Nursing's duty of care: From legal obligation to moral commitment

Te kawenga kia āta tiaki te ao tapuhi: Mai i te herenga ā-ture ki te whakaūnga ā-tikanga

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Abstract

Duty of care is a legal, ethical and professional obligation and commitment for nurses to provide quality care and protect patient safety. Although 'giving care' and 'to care' has been discussed widely in nursing literature, less attention has been given to 'duty of care' as a fundamental basis for practice. This narrative review, through a critical analysis of peer reviewed literature, legislation, codes, professional prescribed competencies and cases upheld by commissions and courts of law, explores the historical origins and development of 'duty of care', alongside nurse's legal, ethical and professional parameters associated with duty to care. Major concepts identified include legal and common law definitions of a duty of care which are relevant to nursing, medicine and midwifery; duty of care as an evolving principle; duty of care that goes beyond legal definitions to include a moral commitment to care; and the relevance of duty of care to nursing practice in New Zealand. This paper concludes that although the origins of a duty to care may have begun in servitude, current expectations of a duty to care are based on outcomes – that of do good and do no harm.

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Ngā ariā matua

Ko te kawenga kia āta tiaki i te tangata tētahi herenga ā-ture, ā-matatika, ā-ngaio, otirā he whakaūnga nui mā ngā tapuhi, kia hora i te toi o te tiaki mō te tūroro me te tiaki i tōna noho haumaru. Ahakoa he nui ngā kōrero mō te 'whakarite kia tiakina' me te 'āta tiaki' i roto i ngā pukapuka tapuhi, he iti iho te tirohanga mō te 'kawenga kia āta tiaki' hei pūhara taketake mō ngā mahi. Tā tēnei arotake ā-pūrākau he tūhura i ngā take tawhito me te whanaketanga o te 'kawenga kia āta tiaki' i te taha o te kawenga ā-ture, ā-matatika, ā-ngaio hoki kia tiaki i te tūroro, mā roto i tētahi arotakenga o ngā pukapuka i āta werohia e ngā hoa, o ngā ture, o ngā rārangi tikanga me ngā pūkenga nā te ao ngaio i whakahau, tae atu ki ngā whakataunga take kōti kua puta i ngā kōmihana me ngā kōti ture. Ko ētahi o ngā ariā matua o roto ko ngā whakapuaki ā-ture, ā-iwi noa hoki, kei roto nei ngā tautohutanga e pā ana ki te mahi tapuhi, ki te ao tākuta me te tapuhi whakawhānau; te kawenga kia āta tiaki hei mātāpono e tupu haere tonu nei; te kawenga kia āta tiaki e piki ana ki tētahi taumata teitei kē atu i ngā tautohutanga ā-ture noa, kia uru mai tētahi whakaūnga ā-tikanga kia āta tiaki; me te hāngai o te kawenga kia āta tiaki ki ngā mahi tapuhi o Aotearoa. Ko te kupu whakamutunga o te pepa, ahakoa i tīmata mai te kawenga kia āta tiaki i roto i ngā here o te mahi mō tangata kē, ko ngā tūmanako i ēnei rā mō te kawenga kia āta tiaki i te tūroro ka takea kē mai i ngā putanga hua - kia mahi i tētahi mahi pai, kia kaua e mahi hē. He mea āta

Nursing's duty of care is regulated by legal, ethical and professional obligations but equally includes a moral commitment to care. These findings suggest duty to care lies at the heart of nursing practice.

whakahaere te kawenga kia āta tiaki i raro i ngā here ā-ture, ā-matatika, ā-ngaio engari ka uru hoki ki roto te whakaūnga ā-tikanga kia tiaki i te tangata. Tā ngā kitenga nei he pānui ki te ao ko te kawenga kia āta tiaki te poutokomanawa o te mahi tapuhi.

Keywords / Ngā kupu matua

Duty of care/ Te kawenga kia āta tiaki; registered nurses/ ngā tapuhi rēhita; professional standards/ ngā paerewa ngaio; legislation/ ngā ture; ethical/matatika; moral commitment/whakaūnga ā-tikanga

Introduction

Caring, whether for individuals, families or communities, is primary to the role of every nurse. In nursing 'to give care' has been described as what nurses do in order to ensure the health, welfare and protection of patients, and 'to care' as the concern or interest that is directed towards another human being. However, less attention has been given to the 'duty of care' as a fundamental basis to the provision of all care. Duty of care is a legal, ethical and professional obligation to prevent patients from coming to harm, which, if breached, can leave nurses at risk of disciplinary action. In a health care environment in which the roles and responsibilities of nurses are constantly evolving, nurses need to be aware of their obligations under their duty of care. This paper examines nurses' duty of care which encompass a range of practices, behaviours and skills, all of which contribute to providing quality care and protecting patient safety. The standards against which nursing practice is measured are discussed and examples from recent international and national decisions are provided. These cases indicate that in order to fulfil their legal, ethical and professional duty of care, nurses must ensure that their practice meets the accepted or expected standards of the profession, as they are outlined in a range of codes, guidelines, and competencies. This paper places the concept of duty of care in its legal, ethical, professional and historical context, drawing on international examples alongside those from Aotearoa/New Zealand.

Design

A narrative review approach was used to summarize empirical and theoretical literature in order to provide a more comprehensive understanding of the phenomenon of duty of care and evidence that may be used for nursing practice. The aim of the review was to examine the legal, ethical, professional and historical context of duty of care and how it has contributed to patient safety and quality care. The key words 'duty of care' and 'nursing' were used to search CINAHL, Medline databases and Google Scholar. In keeping with the objective of examining current perspectives, analysis was mainly restricted to material published between 2005 and 2015. Additional material was identified from the bibliographies of retrieved items. Current policy documents relating to nursing duty of care from a range of local and international nursing organisations were also analysed. One hundred and six items were included for analysis. Decisions on cases involving nurses investigated by the Health and Disability Commissioner and published between

2010 and 2015, representing 42 reports, were also reviewed. Data were extracted from primary sources on sample characteristic and method, as well as references to the concept of duty of care. Categories were extracted to include a historical development of duty of care; legal, ethical and professional concepts and cases of application to practice. Data was synthesised into key concepts which include the legal duty of care; a nursing duty of care; duty and care in nursing history; duty of care as an evolving principle; defining a standard of care and relevance to nursing practice.

The legal duty of care

In common law, 'duty of care' is a specific concept that refers to the obligation for people to not cause harm to one another (Fullbrook, 2005, 2007a; Johnson, 2004). Common law refers to the system of law developed by the courts over centuries rather than through specific legislation. The International Council of Nurses (ICN) states nurses "have an obligation to… actively promote people's health rights… ensuring that adequate care is provided" (ICN, 2011, p. 1). In New Zealand, that obligation is described as "a legally imposed obligation or duty (as described in common law) on us all to 'take care'" (New Zealand Nurses Organisation [NZNO], 2016, p. 1). According to Murphy (1980), the emergence of the modern concept of duty of care, in late-nineteenth-century common law, was the expression of the ethical principle that people should act with regard to the safety of others: "The judicial process had become a mechanism to teach the members of the body politic how they could live safer and therefore better lives" (Murphy, 1980, p. 150). The question of whether someone owes another person a duty of care, and whether this duty has been breached, is central to the branch of law known as torts, and in particular to the tort of negligence. The term 'tort' derives from the Latin *tortere,* meaning 'to hurt', and refers to cases of civil wrongs, where one party takes legal action against another for some form of hurt or damage (Bryden & Storey, 2011).

Modern definitions of duty of care and its significance for legal cases of negligence stem from a landmark 1932 British tort case, *Donoghue vs Stevenson*, also known as 'the snail in a bottle case' (Bryden & Storey, 2011; Fullbrook, 2005; Johnson, 2004; Murphy, 1980). In this case a woman who found a dead snail in a bottle of ginger beer purchased for her by a friend successfully sued the ginger beer manufacturer for negligence. At appeal to the House of Lords, the presiding judge, Lord Atkins produced an oft-quoted judgement which has since defined the common law principle of duty of care:

> *The rule that you are to love your neighbour becomes in law you must not injure your neighbour; and the lawyer's question "Who is my neighbour?" receives a restricted reply. You must take reasonable care to avoid acts or omission which you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts of omission which are called in question (Johnson, 2004, p. 155).*

In establishing negligence, several elements must be proven by the claimant: that a duty of care was owed to them by the defendant; that the duty was breached by the defendant; that the claimant suffered some form of reasonably foreseeable harm or damage; that this harm was caused by the defendant's breach of duty of care (Bryden & Storey, 2011; NZNO, 2016).

For New Zealand nurses, the legal application of a duty of care is informed by other legislation including the Health Practitioners Competence Assurance Act 2003 (HPCA) and the New Zealand Nursing Council Registered Nurse Scope of Practice and Competencies. The HPCA Act was introduced in 2003, based on the previous Medical Practitioners Act 1995 with the intent of protecting the patient and public safety and self-regulation by the profession (HPCA Act, 2003). Central to the HPCA Act is that health professionals must be competent to practice in their scope of practice; that only health professionals registered under the Act are able to practice in that profession regulated by the HCPA Act. Nursing Council of New Zealand (NCNZ) is responsible under the HCPA Act 2003 to regulate and ensure nurses are safe and competent to practice. The NCNZ state that "registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards" (NCNZ, 2016, p. 5). Nurses, therefore, must practice in accordance with legislation and common law, codes of conduct and guidelines that regulate the competencies required for registered nurses' scopes of practice (NCNZ, 2016).

Nursing's duty of care

The case of a dead snail in a bottle of ginger beer may not appear to be relevant to nursing practice, but in most countries that follow common law principles, the tort of negligence also applies to health practitioners. Just as the manufacturer of the ginger beer was found to have had a legal duty of care not to cause harm to consumers, so too, are doctors and nurses held to have a legal duty of care not to harm to their patients. The duty of care to not harm another, applies not only in the context of health practitioners' formal practice, but also in their personal lives; for example, Rolls and Thompson (2008) note that if a neighbour seeks advice about a sick child, the nurse is accountable for the advice provided. The crux of a case of medical negligence usually revolves around establishing whether or not this duty of care has been breached. Therefore, most of the literature on nursing's duty of care concentrates upon how common law defines a breach of the medical duty of care. In British common law, the landmark case is *Bolam v Frien Hospital Management Committee* [1957]. John Bolam received electro-convulsive therapy while a voluntary mental health patient. No muscle relaxants or physical supports were provided during the procedure, and he suffered several severe fractures. Therefore, he sued the management of the medical institution for negligence. In deciding against the plaintiff, the judge outlined a crucial test for establishing whether a medical practitioner had been negligent; known as the Bolam test. A medical practitioner was "not guilty of negligence if he has acted in accordance with the practice accepted as proper by a reasonable body of medical men [sic] skilled in that particular art" (Samanta & Samanta, 2003, p. 443).

For many decades the courts have interpreted Bolam as meaning that to refute a charge of negligence, a health practitioner only had to produce some colleagues to state that they would have performed the same actions in those circumstances. The Bolam test has, therefore, been criticized as being too weighted in favour of the health profession against the interests of the patient, and for being too deferential to medical opinion (Bryden & Storey, 2011; Samanta & Samanta, 2003; Young, 2009). As Young (2009, p. 3076) points out, one of the consequences of Bolam was that it effectively allowed health practitioners to set their own standards of

acceptable practice, and "this approach does not always lead to very 'high' benchmarks, merely a basic minimum."

However, Bolam has also been interpreted differently in the case of *Bolitho v City and Hackney* (1997), where a doctor failed to attend a child with severe respiratory difficulties. The child subsequently suffered a cardiac arrest and later died. The issue at court was whether it was negligent of the doctor not to have arranged for prophylactic intubation. The defence argued that medical intervention would have made no difference to the outcome, a position that was supported by an impressive body of medical opinion. The judge stated that defence against medical negligence requires a body of opinion which is 'responsible, reasonable and respectable' but added that the opinion must also have a 'logical basis' (Fullbrook, 2005; Samanta & Samanta, 2003; Young, 2009). As a result, judges have more latitude to define medical negligence, rather than leaving it up to the medical profession. After Bolitho, judges have shown more inclination to question expert medical opinion, to see if it meets the standard of having a logical basis, and whether the health practitioner has carried out an adequate risk assessment in deciding upon a particular course of action (Fullbrook, 2005; Samanta & Samanta, 2003; Tingle, 2010; Young, 2009). Fullbrook (2005, p. 80) notes in her discussion of the consequences of Bolitho for nursing practice that this has involved a shift towards assessing best interest, or "reaching a decision based on the best possible option available". She cites the case of *Reynolds v North Tyneside Health Authority* [2002], where a baby was born with cerebral palsy resulting from foetal distress experienced during delivery. The midwives involved in the delivery were sued for negligence, and argued in their defence that it was not usual practice to perform a vaginal examination, which would have determined the baby was in a breech presentation. The arguments, put forward by midwives in their defence, were dismissed by the judge because other circumstances in the case indicated that a vaginal examination was advisable, and the disadvantages of performing one were far less than the consequences of not performing one. The judge concluded that the midwives, in failing to properly assess the risk of not taking this precaution, breached their duty of care (Fullbrook, 2005).

In contrast to the tort system of other common law countries, New Zealand has a tax-payer funded accident compensation scheme for personal injuries, including those stemming from medical negligence (Johnson, 2004). Adopted in 1976, the Accident Compensation Corporation (ACC) legislation curtails the right to sue in cases of medical negligence. Any person who is eligible for compensation under the ACC scheme may not sue for compensatory damages in regards to any injury covered by the scheme. However, this does not mean that health practitioners are unaccountable for negligent practice. The Health and Disability Commissioner Act (1994) was intended to promote and protect the rights of health consumers and disability services consumers, and, to that end, facilitate the fair, simple, speedy and efficient resolution of complaints relating to the infringements of those rights (Health and Disability Commissioner [HDC], 2004). Individual health practitioners and health institutions can be investigated by the HDC to determine if there has been a breach of the Code of Health and Disability Services Consumer Rights. The ten Rights of the Code, which include the Right to Services of an Appropriate Standard (Right 4) and the Right to Make an Informed Choice and Give Informed Consent (Right 7), cover the elements which constitute

health practitioners' duty of care. In addition to the HDC, the HPCA Act (2003) established the Health Practitioners' Disciplinary Tribunal, which investigates cases that have been passed on from the Health and Disability Commissioner for disciplinary action. The independent regulatory bodies of the various health professions, for example, the Nursing and Midwifery Councils, also have processes to investigate complaints and impose sanctions, such as suspension and de-registration, against practitioners.

According to *Understanding Duty of Care*, nurses are expected to take the same amount of care to prevent harm to patients as any "reasonably regulated nurse or midwife" (NZNO, 2016, p. 2). Although New Zealand's system of dealing with cases of medical negligence is very different to the tort system that characterizes other common law countries such as Britain, Australia, Canada and the United States, many of the same principles still apply. The question of what constitutes a breach of duty of care, and what standards health practitioners should be held to, still lies at the heart of complaints against health practitioners.

'Duty' and 'care' in nursing history

For nurses, duty of care goes beyond a legal obligation not to cause harm. The concepts of both 'duty' and 'care' lie at the heart of many definitions of nursing. Duty is central to what many understand nursing should be, expressing the vocational elements of the profession. Despite the increasing clinical and technical nature of modern nursing practice, compassionate caring remains central to nursing praxis.

The focus upon duty and care as core values in nursing reflects the profession's historical roots. Modern nursing has its origins in religious traditions of the duty to care for the poor and sick. Therefore, the Christian commandment to love thy neighbour is not only the basis of the legal duty of care, but was also the basis for the first organized forms of nursing in the West, carried out by religious communities (Summers, 1997). The religious impulse to *love thy neighbour* remained significant even into the period of nursing reform and professionalization in the late nineteenth century. Florence Nightingale, for instance, was heavily influenced by religious concepts of the nurse's duty, which helped her to differentiate her vision of nursing from the menial domestic labour which characterized hospital nursing at the time (Summers, 1997). For Nightingale, nursing was a 'calling', and it was this sense of calling that determined whether a nurse could fulfil their duty to ensure no harm came to the patient:

> *A nurse who has such a "calling" will look at all the medicine bottles delivered to her for her patients, smell each of them, and, if not satisfied, taste each. Nine hundred and ninety-nine times there will be no mistake, but the thousandth time there may be a serious mistake detected by her means. But if she does not do this for her own satisfaction, it is no use telling her. (Nightingale, 1859, cited in Skretkowicz, 2010, p. 261).*

Nursing reformers such as Nightingale were eager to demarcate the 'new nurse' from the working class and village 'handywomen' who had traditionally provided care for the sick and for women in labour, as well as helping with death rituals (Summers, 1997). The latter were famously caricatured by Charles Dickens in *Martin Chuzzlewit*, in the comic

characters of the ignorant and drunken 'Sairey Gamps' and 'Betsy Priggs'; the term 'Gamps' passed into general use by the late nineteenth century to denote any untrained midwife. It was the safe and compassionate care provided by the new nurse that reformers claimed distinguished her from her dangerous predecessors. Modern nursing was therefore defined by what would later be referred to as a duty of care; a commitment to care for patients and protect them from harm.

By the early twentieth century, leaders of the nursing profession in many countries were calling for systems of nursing registration to further differentiate trained nurses from untrained, and therefore dangerous, practitioners. Grace Neill, Deputy Inspector of Hospitals in New Zealand from 1895 to 1906, was NZ's main architect of nursing registration, arguing: "For the protection of the public and to give a professional standing to the women of a noble profession, hospital-trained nurses should be registered" (Maclean, 1932, p. 24). According to the Nurses Registration Act (1901), any nurse found guilty of 'grave misconduct' could have her name erased from the nurses' register. Therefore, the professionalization of nursing and the introduction of state registration entailed an obligation upon nurses to practice according to the standards of behaviour determined by the profession. This would seem to imply that nurses could be open to charges of negligence if harm were to befall a patient. Johnstone (2009), however, argued that the ambiguities around nursing's professional status meant that, early in the twentieth century, nurses were generally deemed not to be accountable for their actions. Instead, in early cases of medical negligence, they tended to be regarded by courts as the servants either of the hospital or the physician, bound by duties of obedience and loyalty, and powerless to question orders that might be to the detriment of patients. Therefore, in legal terms, the nurse's duty of care to patients was overshadowed by their primary duty to obey the doctor's orders (Johnstone, 2009). The perception of nurses' duty to doctors was modified over the course of the twentieth century, and courts gradually became more willing to hold nurses liable for their actions, particularly in cases where they had followed orders that were obviously incorrect or not in keeping with normal medical practice. One of the earliest and most controversial examples of a nurse being held responsible for negligent care was the Somera case in 1929. Lorenza Somera, a nurse, was charged with manslaughter following the death of a girl during a tonsillectomy after being given the wrong drug. Somera was found guilty of negligence for failing to question the drug order and sentenced to one year, even though the doctors who ordered, verified, and administered the drug were acquitted (Johnstone, 2009).

Concepts of duty and care are increasingly crucial to the identity of nursing. For example, the NZNO's Code of Ethics states that "Nursing was founded on the moral premise of caring and the belief that nurses have a commitment to do good" (NZNO, 2010, p. 7). However, nursing's duty of care is no longer based upon a sense of Christian duty, but upon a humanist ethical foundation. From the perspective of modern bioethics, it is the ethical principles of beneficence and non-maleficence that underpin nursing's duty of care; the commitment to do good and to do no harm (Fullbrook, 2007a; Johnstone, 2009; Pfrimmer, 2009; Ruderman et al., 2006).

Duty of care as an evolving principle

Transformations in health care and in wider society have had profound implications for nursing's duty

of care. Croke (2003) notes the increase in nurses being held responsible for negligence in recent decades, which suggests that fulfilling the duty of care has become more complex. There are a number of factors which might contribute to this. Since the 1970s, the earlier emphasis upon nurses' duties of loyalty and obedience to doctors has been gradually replaced by the obligation for nurses to advocate for patients. Johnson (2004) notes that following doctors' orders is no longer accepted as a defence against charges of breaching duty of care and in some cases, courts have held that the nurses' duty of care extends to informing hospital management of any departure from normal care that puts a patient's life in danger. While this has been welcomed by many in the profession, patient advocacy by nurses is not always straightforward. Some argue that it places unrealistic expectations upon nurses to advocate for patients in circumstances that are not always conducive to advocacy (Water, Ford, Spence & Rasmussen, 2016). Croke (2003) includes "failure to act as a patient advocate" (p. 57) as one of the six major categories of negligence in a study of 250 American cases of nursing negligence, suggesting that nurses are struggling to fulfil this aspect of their duty of care.

Along with the responsibility to advocate, fulfilling the duty of care requires nurses to master an increasing range of technical tasks and complex technologies. As Young (2009) notes, clinical knowledge and professional practice are constantly evolving. Tingle (2002) further highlights the legal duty for health practitioners to stay abreast of the latest professional literature to ensure they are familiar with the most up-to-date practice. Increasingly, nurses are also being called upon to extend their practice in the form of the advanced practice role, adding a range of new responsibilities to their roles. Some authors suggest this creates uncertainty for nurses regarding their scope of competencies, potentially leaving them open to accusations of breaching of duty of care if things go wrong (Croke, 2003; Tingle, 2002; Young, 2009). The ICN notes that the expansion of nurses' responsibilities in practice has often exceeded the scope of legally assigned responsibilities and that nurses' accountability is often not easily determined (ICN, 2011).

Public expectations of health care have also changed as earlier paternalistic models have been slowly transformed by more person-centred approaches. Many patients are more informed about treatment options, through modern day technology that is easily accessed. Therefore, they can be more assertive about demanding what they regard as appropriate treatment or standards of care, resulting in more complaints about health practitioners (Croke, 2003; Fullbrook, 2007a; Young, 2009). However, Young (2009, p. 3072) notes, "increased expectations of what *can* be provided do not necessarily reflect what *must* be provided by practitioners". As Tingle (2010) points out, in the context of the British National Health Service (NHS), these expectations may not always be realistic within the available resources. Patient expectations of public health services compete with fiscal barriers, along with the spiralling cost of public health, has seen many governments imposing budget constraints over the last three decades. Resource constraints create situations where some nurses believe they are being forced to work in challenging environments that they are unable to properly fulfil their duty of care to patients (Osborne, 2014). For example, one of the lessons from the Mid Staffordshire NHS Foundation Trust Public Inquiry is the detrimental effect that the prioritization of improving fiscal status and achieving government targets had on

the delivery of patient care. In terms of nursing, this had an impact upon staffing numbers, skills mix and staff morale, leading to major failures in care.

Broader social changes have huge significance for nursing praxis. Demographic change has resulted in an increasing population of older people. Nurses working with older people will require increased skills in the management of long-term conditions, made increasingly complex with greater co-morbidities, in a context of constrained government health spending. These complexities create major challenges for nurses in fulfilling the duty of care for older patients. Of the 42 complaints about nurses investigated by the HDC between 2010 and 2015, more than two thirds involved failures in the care of older patients (HDC, 2016).

Many of the other cases that have come before the HDC involved complex dilemmas balancing the need to protect patient safety against the patient's right to independence and autonomy. There are possible tensions between duty of care, based upon the ethical principle of beneficence, and the ethical principle of autonomy (Fullbrook, 2007a). Examples include the dilemmas involved in treating distressed patients with acute mental health presentations in emergency departments. The necessity of emergency treatment, enforcement of the Mental Health Act 1992 and the health practitioner's duty of care must be balanced against the patient's right to autonomy. Fulfilling a duty of care towards patients treated under the Mental Health Act who do not want to be treated can therefore be a difficult process which requires particular training in communication and negotiation.

Recent pandemics and natural disasters, such Ebola outbreaks in Africa and the catastrophic earthquakes in Haiti and Christchurch, also raise crucial questions about the extent of nursing's duty of care. Some authors suggest there is a lack of clarity about what nurses' professional, ethical and legal responsibilities are in such circumstances (Pfrimmer, 2009; Ruderman et al., 2006). In the case of an epidemic or major natural disaster, the emergency response depends upon health practitioners carrying out their duties. But are they required to do so at the expense of their personal obligations and safety? As the NZNO note in their guide *Obligations in a pandemic or disaster* nurses' duty of care "does not occur without limits" and risk to nurses' personal safety and that of their families and whanau must be considered when providing care during pandemics or disaster situations (Rolls & Thompson, 2008, p. 12). However, there are currently no rules to determine the limits to the duty of care, or any consensus about who should decide where those limits lie. A nurse's decision that the risk to themselves in treating a patient outweighs the benefits to a seriously ill or injured patient may not be shared by the nurse's employer or regulatory bodies. In the case of the SARS pandemic in Hong Kong and Canada in 2003, health care professionals represented around 30% of cases (Ruderman et al., 2006). While many displayed considerable courage in treating patients with the infection, others baulked at providing care to patients, and were dismissed from their positions as a result. Some health care professionals were put in the position of being forced to care for patients either because they feared losing their jobs, or because hospitals were quarantined without warning, and there were complaints that they and their families were inadequately protected (Pfrimmer, 2009). Pfrimmer concludes that health care professionals do have an ethical obligation to fulfil their duty of care in such circumstances, but health care institutions also have the obligation

to provide maximum protection for staff and their families, in the form of anti-viral agents, vaccines and protective gear.

In response to these concerns, the Canadian Nurses Association (CNA) Code of Ethics introduced the notion of unreasonable burden as a justification for a nurse to withdraw from providing care (CNA, 2008). An unreasonable burden may be said to exist when a nurse's ability to provide care is compromised by threats to personal wellbeing, unrealistic expectations, or lack of resources. The NZNO also notes that the Code of Health and Disability Services Consumers' Rights provides some protection for health practitioners working in the extreme circumstances of a disaster or pandemic, where it states that "[a] provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code. The onus is on the provider to prove that it took reasonable actions. For the purposes of the clause, 'the circumstances' means all the relevant circumstance, including the consumer's clinical circumstance and the provider's resources constraints" (Health and Disability Commissioner, 2004, p. 4; NZNO, 2016).

Relevance of a duty of care to nursing practice: Defining the standard of care

Central to the modern understanding of the duty of care are the legal, professional and ethical standards which nurses are expected to meet. In common law, failure to meet the standard of 'the ordinary skilled man exercising and professing to have that skill' is regarded as a breach of duty of care (Bryden & Storey, 2011). Young (2009) notes that the concept of duty of care is inexorably linked with standards and performance in health care. The codes, clinical guidelines, standards, scopes of practice and competencies produced by various health care regulatory and professional bodies indicate the standard of care that is expected of nurses. Taken together, these help to define nursing's duty of care, by outlining the behaviour, skills and actions expected of the nurse. For example, the NCNZ describes its Code of Conduct for Nurses as "a set of standards…describing the behaviour or conduct nurses are expected to uphold…Failure to uphold these standards of behaviour could lead to a disciplinary investigation" (NCNZ, 2012, p.2). As many authors have noted, in a rapidly transforming health care environment, nurses who wish to ensure they are working according to acceptable standards need to make sure they are familiar with the latest versions of these documents (Fullbrook, 2007b; Tingle, 2002; Young, 2009).

Definitions of the standard of care expected of nurses vary from country to country and from document to document. The New Zealand Health and Disability Services General Standards defines good practice as "the current accepted range of safe and reasonable practice that result in efficient and effective use of available resources to achieve quality outcomes and minimize risk for the consumer" (Standards New Zealand, 2008, p. 7). The Code of Health and Disability Services Consumer Rights also refers to providing safe and reasonable levels of care (Carter & Ford, 2013). The NZNO fact sheet *Understanding Duty of Care* describes the standard of care expected from nurses as 'the amount of care the 'reasonably regulated nurse or midwife' would do in that situation" (NZNO, 2016, p. 2). Internationally, the Canadian Nurses Association Code of Ethics states that "nurses have a professional duty and a legal obligation to provide persons receiving care with safe, competent, compassionate and

ethical care" (Canadian Nurses Association, 2008, p. 24). Somewhat more prosaically, the Australian Nursing and Midwifery Board's Code of Professional Conduct for Nurses states its purpose is to outline a set of minimum standards of conduct members of the nursing profession are expected to uphold (Nursing and Midwifery Board of Australia, 2008). A new *Code of Conduct* issued by the Nursing and Midwifery Council in the United Kingdom describes the standards specified in the code as signifying "what good nursing and midwifery practice looks like" (Nursing and Midwifery Council, 2015, p. 3). However, the new code has caused controversy for its detailed descriptions of the care expected from nurses, including clauses referring to the need for nurses to ensure that patients have adequate access to nutrition and hydration (Osborne, 2014). Many nurses have seen the prescriptive nature of the new code as an insult to the nursing profession, and a knee-jerk reaction to the Francis Report on the failures in nursing care at Mid Staffordshire NHA Foundation Trust. In general, the statements in these documents indicate that around the world the standards expected of nurses equate to safe and competent nursing care.

Analysis of the decisions made by the New Zealand HDC regarding alleged breaches of the Code helps to demonstrate how nursing standards are defined in New Zealand. The reports provided to the Commissioner by independent nursing advisors measure the actions and behaviours of nurses against expected standards of practice or accepted standards of practice. Breaches of the Code are rated as either a minor, moderate or severe departure from accepted/expected standards of practice. For example, in Decision 13HDC00405, a complaint over the palliative care of a cancer patient, the nursing advisor concluded "the decision not to seek advice when [Mrs. A's] daughters raised concerns that their mother was in pain is in my opinion a moderate departure from expected standard of practice" (Deputy HDC, 2015a, p. 37). The Deputy Commissioner concluded that the nurse "failed to comply with professional and legal standards and, accordingly, breached Right 4(2) of the Code" (Deputy HDC, 2015a, p. 21). In Case 14HDC00157, a medication error that resulted in the death of the patient, the nursing advisor concluded "as an RN peer, I consider the practice of [RN F] to have severely departed from the expected standard of nursing care in relation to safe medication administration" (HDC, 2015b, p. 37). The Commissioner accepted this advice and concluded that the nurse had therefore breached the Code, and also recommended that the NCNZ consider a review of the nurse's competence.

Many of the cases emphasise nurses' personal accountability for the standards of care provided to patients. In Case 13HDC00482, involving multiple failures in the post-operative care of a patient, the nursing advisor noted that the lack of clarity in the doctor's charting did not excuse the nurses' failure of care:

> *[Dr. B's] charting does not abdicate the nurses for their lack of critical thinking and assessment in this case. Registered Nurses are accountable for ensuring all health services that they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. (HDC, 2015a, p. 60)*

In Case 14HDC00157, while both the Commissioner and the nursing advisor noted problems with the working environment and workload at the hospital, and found the Canterbury District Health Board guilty of breaches of the Code, this did not absolve the staff involved of their individual responsibility for the

medication error. The nursing advisor stated "whilst I acknowledge that clinical workload contributed to this error occurring, I do not consider it to mitigate the severity of the departure" (HDC, 2015b, p. 37).

The emphasis upon the nurses' accountability reflects a common theme throughout the national and international codes of conduct and ethics. For example, the ICN Code of Ethics states that "the Nurse carries personal responsibility for nursing practice" (ICN, 2012, p. 3). The American Nurses' Association Code of Ethics states that "nurses bear primary responsibility for the nursing care that their patients and clients receive and are accountable for their own practice" (American Nurses Association, 2015, p. 19). The NCNZ Code of Conduct states that "as professionals, nurses are personally accountable for actions and omissions in their practice, and must be able to justify their decisions" (NCNZ, 2012, p. 3). Nursing's professional status is intrinsically tied to their responsibilities and liabilities in regards to their duty of care.

It should be noted that *accepted* standards of practice do not necessarily mean *best* standards of practice. In Case 14HDC00958, albeit in regards to the practice of a doctor rather than a nurse, the independent medical expert noted that "while [Dr C's] management of [Mrs. A] was not consistent with recommended best practice, it was consistent with common practice" and therefore recommended that there had been no breach of the Code (Deputy Health and Disability Commissioner, 2015c, p. 27; NCNZ, 2012). The Commissioner accepted the medical expert's advice and did not find the doctor in breach of the Code. This calls to mind the criticisms made of the Bolam test in tort law discussed earlier; should health practitioners be held to the standard of best practice, or just accepted practice? The Commissioner's judgment differs from the expectation for nurses to be up-to-date with current literature and practice standards and hence demonstrates various standards to which duty may be held.

Alongside the advice provided by the nursing experts, the Commissioner also considers a range of relevant standards, guidelines and competencies. For example, Case 13HDC01720 refers to the Health and Disability Sector (Core) Standards NZS 8143:2008; HPCA Act 2003; Age-related residential-care services agreement 2013; the Code of Health and Disability Service Consumers Rights 2009; NCNZ Registered Nurse Scope of Practice and Competencies; Medicine Care Guides for Residential Aged Care 2011; Standing Order Guidelines 2012; New Zealand Handbook Indicators for Safe Aged-Care and Dementia-Care for Consumers SNZ HB 8163:2005 (Deputy HDC, 2015b). It is the standards specified in these documents that assist the Commissioner to come to a conclusion about whether there has been a breach of the Code. For example, in introducing her opinion in this case, the Deputy Commissioner noted that "the Nursing Council of New Zealand Competencies for Registered Nurses state that the standard expected of a registered nurse in management is to promote a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice" (Deputy HDC, 2015b, p. 25).

Conclusion

Throughout the evolution of modern nursing, care has been a fundamental value. The obligation for nurses to care, however is more than individual philosophy; it is informed by legislation, public expectation and professional standards. Duty of care is a useful framing of the character and characteristics of nurses both nationally and internationally.

The healthcare system will continue to operate with competing aims of fiscal responsibility to central government and provision of quality service to healthcare consumers. There are professional, regulatory and public expectations for nurses to provide safe competent and compassionate care; this can leave nurses with dilemmas around how to meet both their legal and moral responsibilities. Understanding what the responsibilities of duty of care entail provide a framework for nurses to understand and challenge situations where this may be difficult to achieve. Nurses need to ensure that their practice meets the accepted or expected standards of the public and the profession in order to meet their legal, ethical and professional duty of care.

While the historical origins of duty began in servitude, whether by virtue of religion or gender, modern expectation is based on outcome rather than motivation. Nurses are required to both do good and avoid harm and may be held to account by those standards. Regulatory bodies around the world have made explicit the need for nurses to demonstrate a high standard of practice; the measure by which inclusion in the profession is maintained. The ICN, despite not using the term 'duty of care' similarly articulates the expectation for nurses to be proactive in delivery of high standards of patient care. Achieving this high standard of care requires a commitment by all nurses to fulfilling their duty of care, informed by ongoing learning and reflection.

Statement

Tineke Water as a co-author and Nursing Praxis in New Zealand Editor has excluded herself from all review, editorial and publication decisions for the article consistent with journal policy.

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