Venepuncture: the medicolegal hazards

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Summary
Venepuncture is commonly regarded as a trivial procedure allocated to the most junior medical staff. The result of this policy is that junior doctors are required to perform a minimally invasive procedure on consenting patients without any structured venepuncture training or assessment. Consequently, inexperienced doctors may perform multiple and sometimes unnecessary, venepunctures, which could damage essential venous access, eg, in the diabetic or renal patient. We review the medicolegal position and suggest that structured venepuncture training is essential and argue that unskilled treatment may be regarded by the Courts as demonstrating the *mens rea* of assault in the form of recklessness.

Keywords: junior doctor, law, venepuncture

Venepuncture, the puncturing of a vein with a needle principally to take blood or inject medication, has traditionally been allocated to the most junior hospital residents, principally because of the repetitiveness of the task and its apparent simplicity. As we can all recall, this is patently not the case (figure 1).

Training

Undergraduate students, rightly so, are no longer allowed to take blood; historically, however, this had served as a partially supervised apprenticeship in venepuncture. Compounding the lack of suitable experience, has been the welcome introduction of phlebotomists, who, in contrast, are required to be trained to a minimum level of competence, with appropriate supervision and assessment.¹ This training involves a basic anatomical review of the arm (figure 2), often forgotten by the doctor, and staff are encouraged to acknowledge limitations in knowledge and competence.² We review the medicolegal position of junior doctors who are now increasingly involved only with establishing venous access and with out-of-hours venepuncture.

The law

Legally, the crime of assault is defined as the attack on the person of another.³ Most assaults involve the attacker’s body or a weapon. The application of force must be intentional and not accidental: in legal terms, the *mens rea* (the guilty mind) of assault requires that the accused should have had the ‘intention to do bodily injury’ (HM Adv v Phipps (1905) 4 Adams 616). The case of Connor v Jessop in 1988, however, decided that *recklessness* might be a sufficient *mens rea* for assault (Connor v Jessop 1988 SCCR 624). In this case a glass was thrown at one person but by mistake hit a bystander. The likelihood of the occurrence was an important factor in upholding the conviction on appeal.

Venepuncture and the law

It is clear that if you stick a needle in someone’s arm, this constitutes assault, but what if the person has consented to the procedure? Scots law takes the view that, subject to certain limitations, the consent to the application of force would

Figure 1 A patient’s arms after venepuncture

Figure 2 The vascular anatomy of the arm

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Venepuncture: key points

- informed consent must be obtained
- adequate training must be provided for junior medical staff
- care must be taken to protect venous access, particularly in patients with chronic illnesses such as renal failure or diabetes

normally be a defence to the crime of assault. Similarly in English law, bodily touching potentially comes within the scope of the crime of battery, in the form of trespass to the person. It is not necessary for the touching to be 'hostile' or aggressive³ for it to constitute the offence of battery (*Faulkner v Talbot* [1981] 1 WLR, 1528, 1534). The absence of consent, however, would be an essential element of the offence, except where a statutory or common law justification is available to the doctor. Without this defence of consent, contact sports such as football and rugby would be criminal activities.⁴

In the case of *Smart v HM Adv* (*Smart v HMAdv* 1975 SLT, 65), it was clearly established that there is indeed a limit to this defence, and that even if a relatively minor degree of force is applied, then as long as there was an intention to cause harm, the matter would be regarded as an assault. The recent English case (*R v Brown* [1992] 2 WLR 441) which involved sado-masochistic activities and which went all the way to the House of Lords, supports the rule that consent in such a case is no defence.⁵

Venepuncture and the doctor

Where does this leave venepuncture in the hospital setting? The junior doctor must first ask for consent, which is often implied by the patient proffering the arm. For the consent to be informed, it is essential that the doctor is clearly identified with respect to his professional status, and the patient should understand what is intended.⁴ Legal problems do not normally arise from a simple venepuncture, if the anatomy of the arm is respected, but if when the initial venepuncture is unsuccessful, the doctor continues to make repeated attempts, this raises the issue of whether the initial consent extends to such repeated attempts to perform venepuncture. Furthermore, if the patient is diabetic or suffers from chronic renal impairment, venous access may be life-saving in the future. Indeed it is not unusual to see patients whose veins have been ruined by the repeated attempts of inexperienced junior staff. While it is not suggested that there is ever any intention to harm, it is nevertheless possible that such unskilled treatment might be regarded by the Scottish Courts as demonstrating the *mens rea* of assault in the form of recklessness. It must not be forgotten that to ignore the risks of fainting, with consequent falling to the floor resulting in serious head or facial injury, might also be perceived as recklessness on the part of the doctor.

In the larger legal catchment area of English Law, Kennedy and Grubb⁶ in their definitive book on Medical Law write, in discussing the absence of consent. "It is clear that battery will be committed by a doctor even if he acts out of what he sees as the best interests of his patient".

Conclusion

We must conclude that venepuncture is a serious business which should be carried out only by medical staff who are appropriately trained in venepuncture and deemed competent. It would also seem reasonable that assistance from a more experienced colleague should be requested after two or three unsuccessful attempts. In conclusion, all those involved with venepuncture should be aware of the importance of informed consent and the medicolegal implications of this procedure, as well as the financial consequences of resultant litigation.

1 UKCC Code of Professional Conduct, June, 1992.

2 Exercise of Professional Accountability. *UKCC scope of professional practice for nursing, midwifery and health visiting*, June, 1992.

3 McCall Smith RAA, Sheldon D. *Scots criminal law*. Edinburgh: Butterworths, 1992; chapter 9.

4 McConnell AA, MacKay GM. Consent in medicine and sport. *JR Coll Surg Edinburgh* 1995; 40: 213-4.

5 Smith Sir JC, Hogan B. *Criminal law, cases and materials* 5th edn. London: Butterworths, 1993; pp 462-70.

6 Kennedy I, Grubb A. *Medical law: text with materials*, 2nd edn. London: Butterworths, 1994; p 90.