Litigation and the practitioner part 4

Dr Nizar K Hirji looks at accountability within civil law and explains the processes surrounding clinical negligence. (C53729, one distance learning point for optometrists and dispensing opticians.)

This series of articles is concerned with key areas of accountability of the optometric/optical practitioner in England. However, many aspects have similarities, or indeed apply in other parts of the UK, and to business registrants of the General Optical Council (GOC). It is not a substitute for formal legal counsel. This article will cover the fifth key area of accountability – civil accountability/liability.

Figure 1 illustrates five key areas of accountability of the practitioner.

Civil
Civil law covers areas such as tort (wrong-doing or harm to another resulting in injury), which includes (not exhaustive):

- negligence,
- false imprisonment,
- trespass,
- defamation,
- family matters,
- employment,
- probate,
- wrongful/deliberate interference with interests in trade/business,
- breach of statutory duty,
- nuisance,
- malicious prosecution,
- land law.

Other than this, civil law covers breach of contract. Clinical negligence is a subsection of the law of tort, and is the term that will be used in this series to refer to litigation against practitioners. Most litigation against practitioners employed within the NHS is for the tort of clinical negligence since no contract between the NHS patient and the practitioner/hospital exists. A contract, briefly, is a legally enforceable agreement creating obligations whereby there is:

- an ‘offer’
- an ‘acceptance’
- and a ‘consideration’ (a fee)

Normally no ‘consideration’ passes directly between an NHS patient and the NHS practitioner/hospital so there is no legally enforceable contract.

This distinction is particularly important to remember when conducting an NHS sight test for patients under a General Ophthalmic Services (GOS) contract with NHS England. In this instance the patient does not have a contract with the NHS but with the GOS contractor, when they make an appointment for a NHS sight test. Claims for clinical negligence in such cases against private optometric/optical practitioners and private hospitals, are therefore often brought both as torts and breaches of contract.

Most litigation by adults will be in their own name. Action on behalf of children or those without the appropriate mental capacity will be brought on their behalf, by a court-approved individual (litigation friend). Litigation on behalf of a deceased patient will be brought about by executors or administrators on behalf of the estate of the deceased.

Negligence claims are made against a person or persons, and NHS hospitals and employers are regarded from a legal perspective as persons or ‘legal entities’ having vicarious liability for their employed staff. This is not so for the self-employed independent locum practitioner, unless the locum contract is so fashioned that the relationship is ‘akin to employment’ where the organisation/practice exercises a high degree of control over the practitioner and their activities.

The NHS Litigation Authority (NHS LA) manages negligence and other claims against the NHS in England on behalf of their member organisations. Figure 2 illustrates an increase of £339m in payments over the previous year by NHS LA to settle NHS clinical negligence claims. Generally the NHS LA tries to avoid litigation and resolves most of its claims without litigation. As a result in 2015-16...
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less than 1% of its claims have been settled in court.

For a legal action of clinical negligence to succeed, the following legal criteria must be met:

- There must exist a duty of care owed by the practitioner to another.
- There must be a breach of that duty of care by the practitioner.
- There must be foreseeable harm/injury as a consequence of the breach.

Duty of care: As detailed in a previous article, the ‘common-law duty of care’ was first recognised in the case of Donoghue v Stevenson.1 As Lord Atkin stated in that case, one owes a duty of care to 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 or omissions which are called in question. This means that all healthcare practitioners and their staff owe a duty of care to patients and customers to exercise the skill and care expected in their discipline. This duty of care is reinforced by the professional duty of care in the form of Standards of Practice for Optometrists and Dispensing Opticians, Optical Students, and the Code of Conduct for all registrants of the GOC.2

Breach of duty of care: To establish the breach of duty of care the courts rely on professional opinion regarding the standard of care. Expert opinions are normally sought and a decision is made based on what is considered to be the standard of care that would be delivered by a competent practitioner in the field.

The ‘Bolam’ test: Established in the case of Bolam v Friern Hospital Management Committee2 when John Bolam, the plaintiff, underwent electro-convulsive therapy (ECT). As a result, he sustained fractures of the socket of the hip joint (acetabula). He was given no muscle relaxant drug prior to administration of the ECT, nor was any significant physical restraint applied during the administration of the ECT. Furthermore, the defendants did not warn him of the risks involved in the treatment. Experts agreed there was a firm body of opinion in the health professions which was opposed to the use of relaxant drugs as a matter of routine with this procedure. The defendants took the view that it was not desirable to warn patients of the risk unless they asked about it, while the expert witness for the plaintiff took the view that it would not be right not to warn a patient of the risk of fracture. After a retirement of 40 minutes the jury returned a verdict for the defendants, ie not negligent on both issues of treatment and consent. This judgement by J McNair established the principle that a health practitioner ‘is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it another way, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.’ It was meant to be justice for the professional by their peers. However, organisations representing victims of medical mishaps saw it rather differently. They suggested that Bolam was no more than a requirement to find experts who would declare that they would do as the defendant did, and then there was the suggestion that Bolam was used to prevent development of doctrine of informed consent (covered in a later article in this series), and to judge welfare interests of patients lacking capacity to make their own treatment decisions.3 Instead of upholding standards that are good, Bolam tended to default to standards supportable by other practitioners even if they fell below what would be objectively acceptable.

Bolitho v City and Hackney Health Authority4 allowed some refinement of the Bolam test. Here the legal action was brought by the administrator of the estate of Patrick Bolitho (PB) aged two years against the defendants for the failure of the doctor to attend to PB when called by the nurse. PB was admitted to St Bartholomew’s Hospital suffering from croup on January 11, 1984. He was sent home adequately recovered on the 15th of January but was readmitted the next day with a recurrence of his breathing difficulties. After two further episodes of respiratory crises on January 17 when doctors were called by the nurse but did not attend, PB died of a cardiac arrest and brain damage. The hospital admitted negligence on the part of the doctor for failing to attend or to arrange a suitable deputy to attend but denied liability on the grounds that even if the doctor had attended she would not have intubated. Intubation was necessary before 2.30pm on January 17 to avoid respiratory failure, the subsequent heart failure and brain damage. Eight expert witnesses gave their testimony. Five experts for the plaintiff agreed that PB should have been intubated after the first episode and definitely after the second episode. The three experts for the defendants however rejected that suggestion, and advocated that intubation of a child...

FIGURE 2 Clinical negligence expenditure including interim payments 2014-15 and 2015-16

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1. Donoghue v Stevenson
2. Bolam v Friern Hospital Management Committee
3. Bolitho v City and Hackney Health Authority
4. Figure 2

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his age would have involved anesthetising, and based on PIBs condition such a course of action was not necessary or desirable. Having considered Bolam, in that, 'The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art' the judge decided that both contradictory but honestly held views of experts of distinction were logical and gave judgment in favour of the defendant.

Bolitoh set a precedent and the Bolam test moved from simply peer view to expert views that must withstand logical judicial analysis and greater scrutiny. The standard applied is the standard of practice, knowledge and understanding which was applicable at the time of the allegation and not at the time of the hearing.39

Expert witnesses: Increasingly practitioners are asked to act as expert witnesses in various judicial and quasi-judicial forums to whom they then become accountable. It is important to remember that the expert witnesses are likely to be asked to give a view about defendant's actions in their clinical setting and about 'the standard of the ordinary skilled man exercising and professing to have that special skill'. It is thus usual for a primary care clinician to act as an expert witness in a case involving primary care, and a secondary care practitioner in a case involving secondary care in specific healthcare disciplines. However, for an optometrist to act as an expert witness in a case involving an optician (and vice versa) or an ophthalmologist in a case involving an optometrist (and vice versa) would most likely be challenged. It is also important that practitioners who put themselves forward as expert witnesses are aware of, and subscribe to, the Civil Procedure Rules39 which place particular expectations on expert witnesses in terms of their duties and accountabilities to the courts.

Clinical guidelines: Clinical practice is increasingly protocol driven and as the role of practitioners and the scope of practice expands and evolves, so have clinical guidelines and standards from various organisations. There is clearly a need for practitioners to keep pace with these guidelines and protocols, and with new ones as they emerge. Not surprisingly these guidelines are on occasions proffered as the standard of care. However, they are really indicative of 'best practice' or 'gold standard' rather than 'peer view' or 'common practice' — unless it can be shown that they are overwhelmingly adopted by the 'front-line' of the relevant profession. However, courts are free to consider such guidelines and protocols in deciding on the logic of evidence. If, however, harm results because of departures from accepted guidelines or protocols without good reason, then litigants are more likely to succeed.

Recent research using standardised patients investigating standards of clinical practice within optometry has revealed very useful information with regards to standards of care and gauging what practitioners actually do — 'peer view' or 'common practice' — in the 'front line'.40,41,42,43,44

Foreseeable harm or injury: The final limb of the legal criteria for a finding of clinical negligence has itself three parts, ie foreseeability; injury or harm; specifically as a result of the breach of the duty of care. The litigant must prove that the damage was reasonably foreseeable (not too remote), and that it was specifically the breach of the duty that caused or materially contributed to the injury or harm. Eye lesions may have a multifactorial or even unclear aetiology, exacerbated by general health, genetics, medication, and complicated by the natural progression of the lesion, occupation of the patient, etc. An example of a foreseeable and not too remote a consequence would be a retinal vascular occlusion in a patient with an attack of acute glaucoma, or a retinal tear/detachment in a patient with a sudden awareness of flashing lights and vitreous floats. Compensation is what legal actions for clinical negligence are normally about. However, the onus is on the litigant to prove causation in their case, especially where a number of different factors could have caused the injury or harm.45 The injury involved may be physical, psychological or economical, caused (on the balance of probabilities) as a result of the breach of the duty of care (causation and causal link).

An 'all or nothing' process: Finally all three elements of the legal criteria of clinical negligence must be present for the legal action to succeed. This is illustrated by the case of Barnett v Chelsea and Kensington Hospital Management Committee,46 regarding a casualty officer who was called by the casualty nurse to examine a night-watchman complaining about vomiting for three hours after drinking tea. The casualty officer did not attend but sent a message that the night-watchman should report to his own doctor. The nurse instructed the night-watchman accordingly; however, the patient died a few hours later from poisoning by arsenic which had been introduced into the tea. His widow took legal action on behalf of the estate, herself and two dependent children against the defendants claiming that her husband's death resulted from the defendants' negligence in not diagnosing or treating his condition when he presented himself at the casualty department. It was held that the defendants had owed Mr Barnett a duty to exercise the skill and care to be expected of a nurse and medical casualty officer. The medical casualty officer was held as negligent in not seeing and not examining the deceased and the defendants were found in breach of their duty of care to the deceased. However, because Mr Barnett would have died of arsenic poisoning anyway, even if he had been admitted to the hospital hours before his death and treated, the plaintiff had failed to establish on the balance of probabilities, that the defendants' negligence had caused the death; and therefore, the claim failed. In the eyes of the law, all three elements of clinical negligence have to be established for a claim to succeed — an 'all or nothing' process.
There is no redress for breach of duty per se without injury or harm being established attributable to the breach.

**Time limitation for claims:** Finally, there is a time limit within which any claim of personal injury must be made as detailed in the Limitation Act 1980. The general rule is that the "limitation period" for compensation claims relating to personal injury in particular, is three years from the date of the negligent event. Effectively, the three-year period does not start to run until the claimant finds out about the problem, the identity of the defendant, that the injury was significant, and attributable to the alleged negligence. For children it does not start to run until they are 18 years of age while people who lack capacity may be able to issue proceedings at any time. However, the court has the discretion to not apply the limitation period if it is equitable and just to do so.

In Nicholas v Ministry of Defence, Doris Timbrell (DT) had been exposed to asbestos while working between 1941 and 1943, assembling gas masks and fitting filters into the masks. She was advised by a doctor that she could make a claim in relation to her asbestosis on or about 26.8.04. The day of knowledge for limitation purposes. The claim was statute barred three years later on 26.8.07 a year and three months before her death. The period of delay from date of knowledge to the date proceedings were commenced by her daughter and executrix of the estate of DT, less moratorium period, was about seven years three months. The decision not to issue proceedings while DT was alive was directly related to the effects of the asbestos exposure and though the deceased wanted to take legal action, she was of the view that she was too ill to do so. There was further delay from death to issue of proceedings. For a large part of that time, solicitors for the claimant were indeed pursuing the matter. Taking into account all the circumstances and the reasons given for the delay in issuing proceedings at the hearing, the High Court judge took the view that it would be equitable to allow this action to proceed and directed that the limitation provisions of the 1980 Act should not apply in this case.

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**REFERENCES**

7. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.