plaintiff, when considered against the evidence produced, and in light of the law as currently applying, is the most probable cause of the matter in dispute. Proving an allegation on the balance of probabilities is a much lower standard of proof than that required in criminal law.

When the plaintiff succeeds in proving the matter in dispute, the final and most important issue to be determined by the court will be the amount of monetary compensation (damages) to be awarded to the plaintiff. In most circumstances, the outcome of the civil law process is compensation. There are some exceptions to this and civil law does provide for other remedies that may compensate the plaintiff. For example, the court could order that the defendant do a certain thing (specific performance) or refrain from doing a certain thing (an injunction). In family law the court may make a decision about access to or custody of children or the division of the assets of the marriage. However, as a general rule, the awarding of a sum of money to the plaintiff is seen as the most appropriate way of resolving the dispute between the parties.

In the awarding of damages by a court, the court itself does not actually give the money awarded to the plaintiff. The court hands down a judgment identifying the amount of compensation it determines the plaintiff is entitled to. The plaintiff must then recover that money from the defendant. In most civil litigation that means recovering the money from the defendant's insurance company. However, if there is no relevant insurance company standing behind the defendant and the defendant is impecunious, then the plaintiff may well be left without compensation. It is a salutary reminder of one of the pitfalls of civil litigation.

Civil and Criminal Consequences

There can be civil and criminal consequences from one action. Having taken pains to distinguish between the civil and criminal law processes, we must now muddy the waters somewhat and point out that one incident can lead to both civil and criminal law proceedings. For example, while driving your motor vehicle one day you wrongfully fail to give way to traffic on your right at an intersection and, as a result, an accident occurs and a number of people in the other vehicle are badly injured. The police will be called, and you, as the driver of the vehicle that caused the accident, will be charged with a number of offences such as negligent driving and failing to give way. Your action and the charge that follows is deemed to be a criminal act pursuant to the legislation covering motor traffic offences in your state or territory, and in due course you will be dealt with before the appropriate court. Assuming your guilt, you will then be punished — you will probably be fined, your licence may be taken away or an even more severe penalty may be imposed, depending on the culpability of your action.

However, the people that you have left badly damaged at the scene of the accident may be more concerned with seeking some money from you to compensate them for the pain, injury, loss and suffering you have caused them as a result of your negligent act — that is, your **civil wrong**. Those people will commence an action against you and allege that, on the basis of certain facts, you drove your car negligently, as a result of which they suffered certain damage. They will have to prove, on the balance of probabilities, the facts and damage they are alleging. Assuming they are successful, they will be awarded damages as compensation for their injuries and the subsequent losses that flow from those injuries.

It will be seen from the above example that the major distinction to be drawn between the civil and criminal act *resides not in the nature of the wrongful act but in the legal consequences that may follow it*.[12] That is, if the wrongful act is capable of being followed by what are called **criminal proceedings**, that means that it is regarded as a **crime** (otherwise called an offence). If it is capable of being followed by **civil proceedings**, it is regarded as a **civil wrong**. If it is capable of being followed by both, it is both a crime and a civil wrong.[13]

Civil and criminal proceedings are (usually) easily distinguishable; the procedure is different, the outcome is different and the terminology is different.

ADMINISTRATIVE STRUCTURE OF AUSTRALIA'S LEGAL AND COURT SYSTEM

The administrative structure of Australia's legal and court system encompasses the Commonwealth and the states and territories. In its day-to-day operation the administration of the law is also divided along criminal and civil lines. In addition, there is a hierarchical structure that determines:

- what matters can be dealt with by particular courts;
- the powers that are vested in the different courts to deal with matters that come before them;
- if a right of appeal exists from a particular court, how and in what circumstances it is to operate.

All the states and territories have a similar basic hierarchical structure of the administration of the law. The titles of the courts may vary from state to state or territory, but not to any significant degree. The following summary of the roles of the various courts should be read in conjunction with **Figure 1.1**, which illustrates the hierarchical structure of courts in Australia.

State and Territory Courts

LOCAL OR MAGISTRATES' COURTS

The *Local Courts Act 1982* (NSW) formally changed the title of magistrates' courts from Courts of Petty Sessions to the Local Courts of New South Wales. The Northern Territory did likewise in 2016. In the other states and territories, such courts continue to be known as Magistrates' Courts.

These courts are at the bottom of the legal hierarchy, but undoubtedly deal with the greatest number of matters. They are presided over by magistrates, who are legally trained and qualified. Even tiny country towns have sittings of the Local

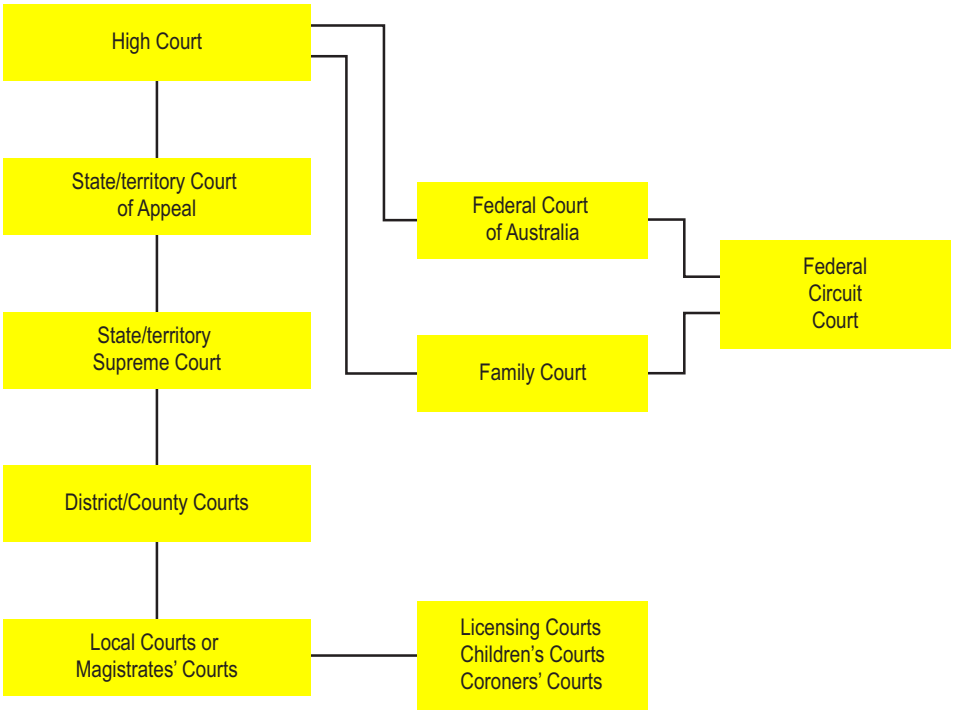

Figure 1.1
Hierarchical structure of courts in Australia.
Source: Staunton P and Chiarella M, *Law for nurses and midwives*, 7th ed, Elsevier, Sydney, 2012.

or Magistrates' Court and, in big cities, Local or Magistrates' Courts are located in many suburbs.

In carrying out their task, magistrates sit without a jury and can deal with criminal and civil matters, including some family law matters. However, magistrates can deal only with those matters they have the power (jurisdiction) to deal with. In general terms, magistrates can deal with civil matters where the amount claimed in damages does not exceed the amount determined by the relevant legislation. In most states and territories that amount is $100 000, with some provision for extending that for money claims excluding personal injury cases. In the Northern Territory the jurisdictional limit is $250 000.

In criminal matters, magistrates deal with a wide range of criminal offences as well as applications for apprehended violence orders and alleged breaches of such orders. Not surprisingly, such offences constitute the bulk of crimes committed in the community. Magistrates' powers to punish are limited to the type of offences with which they deal.

One extension of a magistrate's role in criminal matters is that, in relation to serious criminal offences which they do not have the power to deal with to finality, they do have the job of deciding whether there is sufficient evidence to establish a *prima facie* case against the accused — that is, based on first impressions and from a consideration of the evidence, whether there is sufficient evidence to show that a jury is likely to find the accused guilty. If they so decide, the accused is then sent for

trial before a higher court. Such proceedings are known as **committal proceedings**. In some states now, the initial committal process has been significantly truncated: instead of having an extensive preliminary hearing at the committal stage, the prosecution simply tenders the statements from those persons they wish to call at trial. Witnesses may or may not be called at that stage. Whatever procedure is observed from state to state and territory, the magistrate is still required to formally commit the accused to stand trial.

Magistrates also deal with the bulk of bail applications. Granting bail to a person arises when the person is charged with a criminal offence and is remanded in custody before they come before a court in the first instance. Very often, when they do appear before the court, an application is made that the person be granted bail — that is, released into the community subject to certain conditions while waiting for their matter to be heard by the court.

Magistrates may also preside over a range of other courts — for example, Licensing Courts, Coroners' Courts and Children's Courts. Of all of those subsidiary courts, the Coroner's Court is most relevant to nurses and midwives. **Chapter 10** outlines the role of the Coroner's Court in more detail.

DISTRICT OR COUNTY COURTS

The next tier in the hierarchy of the court and judicial system is the District or County Court, depending on the state or territory. In New South Wales, Queensland (Qld), South Australia (SA) and Western Australia (WA) it is known as the District Court, whereas in Victoria (Vic) it is called the County Court.

Because of their relatively small size or population, the Australian Capital Territory (ACT), the Northern Territory (NT) and Tasmania (Tas) do not have an equivalent intermediate court, and rely on the Magistrates' Court and Supreme Court to cover their criminal and civil jurisdictions.

Sittings of the District or County Court are presided over by a judge appointed from the legal profession. The judge sits with a jury in criminal matters, but generally sits alone in civil matters. The role of the jury in criminal matters is to decide on the guilt or innocence of the accused. The role of the judge in criminal matters is to decide questions of law, direct the jury on relevant points of law that arise, and punish the accused when, and if, he or she is found guilty of the offence. Juries are not routinely used in all civil matters. When they are, their role is to decide the issue in dispute and, if decided in favour of the plaintiff, to generally determine the amount of compensation to be awarded.

The role of the District or County Court judge is divided into civil and criminal sections and, like the Local and Magistrates' Courts, there is a limit placed on the jurisdiction of these courts to deal with such matters. There are variations between the states; in New South Wales, for example, the jurisdiction of the District Court to deal with civil matters is limited to those matters where the amount claimed in damages does not exceed $750 000 and is unlimited in relation to motor vehicle injury claims.

In criminal matters the District or County Court deals with all major criminal offences except murder, piracy and treason. In other states and territories the civil and criminal jurisdiction of this court does vary. The power of this court to punish extends to the penalties provided for the offences it has to deal with. Judges of this court sit daily in the capital cities and large country towns and travel on circuit to smaller country towns for a week or two at regular intervals.

Judges of this court can also hear appeals from a decision of a magistrate in certain matters.

SUPREME COURTS

All states and territories have a Supreme Court. It is the highest or most senior court in the judicial system within state and territory boundaries. Sittings of this court are presided over by judges appointed from the legal profession and, in carrying out their task, they sit with a jury in the same circumstances as judges in the District or County Court. The role of this court is divided into civil and criminal sections. This court has unlimited financial jurisdiction in civil matters and its criminal role is generally confined, as a matter of practice, to dealing with the capital offences of murder and serious sexual offences.

Like the District or County Court judges, judges of the Supreme Court sit daily in the capital cities. There are regular sittings of the court in major country towns, which are presided over by the judges travelling on circuit in the same way as the District or County Court judges do.

One of the additional tasks of the Supreme Court is to hear appeals from the lower courts and from decisions of a single judge of the Supreme Court. To do this, a Court of Appeal has been established within the Supreme Court and is presided over by at least three judges of appeal. Once again the appellate role of the Supreme Court is divided into civil and criminal sections.

Commonwealth Courts

FEDERAL CIRCUIT COURT (PREVIOUSLY KNOWN AS FEDERAL MAGISTRATES COURT)

The Federal Magistrates Court was created by the Commonwealth Parliament in 2000 by the enactment of the *Federal Magistrates Act 1999*. In 2013, the Federal Magistrates Court was renamed the Federal Circuit Court.

The court was created to alleviate the large workloads of the Federal Court and the Family Court. As such, the Federal Circuit Court shares concurrent jurisdiction with the Federal Court and the Family Court over these areas of law:

- family law and child support;
- administrative law;
- bankruptcy;
- unlawful discrimination;
- consumer protection and trade practices;
- privacy law;
- migration;
- copyright;
- industrial law;
- admiralty law.

The Federal Circuit Court does not deal with criminal matters. Although the court shares concurrent jurisdiction with the Federal Court and the Family Court, its jurisdiction is limited in certain areas. For example, it does not have the power to deal with adoption and applications concerning nullity or validity of marriage under its family law jurisdiction.

Appeals from final decisions of federal magistrates are available as a right to appeal to the Full Court of the Federal Court or the Family Court, depending on the jurisdiction exercised by the court.

FAMILY COURT

The Family Court was created by the Commonwealth Parliament in 1975 by the enactment of the *Family Law Act 1975* to deal with issues arising in relation to marriage, children and property rights. Within the Family Court structure, there is provision for an appeal court of three judges known as the Full Court of the Family Court. That court hears and determines appeals from decisions of single judges of the court and from the Federal Circuit Court. There is also an appeal right with leave from the Full Court of the Family Court to the High Court.

FEDERAL COURT

The Federal Court was created by the Commonwealth Parliament in 1976 by the enactment of the *Federal Court of Australia Act 1976*. The main reason for its creation was to relieve the High Court of its workload that arises from some of the exclusive constitutional powers of the Commonwealth — for example, trade practices, bankruptcy, immigration and federal industrial issues. Within the Federal Court structure, there is provision for an appeal court of three judges known as the Full Court of the Federal Court. That court hears and determines appeals from decisions of single judges of the court and from the Federal Circuit Court. There is also an appeal right with leave from the Federal Court to the High Court.

HIGH COURT

The High Court was created by the *Commonwealth of Australia Constitution Act*, which has been previously referred to. The initial intent in creating the High Court was that it would deal with constitutional disputes that arose between the Commonwealth and the states and territories.

In addition to dealing with constitutional matters, the role of the High Court as a senior and final court of appeal from the Supreme Courts, as well as the Federal and Family Courts of Australia, has increased considerably to embrace civil and criminal matters. An appeal in such circumstances is not automatic, as the High Court must grant leave to appeal and will do so only if the matter to be appealed constitutes a point of law of general public importance.

For many years there was a right to seek leave to appeal from a decision of the High Court to the Privy Council in the United Kingdom, but this was abolished in 1975.

The High Court is the final Court of Appeal in Australia on all matters.

Other Court Systems and Tribunals Including Professional Disciplinary Tribunals for Nurses and Midwives

Coexisting with Australia's courts, and feeding into them at various points, generally for appeal purposes, is a wide range of courts and tribunals dealing with specific matters — for example, industrial courts, workers compensation courts, land and environment courts, anti-discrimination and administrative appeals tribunals as well as professional disciplinary tribunals. **Chapter 8** outlines in more detail the role of the nurses' and midwives' professional disciplinary tribunals.

The Appeal Process

Generally speaking, there is nothing to prevent a person or party who so wishes from appealing against a decision of a magistrate to a higher court. Such an appeal may be based on a number of points — for example, that the magistrate erred on a point of law or that the punishment imposed was too severe or too lenient. Likewise, the decision of a District or County Court judge or a single Supreme Court judge may also be appealed against to the appeal court of the Supreme Court on similar grounds. From there, an appeal may be made to the High Court, subject of course to leave being granted by the High Court.

CONCLUSION

Understanding Australia's legal system and court structure is an important first step that should assist nurses and midwives to readily and correctly incorporate their professional and legal responsibilities into the appropriate legal context.

CHAPTER 1 REVIEW QUESTIONS

Following your reading of Chapter 1, consider these questions and the issues they raise for discussion and reflection.

1. What are the two major sources of law in Australia's legal system?
2. Both the Commonwealth and the state and territory parliaments have the power to make laws in relation to the delivery of health services including the registration and regulation of health professionals. Name two areas of healthcare where laws have been made by the Commonwealth Parliament and two that have been made by a state or territory parliament in which you currently practise as a nurse or midwife.
3. Is it possible to have a civil law action and a criminal law action arising out of one action? If so, give an example where such a situation may arise and describe the distinction between a criminal offence and a civil wrong.
4. If a nurse or midwife were negligent in the course of their professional practice and a patient suffered harm as a result, what circumstances would need to be established to warrant the nurse or midwife being charged with criminal negligence as distinct from civil negligence?
5. In a claim alleging a civil wrong, what is the general outcome that a person would be asking the court to determine?
6. If a person is charged with a criminal offence, what are the alternative outcomes that may occur?

Endnotes

1 A new *Code of conduct for registered nurses* and a *Code of conduct for midwives* were issued by the Nursing and Midwifery Board of Australia, effective from 1 March 2018.

2 In March 2018 the Nursing and Midwifery Board of Australia, the Australian College of Midwives, the Australian College of Nursing and the Australian Nursing and Midwifery Federation jointly

adopted the International Council of Nurses (ICN) and the International Council of Midwives (ICM) *Code of ethics*.

3 The Nursing and Midwifery Board of Australia: *Registered nurse standards for practice*: June 2016. See **Chapter 8** for more information.

4 It is worthwhile reflecting on recent developments in Australia where parliaments have passed laws in relation to each of these areas, all of which were subject to diverse community views. For example:

(i) in December 2017, the Commonwealth Parliament approved an amendment to the *Marriage Act* permitting same-sex marriage in Australia;

(ii) in October 2018, the Queensland Parliament decriminalised and approved the availability of abortion on request in the first 22 weeks of pregnancy: Qld *Termination of Pregnancy Act 2018*;

(iii) in November 2017, the Victorian Parliament approved the *Voluntary Assisted Dying Act* permitting a person to voluntarily request medical assistance to end their life in circumstances where the person had a terminal illness together with a life expectancy of less than 12 months;

(iv) in 2019, the NSW Parliament decriminalised abortion by removing it as an offence under the current NSW *Crimes Act*.

5 Scotland has developed a slightly different legal system from England, Wales and Northern Ireland, based on a combination of common law and Roman law principles.

6 For example:

(i) in May 2013 a registered nurse, Roger Deans, pleaded guilty to 11 counts of murder and eight counts of causing grievous bodily harm arising from his actions in starting a fire in a nursing home in NSW. He started the fire to cover up his theft of prescription drugs particularly drugs of addiction. He was sentenced to 11 life sentences;

(ii) in 2016 a registered nurse, Megan Hains, was sentenced to 36 years imprisonment with a non-parole period of 27 years for the murder of two elderly patients in a nursing home in NSW. It is alleged she injected them with insulin. She has appealed her conviction and sentence;

(iii) in March 2019 a midwife, Lisa Jane Barrett, went on trial for manslaughter over the deaths of two babies in South Australia delivered in October 2011 and December 2012. On 4 June 2019, following a trial in the Supreme Court of South Australia, she was found not guilty on two counts of manslaughter. See *R v Barrett* (No 3) [2019] SASC 93.

7 *R v Bateman* (1925) All ER 45.

8 Ibid, at 47.

9 Ibid, at 49, 51.

10 *Wilson v The Queen* (1992) 174 CLR 313 at 333 approving the formulation as established in *Nydam v The Queen* (1977) VR 430 at 445.

11 *R v Barrett* (No 3) [2019] SASC 93, Vanstone J, at 110.

12 Williams G, *Learning the law*, 10th ed, Stevens, London, 1979, p 2.

13 Ibid, p 62.

CHAPTER 2

The relationship between law and ethics

LEARNING OBJECTIVES

In this chapter, you will:

- consider differences and similarities between law and ethics
- examine well-known ethical theories and principles
- identify and explore a practical model for ethical decision-making
- apply ethical theories and principles and an ethical decision-making model to an ethical dilemma.

INTRODUCTION

This chapter provides a basic overview of the relationship between law and ethics and a practical example of how the two both interlink and diverge. It explains ethical theories and principles, offers a practical model for ethical decision-making and, perhaps most importantly for the reader, provides excellent references in the endnotes for those who wish to explore ethical decision-making in greater depth. In keeping with the objectives of this book, the chapter has a practical, rather than theoretical, focus.

THE APPLICATION OF LAW AND ETHICS TO PRACTICE

To use a personal example to explain the relationship between law and ethics, if you were told you needed to have an operation, there would be a number of concerns you would wish to have addressed:

- You would want to be informed adequately about the nature and consequences of the surgery so that you would be able to make a wise choice.

- You would want to know that the surgeon and anaesthetist are competent, that the nursing staff are competent and will care for you in a compassionate manner, and that the private information you choose to share with the nursing and medical staff will be treated confidentially and not discussed inappropriately.

For each of these concerns to be addressed properly, the nursing and medical staff who care for you will be required to behave in a professional manner; in the majority of cases, this is indeed how nursing and medical staff do behave.

All of the above professional behaviours are ethical behaviours — they comply with established ethical principles and theories. Nurses, midwives and doctors normally behave in these ways because they are professional and they wish to give the best possible care to their patients. However, in Australia all of these behaviours are also legal requirements; these behaviours are so fundamental to people's expectations of health professionals that they have been either incorporated into the common law or enshrined in legislation. **Chapter 1** discussed this need to provide for orderly and good conduct through the development of legal systems.

The major difference between these professional expectations being legal, as opposed to ethical, is that, from a legal perspective, if these expectations are breached there will usually be some form of sanction or adverse consequence for the health professional concerned.

However, sometimes the alliance between legal and ethical requirements is not as clear as in the above example. Not all laws are necessarily ethical — for historical examples, consider the laws governing slavery in America, the laws allowing persecution of the Jews in Nazi Germany, or the apartheid laws in South Africa. Throughout history many people, believing strongly that certain laws were unethical, did not comply with them and as a consequence put themselves at considerable personal risk. These are obviously extreme examples, but there are other scenarios where two or more possible courses of action are available, each of which may be perfectly legal, but over which there may be disagreement as to the best, or most ethical, course of action. Such situations may offer a range of alternative solutions, none of which will offer an ideal outcome. Consequently, these will create ethical quandaries or dilemmas for the people involved. A moral or ethical dilemma is usually a choice between two or more unacceptable alternatives. Ganz, Wagner and Toren elucidate on this:

> Nurses are often confronted with ethical dilemmas where the nurse is expected to choose between unsatisfactory alternatives. The nurse is conflicted because each of the opposing choices is ethically supported while each of the opposing choices is also considered ethically problematic. Some information supports both choices as being morally right, while other evidence suggests that the same choices are morally wrong. The nurse, therefore, has difficulty deciding between two or more choices that are equally unsatisfactory.[1]

However, there is more to making ethical decisions than simply adopting a moral stance, for example, according to strong religious or moral beliefs. Ethical decision-making is a complex and rigorous process, whereas our morality is what propels us to adopt a particular stance based on a particular set of beliefs, many of which have been inculcated into us since childhood. Johnstone, who (unusually) argues that there is no philosophically significant difference between ethics and morality, nevertheless points out that:

> . . . while our 'ordinary moral apparatus' may motivate us and guide us to behave ethically as people, it is often quite inadequate to the task of guiding us to deal safely and effectively with the many complex ethical issues that arise in nursing and healthcare contexts.[2]

Ethics requires a consideration not only of morality but also of many other factors, as will be discussed further later in this chapter.

Because of the human and complex nature of healthcare, ethical dilemmas are not uncommon in clinical practice and have received much attention in both academic and media circles over the past three decades. The study of ethical dilemmas in healthcare is often called *bioethics*. There are many comprehensive texts available on the subject, a number of which are used as references in this chapter.

Some of these ethical dilemmas have been major issues for society as a whole to ponder, such as resource allocation, euthanasia and gene technology; but other, more individual clinical dilemmas, such as telling patients the truth, challenging doctors about choices of treatment and prioritisation of care, have also been reported by nurses and midwives as causing considerable angst.[3]

Making decisions about any ethical dilemma is complex. Usually there are no simple answers; otherwise there would be no dilemma. However, it is possible to become skilled at ethical decision-making by developing and refining those decision-making processes and by being aware of the motives and values with which they are undertaken. Justice Michael Kirby made the observation that 'good law and good ethics must be grounded in good data'.[4]

In analysing ethical dilemmas, the legal parameters of the situation are inevitably important aspects, but are unlikely to be the only considerations. While it is far beyond the scope of this chapter to provide a sound grounding in ethical decision-making or reasoning, it does set out some basic ideas about ethics and provide a range of sources, some practical, some more theoretical, to enable you to research the issues in more depth. To begin, the next section attempts to define ethics and differentiate it from other concepts with which it is commonly confused.

ETHICS: WHAT IT IS

Kerridge, Lowe and Stewart state that 'ethics is the study of what we ought to do. Or if we restate this in the way of the Ancient Greeks, ethics asks each of us "How should I live?" '.[5] Words like 'should' and 'ought' are often used in ethical discussion, but, although they are helpful as a starting point, they are sometimes limiting, as such terms can also be applied to school rules and table manners. Kerridge et al. go on to provide a helpful amplification to this introduction by listing five general statements that can be applied to systems of ethics; see **Box 2.1**.[6]

It is this systematic approach to addressing problems that is probably the most important aspect of ethics for nurses and midwives who are commencing on a path of ethical inquiry and study and it is for this reason that the need to understand ethics is as important as the need to understand clinical practice. Maeckelberghe and Schröder-Bäck make the point that:

> Ethical reflection is not done in splendid isolation but thrives on the collaboration between the parties involved, in this case . . . researchers, professionals, and practitioners alongside ethicists.[7]

Perhaps it would be fair to say that ethical decision-making is as much about asking questions as it is about finding answers. Clearly, the process of making careful ethical decisions takes time, yet often nurses and midwives are confronted with ethical dilemmas in the course of their working day and may have little opportunity

BOX 2.1 WHAT ETHICS IS

1. Ethics is broadly concerned with human flourishing and wellbeing and the construction and maintenance of a peaceful society in which all may benefit.
2. Ethics is prescriptive — it refers more to what we *should* do than to what we *actually* do.
3. Ethics is a systematic approach that uses reason to define what ought or ought not to be done, either as action or process.
4. Ethics is relevant to all individuals, and if we develop moral concepts, principles and action-guides they should apply equitably to all persons equally.
5. Ethics is of greater significance than the law, politics or self-interest (although, in practice, ethics is often overridden by considerations of law, politics or self-interest).[6]

Source: Kerridge et al., 2013, Courtesy of Federation Press.

to consider their immediate response. That is why the academic study of ethics is so helpful to nurses and midwives, as it enables them to explore in advance issues that might arise regularly and to develop at least some rudimentary decision-making skills. However, junior clinicians are always advised to discuss ethical dilemmas with more senior, experienced colleagues or other clinicians who may have more expertise in this area.

Singer, in his seminal text *Practical ethics*, makes the point that ethics is fundamentally a practical concern.[8] It is concerned with making decisions and taking (or not taking) actions. Johnstone offers the idea of 'the task of ethics', which she says is 'to find a way to motivate moral behaviour, to settle disagreements and controversies between people, and to generally bind people together in a peaceable community'.[9] Both undergraduate and some specialist postgraduate programs now contain the study of ethics within their curricula, which provide nurses and midwives with opportunities to hone and practise these skills away from the immediacy of the clinical environment.

ETHICS: WHAT IT IS NOT

Charlesworth points out a major problem — that ethical discussions often take place:

> . . . between people with widely differing interpretations of what the terms of the discussion mean, how the facts may be interpreted or described, and also with differing ethical stances.[10]

For this reason, it is helpful to differentiate ethics from other issues with which it is often confused. This enables nurses and midwives to look at what other value systems and ideas they might bring to any ethical decision-making process and to be explicit about identifying them. In differentiating ethics, it also needs to be recognised that all of these factors are likely to be involved in and inform ethical

decision-making. Although the famous bioethicist Peter Singer[11] was probably one of the first to embrace this differentiation approach, a number of other authors on health law and ethics have adopted it in recent times. These other issues are listed below and then an example is given that explores each issue.

- Ethics is not a professional code of ethics or a set of guidelines that, if followed, will lead to correct behaviour.
- Ethics is not professional etiquette or opinion.
- Ethics is not hospital policy or medical authority.
- Ethics is not religion or morality.
- Ethics is not law.
- Ethics is not gut feeling or intuition.
- Ethics is not empirical data.
- Ethics is not public opinion or consensus.
- Ethics is not following the orders of a supervisor or manager.[12]

An example of an ethical problem is explored in **Case study 2.1**. Although this example is a nursing example, the questions it raises and the way that it is worked through are of equal value to students and practitioners of midwifery and could equally be applied to an ethical dilemma experienced by a midwife.

CASE STUDY 2.1

An ethical dilemma

Mr X, an 89-year-old man, has been admitted in extreme pain with urinary retention. He has prostate cancer with multiple secondaries throughout his abdomen. He is middle European in origin and has limited English. His distraught wife and two sons are with him — both sons speak fluent English. Effective analgesia has been provided and he is sleeping when the surgeon arrives to see him.

The surgeon speaks with the sons and explains that the situation is terminal and that only palliative surgical measures will be undertaken to relieve his symptoms. The sons request that their father not be given his diagnosis. They explain that culturally it is the role of the family to be the decision-makers during illness and that their father would not expect to be involved. Furthermore, they all believe it would be detrimental to their father's wellbeing for him to be given a terminal diagnosis.

The surgeon reluctantly accedes to this request because the sons are so adamant about their cultural practices. He simply tells Mr X that they will insert a supra-pubic catheter later that day 'to bypass your blockage and sort out your pain'. However, when you are caring for Mr X during that day, he constantly asks you, in his limited English, whether or not he is dying. How would you deal with this situation?

How Might a Nurse Respond to an Ethical Problem?

Case study 2.1 outlines a difficult situation, which requires skilful and careful ethical decision-making. It may well be that you have already had an immediate reaction to this scenario — a *gut feeling* as to what *ought* to be done. You may have strong *religious* or *moral* convictions and believe that your only option would be to answer Mr X truthfully that he is dying. You may already have found yourself taking sides in this situation, believing that the *consensus / cultural* view taken by the surgeon and the sons was 'wrong'. Conversely, you may feel that the surgeon is in charge; he has made the decision and *professional etiquette* demands that you do not challenge him.

The *law* here is clear. Mr X has a legal right to be informed of all material risks relating to his treatment options (see *Rogers v Whitaker*, which is discussed in detail in **Chapter 3**).[13] Such a right would require him to be aware of his diagnosis in order to evaluate the treatment options before him. The *hospital policy*, particularly in relation to consent for surgical treatment, would mirror the law and would undoubtedly state that Mr X must be informed of his diagnosis and treatment options. Your immediate response might be to comply with the law and hospital policy in disregard of the family's wishes and advise Mr X of his diagnosis. Only 'therapeutic privilege' would permit the surgeon not to inform Mr X fully about his surgery, and this limited defence can be exercised if either the patient expressly states that he or she does not wish to know (in which case it would be the patient's choice), or if the surgeon believed the information would be likely to cause serious physical or psychological harm to the patient. Therapeutic privilege is discussed in **Chapter 4**. The surgeon has conceded 'reluctantly' to the family's request and would probably consider the scenario does stretch the ambit of therapeutic privilege. However, a decision not to advise the patient may cause significant ethical distress for you, even if you decide to *follow the orders of your manager* and not provide information to the patient. Thus it can be seen that clinical decisions may be made for a range of reasons, not all of which may conform to the health professional's sense of what is ethically appropriate.[14]

If you were to consult the International Council of Nurses (ICN) *Code of ethics for nurses*,[15] adopted by the Nursing and Midwifery Board of Australia (NMBA) on 1 March 2018, you would find some relevant advice. For example, Element 1 of the code states that 'the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected'. It also stipulates that '[t]he nurse ensures that the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment'. Element 1 of the code is outlined in full in **Box 2.2**. (There is a separate *Code of ethics for midwives*, also adopted by the NMBA on 1 March 2018.)[16]

You might wonder if it is possible in the circumstances under consideration to provide accurate, sufficient and timely information to the patient in a culturally appropriate manner. Further, you might question how you can reconcile respect for values and customs with the patient's right for information. This conundrum does not negate the value of a code of ethics, even though it clearly demonstrates why a code of ethics cannot be a manual for ethical behaviour. Rather, the code will help you identify the ethical issues involved in your dilemma so that you can then address them and, if necessary, make a choice between them.

BOX 2.2 ***THE ICN CODE OF ETHICS FOR NURSES,* ELEMENT 1. NURSES AND PEOPLE**[15]

The nurse's primary professional responsibility is to people requiring nursing care.
In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.
The nurse ensures that the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment.
The nurse holds in confidence personal information and uses judgment in sharing this information.
The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.
The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services.
The nurse demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity.

You will remember that Michael Kirby stated that 'good ethics must be grounded in good data'.[17] All the responses and pieces of information discussed above will form part of your ethical decision-making process. However, having all the *empirical data* before you will not ultimately provide you with the reason to make this decision. For example, there may be pieces of information you choose to reject — possibly you may decide that the family will suffer immeasurably if the father is told the truth, despite the fact that you discover he really wants to know. But you still need to recognise that the family members are present in your thought processes and acknowledge the influence they will have on your decision. When you make an ethical decision, it will be necessary to justify both ethical actions in terms of ethical purposes and also the ethical purposes themselves.[18] Thus the questions you ask and the discussions you have with the key participants in such a scenario will determine the quality of the decision you eventually make.

What Resources are Available to Assist Nurses and Midwives to Address such Dilemmas?

All of the information discussed above as part of the nurse's immediate response is critical to the decision-making process and will inform the final decision. The nurse needs to know what the law says and what the hospital policy states. The nurse will

be assisted greatly by being familiar with the elements of *The ICN code of ethics* and any other codes of ethics or conduct which might bear upon nurses' practice (e.g. some health departments also have codes of ethics and / or conduct). The nurse's own religious or moral convictions may influence the way he or she feels about whatever decision is finally made, even if the outcome is that the nurse opts not to be involved in the management of this problem. However, to obtain 'good data' and to 'justify the decision' the nurse does need to ask more questions and have further discussions with all parties involved in the situation. Furthermore, even a basic understanding of ethical theories and principles will assist the nurse to make better decisions.

However, people don't usually make ethical decisions based on theories alone. Some very useful practical skills which are essential for ethical decision-making are listening skills, communication skills and the ability to trust ourselves and to value our own experiences, although not to the exclusion of those of our peers. We also need to be aware of the influence of power relationships on our ethical decisions. As nurses, we often imagine that we are powerless in clinical situations, but frequently it is the patient who is the least powerful participant.[19] The risk of privileging such an important process as ethical decision-making to the sole domain of health professionals is that it can disempower the very group it had set out to assist.

The remainder of this chapter highlights major ethical theories, principles and models for ethical decision-making, and recommends useful resources for further reading.

MAJOR ETHICAL THEORIES

The study of ethics, of determining 'what ought to be done', has been around since the time of the Ancient Greeks, and their ways of examining ethical behaviour provide the foundations for the two main branches of study of ethical theory: deontology and teleology. Other theories have developed over time, such as feminist moral theories and virtue ethics, and these are considered by some ethicists to be more appropriate to the caring professions. Both Johnstone and Kerridge et al. provide readable discussions on the different schools of thought in relation to these theories and their relevance to healthcare. All of these theories in their most extreme application can be controversial, and Johnstone recounts a number of concerns that have been expressed about traditional moral theories and principles.[20] However, one of the most useful aspects of learning about ethical theories for ethical decision-making is that nurses are able to identify the sources of the differing arguments being put forward by key players — it helps nurses to work out 'where (ethically) a person is coming from'.

Deontological or Intrinsicalist Theories

Deontological theories are sometimes known as intrinsicalist theories because they propose the view that actions are intrinsically right or wrong in themselves, and thus the way to determine what one ought to do is guided by the action itself. For example, if a nurse believed that telling the truth was intrinsically right, then that nurse's view of the correct action in our scenario would be determined according to that belief. Similarly, if a nurse believed that taking a person's life was intrinsically wrong, then that nurse's position in any debate about euthanasia would be clear.

Kerridge et al. point out:

> . . . the value of deontological theory is that it reminds us of the importance of rationality in moral judgment and of moral standards, independent of consequences. It has tremendous appeal for those who seek certainties in life and for institutions (such as the church or government) who have a need to bind together groups of people under some identifiable moral code.[21]

Indeed, deontological positions are more likely to be held by people with strong religious beliefs.

Teleological or Consequentialist Theories

Teleological theories are sometimes known as consequentialist theories because an action is not necessarily considered to be morally right or wrong in and of itself, but rather is judged to be morally appropriate because of the consequences its position produces. The best-known branch of the teleological theories is known as utilitarianism, which is popularly described as an attempt to obtain 'the greatest good for the greatest number'.[22] Taken to extremes, of course these theories can have bizarre outcomes. Nurses will find that such theories are often invoked in discussions about resource allocation. However, they usually arrive at an individual level for health professionals when faced with a particular patient who would be disadvantaged by resource restrictions.

Kerridge et al. describe the value of consequentialism as reminding us 'that the consequences of our actions have moral significance and must be taken into account in the evaluation of actions and situations'. They go on to point out that:

> Consequentialism at least attempts to develop a rational process of moral reasoning that enables the resolution of moral conflict, although in the end it probably does not succeed. Finally, consequentialism attributes moral worth to specific situations or contexts in a manner that has immediate intuitive and clinical appeal, even for those who profess the central importance of rules.[23]

Modern Feminist Ethics

Modern feminist ethics has come to the fore with the rise of the feminist movement over the past three decades. Fundamentally, modern feminist ethicists criticise traditional ethical theories for disregarding both the contribution of women to and the needs of women in ethical debate, particularly in relation to ethics of care and of interpersonal relationships. Feminist ethicists (*inter alia*) have challenged why such moral attributes as reason, which has been revered by philosophers over the centuries, should be given supremacy over such attributes as empathy, compassion, sympathy or caring in moral decision-making and thinking. Kerridge et al. helpfully identify a number of characteristics in feminist philosophies, namely:

a. rejecting the overemphasis on individual rights, autonomy and rationality in bioethics (Parsons, 1986);
b. criticising the dualistic thinking (or traditional dichotomies) that has structured Western philosophy and ethics and supported the subordination of women, e.g. reason–emotion, mind–body, objective–subjective, public–private, general–particular, fact–value, male–female, autonomous–dependent;
c. denying the requirement for value-neutral philosophies or abstract ethical principles (Harding, 1991);

d. rejecting the adversarial nature of moral conflict as a means for resolving ethical issues in clinical practice;
e. stressing the significance of values such as empathy, interdependence and caring, and the importance of the shared responsibility all members of society have to each other; and
f. emphasising the importance of context and the relevance of politics and power to understanding ethics and healthcare.[24]

Other ethical theories and concepts include rights-based theories, virtue ethics, discourse ethics and narrative ethics, all of which are accessibly covered to varying depths in either Johnstone or Kerridge et al. Kerridge et al. also provide an excellent critique of nursing and nursing ethics but overall reject the notion of a specific ethics of nursing in favour of incorporating that which is best in the nursing ethics discourse into the wider healthcare discourse.[25] Johnstone, on the other hand, argues that nursing ethics is 'inevitable'. She says that:

> So long as nurses interact with, and enter into professional caring relationships with other people, they will not be able to avoid or sidestep the 'distinctively nursing' experience of deciding and acting morally while in these relationships. It is in this respect, then, that nursing ethics can be said to be inevitable.[26]

Most bioethics texts recognise the inadequacy of ethical theories in their application to practical bioethics. However, these inconsistencies and differences probably reflect the real difficulties nurses have in ethical debate in clinical practice, where many competing imperatives will shape the dilemma, as seen in **Case study 2.1**. Notwithstanding these criticisms of ethical theories, using theories, concepts and principles to inform our ethical thinking is of great importance if we are to improve our ethical practice as clinicians. Johnstone argues that one of the major moral problems nurses (and other health professionals) encounter is that of 'moral unpreparedness'. She argues that this is analogous to and as unacceptable as clinical unpreparedness — for example, putting a clinically unprepared nurse in charge of a ventilated patient in intensive care.[27]

Perhaps more recognisable to clinicians than ethical theories are the four ethical principles identified by Beauchamp and Childress. These are widely accepted as valuable in bioethical decision-making.[28]

The Four Major Ethical Principles

The notion of a principle is that it is a rule or standard to be applied in any given situation. There is a sense in a principle that it is the right thing to do, that it will guide one's behaviour. The four ethical principles commonly used in bioethics are:

1. autonomy;
2. beneficence;
3. non-maleficence; and
4. justice.

Just as with ethical theories, these principles are not without controversy and, as will be seen in the ensuing discussion, can also be in competition with one another in any given situation. But their usefulness as a means of examining ethical dilemmas is apparent from their popularity in models of bioethical decision-making.

AUTONOMY

Autonomy is commonly described as the right to self-determination, the ability to control what happens to us and how we behave. This exercise of our own free will is acceptable only if it does not adversely affect the rights of others. It is an important ethical principle as it involves respect for individuals and their personal space. This principle is also reflected in a number of areas of health law, particularly in relation to one's right to consent to treatment and to receive information about one's treatment; however, this ethical principle is not upheld in law in every situation. For example, people do not have the right to exercise autonomy in relation to voluntary euthanasia, as it is illegal, nor do people have the right to be assisted to die at any time they may choose.

Nurses and midwives need to remember that, to exercise autonomy, it is often necessary to be assertive. It is not always easy for a patient to be assertive when they are 'at the mercy' of the nursing and medical staff, particularly if their exercise of autonomy would bring them into confrontation with those staff. Nor has it always been easy for nurses to be assertive, schooled as they have been in the past in the need for absolute obedience, particularly to the doctor.[29] Furthermore, the principle of autonomy is, as seen in **Case study 2.1**, culturally a Western concept. Some other cultures do not think primarily in terms of autonomy and individualism, but rather in terms of interdependence and community, and yet the laws in Australia usually uphold the principle of autonomy.[30]

BENEFICENCE

Beneficence is often described as the principle of 'above all, do good'. This desire to do good is undoubtedly what motivates most health professionals. However, it is valuable to recognise that there are times when people's idea of what constitutes 'doing good' may go against the wishes of an individual — for example, when a patient is terminally ill and may be prepared to die, but the doctors and nurses cannot bear to cease treatment. One of the important questions to ask in situations relating to beneficence is: 'Whose good are we trying to serve?' Kerridge et al. point out that if a patient's autonomy is overruled on grounds of beneficence, this is known as paternalism.[31] Beneficence and non-maleficence are often two sides of the same coin — but often the difficulty in practice is to work out where one ends and the other begins. For example, if a nurse is debriding burns or performing some other painful dressing for a patient, the nurse may well be causing the patient some discomfort (at least) which could be construed as 'doing harm' and yet the nurse's motives for undertaking the dressing or debridement are to 'do good'. In such a situation, it is clear that the nurse must debride the wound, yet the principles could be construed as being in conflict with one another.

NON-MALEFICENCE

Non-maleficence is the principle of 'above all, do no harm'. This is a very strong principle in healthcare and forms the basis of nurses' and midwives' duty to take care in the way in which they look after their patients. It can also be recognised in the 'duty of care', which is one of the elements of the tort of negligence. This obligation to do no harm is argued to override the principle of beneficence ('above all, do good'). Beauchamp and Childress argue that our duty to do no harm is greater than our duty to do good, particularly where our duty to do good may put others or ourselves at risk.[32]

JUSTICE

Justice has two meanings in ethics: justice as fairness, and justice as an equal distribution of burdens and benefits. Justice as fairness also has two interpretations: that of treating people equally and that of 'getting one's just deserts' — deserving what happened.

The principle of justice as fairness implies and expects a level of impartiality and neutrality in dealings with others. However, treating people equally does not necessarily equate with treating people in the same way. Patients are not the same in terms of their social, educational and cultural backgrounds, and nurses may need to adopt widely differing strategies to achieve equal treatment for two patients. For example, providing adequate information about a laparoscopic cholecystectomy for an elderly man from a non-English-speaking background may require very different strategies than providing the same information to a university-educated, English-speaking 45-year-old woman. With these considerations in mind, justice as fairness is the basis for the requirement to avoid discrimination against people who are different for whatever reason.

The second meaning of justice as an equal distribution of burdens and benefits is sometimes known as distributive justice. This principle is often used to address questions relating to resource allocation. The central tenet is that whoever we may be in society, the benefits and burdens would be equally shared between us. It is clear to see that this is not the case in modern society. This concept creates huge ethical difficulties for health professionals when they are required to apply the principle in practice. Questions arise such as: Which patients should receive treatment? If we close our mental institutions, how do we fund care in the community adequately? Such questions pose real dilemmas for health professionals, who have traditionally tended to operate in terms of individual patient relationships.

MODELS FOR ETHICAL DECISION-MAKING IN HEALTHCARE

With these theories and principles in mind, a number of authors have suggested models to assist in ethical decision-making, some of which are more complex than others.[33] All adopt a problem-oriented approach to ethical decision-making and involve a number of steps which include assessment, information-gathering, planning or goal-setting (including weighing options) and implementing and evaluating the chosen plan. Kerridge et al. suggest that the legal parameters of the problem should be identified, as these will often provide a structural background to the course of action.[34] However, it may be that the issue is not so clear-cut, in which case a decision-making model may help the individual work through the ethical dilemma. One of the more comprehensive decision-making models, by Kerridge et al., is reproduced in **Box 2.3** with their permission.

If this model were used to address the dilemma in **Case study 2.1**, it would clearly provide useful pointers as to how to deal with the issue.

Clearly State the Problem

How one frames this problem will depend on one's own value systems. But, in anyone's language, there seems to be a discrepancy between what Mr X has been told about his condition and what he has a legal right to be told. Furthermore, what he has been told is not complete and he seems to be asking for more information. However, it will be important to ascertain linguistically that this is exactly what he is asking, as he

BOX 2.3 A MODEL FOR ETHICAL DECISION-MAKING

Clearly state the problem:

Consider the problem within its context and attempt to distinguish between ethical problems and other medical, social, cultural, linguistic and legal issues. Explore the meaning of value-laden terms — for example, futility, quality of life.

Get the facts:

Find out as much as you can about the problem through history, examination and relevant investigations. Take the time to listen to the patient's narrative and understand their personal and cultural biography. Are there necessary facts that you do not have? If so, search for them.

Consider the fundamental ethical principles:

Autonomy: what is the patient's approach to the problem?
Beneficence: what benefits can be obtained for the patient?
Non-maleficence: what are the risks and how can they be avoided?
Justice: how are the interests of different parties to be balanced?
Confidentiality/privacy: what information is private and does confidentiality need to be limited or breached?
Veracity: has the patient and their family been honestly informed and is there any reason the patient cannot know the truth?

Consider how the problem would look from another perspective or using another theory:

Who are the relevant stakeholders? What is their interest? What do they have to lose?
How salient are their interests? How powerful are they? How legitimate are they? How urgent are they?
How would the problem look from an alternative ethical position? For example, consequentialist, rights-based, virtue-based, feminist, communitarian, care-based.

Identify ethical conflicts:

Explain why the conflicts occur and how they might be resolved.

Consider the law:

Identify relevant legal concepts and laws and how they might guide management.
Examine the relationship between the clinical–ethical decision and the law.

Continued

BOX 2.3 A MODEL FOR ETHICAL DECISION-MAKING—cont'd

Make the ethical decision:

Clearly state the clinical–ethical decision and justify it; for example:

- identify ethically viable options;
- make the decision and justify it; for example, by specifying how guiding principles were balanced and why;
- take responsibility for the decision;
- communicate the decision and assist relevant stakeholders to determine an action plan;
- document the decision;
- evaluate the decision.

Source: Reproduced courtesy of Federation Press from Kerridge I, Lowe M and McPhee J, *Ethics and law for the health professions*, 2nd ed © The Federation Press, Sydney, Australia, 2005, pp 84–5.

has limited English and may be requiring a different outcome, such as reassurance, or even denial. We also know that the surgeon is not happy about the situation but has reluctantly agreed to the family's request on cultural grounds. However, little conversation has taken place between Mr X and the surgeon. It will also be necessary to factor in the impact on the family if a decision were made to inform Mr X of his diagnosis in contravention of the family's wishes. This problem raises cultural and legal issues as well as ethical issues, and there are a number of people already involved in **Case study 2.1** — Mr X, his wife and sons, the surgeon, and you, at the very least.

Get the Facts

There is much work to be done to find all the facts in **Case study 2.1**. Further discussions are required with the surgeon, the family and the other health professionals involved in caring for Mr X, even including community carers such as his GP or community nurse. This is a critical time in the lives of Mr X and his family, and the hospital staff who are currently caring for him probably know him least well. Discussion is especially required with Mr X to ascertain what information he really wants to know. It may be advisable to use an interpreter rather than a family member to assist the surgeon and you in having these conversations with Mr X. However, at this stage you will need to be particularly aware that you and the interpreter are trying to find out all the facts, not institute solutions. Each conversation may lead to more information being required. It is most important to have all the information you need before you determine what ought to be done.

Consider the Fundamental Ethical Principles

Autonomy: What is the patient's approach to the problem?
Beneficence: What benefits can be obtained for the patient?

Non-maleficence: What are the risks to the patient, and how can they be avoided?

Justice: How are the interests of different parties to be balanced?

Confidentiality / privacy: What information is private, and does confidentiality need to be limited or breached?

Veracity: Has the patient and their family been honestly informed, and is there any reason the patient cannot know the truth?

Your consideration of these principles will depend on what facts and information you have found. However, it seems clear that Mr X's wishes must be balanced against the family's desire to 'do good' according to their culture and both your and the surgeon's desire to 'do no harm'.

The question of veracity, particularly from the patient's perspective, is highly significant here.

Consider the Problem from Another Perspective or Using Another Theory[35]

Questions about the key stakeholders are critical here, particularly as they will undoubtedly become clearer as further information emerges. You will also need to consider questions of power if your preferred ethical decision is in conflict with that of other members of the healthcare team, especially if you are not in a position of authority. Rights-based ethics may move the decision in favour of advising Mr X but, conversely, if you determine that his relationship with his family is more important than his need to know his prognosis, an ethic of care may prevail.

Identify Ethical Conflicts

At first glance there do appear to be ethical conflicts between the need to enable Mr X to exercise autonomy by providing the information he seems to be seeking and the desire to do good by respecting his and his family's cultural norms. However, the need to do no harm through avoiding any disharmony with the family dynamics is also critical. Other conflicts may also arise as you discover more information. On the other hand, it may transpire that when you have gathered all the information these conflicts will resolve.

Consider the Law

As already stated, the law is fairly clear in this situation. One question which has framed this ethical dilemma in the first place is whether the legal requirement to give information and consent can be overridden because of either therapeutic privilege or cultural norms.

Make the Ethical Decision

Clearly state the clinical–ethical decision and justify it; for example:

- identify ethically viable options;
- specify how guiding principles were balanced and why;
- take responsibility for the decision;
- communicate the decision and assist relevant stakeholders to determine an action plan;
- document the decision.

Evaluate the Decision

Whatever decision you finally make will be determined by the facts you discover in your decision-making process and the value you place on the differing pieces of information. Before you implement the decision, step once again through your justification, ensuring that your rationale is considered and robust. It may be that there is no consensus on the best way forward, in which case a decision will have to be made and any differing views ought to be documented. If your preferred decision is the one to be implemented, then it is critical that you take responsibility for the decision and manage the consequences of the decision, following through on both positive and negative outcomes. Any difficult decision will not produce perfect outcomes, and it is vital that the impact of the decision is handled with care and compassion. Evaluating the process as well as the outcome is essential, as otherwise you will have learned little from the experience.

The opportunity to reflect on our most difficult dilemmas and the choices we made about them is always to be welcomed. However, it is important to recognise that real reflection, as opposed to post-hoc justification, can sometimes be painful. We may honestly feel on reflection that we could have managed the situation better or made better decisions. But clinical–ethical decision-making is often made 'on the run' and, with the best will in the world, we will not always get it right. It is important to welcome the evaluation as a learning opportunity and to recognise the potential for improvement.

CONCLUSION

Law and ethics are not the same, although ethical decision-making will always involve a consideration of the law. In addition, good laws should arguably also be ethical laws but, as seen from the ethical theories and principles presented above, there may be disagreement about their morality depending on which ethical theory or principle is being promulgated. However, there are a number of desirable healthcare practices, such as the requirements for confidentiality and consent, respect for persons, and care, in terms of both compassion and rigour, which are both ethically sound and legally required. Freckleton and Petersen point out that 'the practice of good ethics should not only bolster professionalism but also protect patients' rights and reduce the need for legal intervention into healthcare'.[36] In addition, when the courts are presented with issues they have not previously dealt with, such as withdrawal of life support (e.g. *Airedale NHS Trust v Bland*), or the harvesting of spermatozoa from a posthumous donor (e.g. *R v Human Fertilisation and Embryology Authority, ex parte Blood*), they draw on ethical principles and theories to assist them in their deliberations.[37] This will become clear in some of the cases discussed later in this book, and the reader might find it interesting to examine the case law with a view to ascertaining which principles were being upheld.

As this chapter has highlighted, ethical theories and principles are not without difficulty in relation to their application to practice. However, using an ethical decision-making model can provide a clear structure to addressing the complex and often difficult dilemmas that nurses and midwives meet in clinical practice. Yet it is also important for nurses and midwives to recognise that, even after they believe they have reached an appropriate ethical decision, the power differentials in healthcare

may mean that their decision is not the decision of choice. This can be extremely frustrating for nurses and midwives and has been the subject of much discussion, particularly in relation to recruitment and retention.

CHAPTER 2 REVIEW QUESTIONS

Following your reading of Chapter 2, consider these questions and the issues they raise for discussion and reflection.

1. Think of an ethical dilemma you have encountered in practice. Would using an ethical decision-making model have assisted you?
2. Apply it to your dilemma now and work through both what you actually did and what you might have done differently had you had such a model available.
3. Consider the ethical principles. How are they applied on an almost daily basis in clinical practice? Give examples of each principle being applied in your own practice.
4. Can you think of examples in healthcare where law and ethics might come into conflict?

Endnotes

Note: all links were last accessed on 23 December 2019.

1 Ganz F, Wagner N and Toren O, 'Nurse middle manager ethical dilemmas and moral distress', (2015) *Nursing Ethics* 22(1):43–51.

2 Johnstone M-J, *Bioethics: a nursing perspective*, 5th ed, Churchill Livingstone Elsevier, Sydney, 2009, p 11.

3 Punjani N S, 'Truth telling to terminally ill patients: to tell or not to tell', (2013) *Journal of Clinical Research in Bioethics* 4:159, http://www.omicsonline.org/truth-telling-to-terminally-ill-patients-to-tell-or-not-to-tell-2155-9627-4-159.php?aid=20446; Chiarella E M, *The legal and professional status of nursing*, Churchill Livingstone, Edinburgh, 2002; Rising M, 'Truth **t**elling as an **e**lement of culturally **c**ompetent **c**are at **e**nd of life', (2015) *Journal of Transcultural Nursing* 28(1):48–55.

4 Kirby M, 'Bioethics and democracy — a fundamental question' in Charlesworth M, *Life, death, genes and ethics — the 1989 Boyer lectures*, ABC Books, Sydney, 1989, p 3.

5 Kerridge I, Lowe M and Stewart C, *Ethics and law for the health professions*, 4th ed, Federation Press, Sydney, 2013, p 3.

6 Kerridge et al., 2013, op. cit.

7 Maeckelberghe E and Schröder-Bäck P, 'Ethics in public health: call for shared moral public health literacy', (2017) *European Journal of Public Health* 27(suppl 4):49–51.

8 Singer P, *Practical ethics*, Cambridge University Press, Cambridge, 2011.

9 Johnstone, 2009, op. cit., p 33.

10 Charlesworth M, *Life, death, genes and ethics — the 1989 Boyer lectures*, ABC Books, Sydney, 1989, p 23.

11 Singer P, 2011, op. cit., pp 3–4.

12 Kerridge I, McPhee J, Jordens C and Clark G, 'Moral frameworks in healthcare: an introduction to ethics' in Freckleton I and Petersen K (eds), *Disputes and dilemmas in health law*, Federation Press, Sydney, 2006, p 18. See particularly Johnstone, 2009, op. cit., pp 21–4 for an interesting discussion on codes of ethics.