ACCOUNTABILITY IN CLINICAL PRACTICE: LITIGATION AND THE NON-MEDICAL PRESCRIBER

presented to
Allied Healthcare Professionals
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SUPPLEMENTARY PRESCRIBER STATUS

Medical Prescribers - Independent Prescriber Status
- Medical practitioners
- Dental practitioners
  - May prescribe any medicine, including controlled drugs
  - May initiate/review an agreed Clinical Management Plan (see below)

Non-Medical Prescribers - Supplementary Prescriber Status
- Nurse Prescribers (Independent Prescribing Status 2003)
- Pharmacist Prescribers
- Allied Healthcare Professionals (since May 2005):
  - Podiatrists
  - Physiotherapists
  - Radiographers
  - Optometrists
    - May prescribe any medicine, including controlled drugs
    - Supplementary Prescribers may prescribe for the patient within an agreed Clinical Management Plan, subject to Independent Prescriber Review
    - Ideally, there should be a voluntary three-way partnership between IP’s and SP’s, with the agreement of patients
Advantages of Supplementary Prescriber Status

• Improved quality of patient care - SP status might be seen as an ‘extra tool’ for AHPs
• Increased speed/responsiveness to patient’s needs
• More direct access as between patient and prescriber - prescriber may often be the first person the patient sees in the community
• Reduced burden upon Medical Prescribers (NB: European Working Time Directive)
• Enhanced status of Allied Healthcare Professionals - more autonomous practitioners - acting as gatekeepers for patient care
ACCOUNTABILITY

- Allied Healthcare Professionals are subject to professional accountability.
- This professional accountability applies to Allied Healthcare Professionals regardless of whether they are registered with Supplementary Prescriber Status.
- Professional accountability includes the following:
  - adhering to nationally agreed and recognised professional standards and practice guidelines, eg NICE, SIGN, CREST, ‘Standards for Better Health’ (DoH, 2004), etc.
  - prescribing, within the scope of your professional role, in the best interests of your patients
  - carrying out an assessment of the needs of each individual patient, including a systematic review/interpretation of the patient’s medical/drugs history, to arrive at a full assessment of that patient’s needs for treatment
  - prescribing for the patients of non-prescribing clinicians?
  - recording and reporting to the patient’s GP/consultant/PCT any unexpected drug reactions or interactions, etc.
  - monitoring, recording and reporting any prescribing errors/anomalies, e.g. patients may themselves report instances where prescribed dosages are exceeded
  - utilising the principles of evidence-based medicine and keeping up to date with relevant literature: Continuing Professional Development
  - resisting undue commercial influences
  - ensuring the security of prescription pads
  - keeping and maintaining proper records
  - providing appropriate information to patients when prescribing
THE LAW OF CLINICAL NEGLIGENCE

At common law, liability for negligence (including clinical negligence) depends upon the following elements:

- a duty of care owed by the clinician to the patient
- breach of the duty of care on the part of the clinician
- causation of loss and damage

- All healthcare professionals, including Allied Healthcare Professionals, are already potentially liable for clinical negligence arising out of their clinical acts or omissions, regardless of whether or not they are registered with Supplementary Prescriber Status.

- Allied Healthcare Professionals with Supplementary Prescriber Status need to understand and appreciate the principles which apply to their potential liability for clinical negligence.
DUTY OF CARE

The law of negligence dictates that all healthcare professionals owe a duty of care to each of their patients.

The law imposes a duty to exercise ordinary and reasonable care and skill as an ordinary and prudent healthcare professional of that particular type. For example:

• A Podiatrist owes a duty to exercise ordinary and reasonable care and skill as ordinary and prudent Podiatrist: this content of this duty will be informed by the principles of professional accountability discussed above.

• Physiotherapists ditto

• Radiographers ditto

• Optometrists ditto
BREACH OF DUTY: the ‘Bolam’ test

The leading case in relation to professional (including clinical) negligence is called Bolam v. Friern Hospital Management Committee [1957] 2 All E.R. 118.

• In Bolam, McNair J. said:
  “...But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is that of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent...it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art...”

• Probably the most important feature of the so-called ‘Bolam’ test was McNair J.’s recognition that there may be a range of differing, but perfectly proper, opinions within the medical professions:
  “…A doctor 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 the other way round, a doctor is not guilty of negligence, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view...”

• In other words, in many clinical scenarios, there may be a range of proper or responsible opinions which a clinician might legitimately hold, whether this is in terms of treatment, prescribing or anything else. The ‘Bolam’ test indicates that clinicians will only be held to be in breach of duty if they have acted, or failed to act, in such a way that falls outside this range of proper or responsible opinions. For this reason, liability for clinical negligence is very much based upon the principles of professional accountability, as interpreted by experts in the field in question.
The ‘Bolam’ test modified by Bolitho

The ‘Bolam’ test has to be considered in the light of the important decision in *Bolitho v. City & Hackney Health Authority* [1997] 4 All E.R. 771.

• In *Bolitho*, Lord Browne-Wilkinson made it clear that, in deciding whether a given body of opinion is ‘responsible’, the court is obliged to weigh expert evidence in a form of risk-benefit analysis: “...The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such an opinion has a logical basis. In particular in cases involving, as they often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparable risks and benefits and have reached a defensible conclusion on the matter...”

• In other words, clinicians will not be able to defend their actions by relying upon an expert opinion which the judge regards as illogical, or irresponsible.

• However, Lord Browne-Wilkinson went on to emphasise that it would seldom be right for a judge to conclude that views genuinely held by a competent medical expert were unreasonable: “...It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such an opinion will not provide the bench mark by reference to which the Defendant’s conduct falls to be assessed...”

• It is important to note that, insofar as the duty of care has been breached by a clinician, the law of negligence takes little account of whether or not the clinician’s intentions were good, bad or indifferent. All that matters is whether or not, according to the above principles, the clinician has acted in breach of the duty owed to the patient.
CAUSATION: the ‘but for’ test

• Traditional approach to causation in the law of negligence is known as the ‘but for’ test. The Claimant must prove that the damage in question would not have occurred ‘but for’ the Defendant’s breach of duty.

• In the context of an action for clinical negligence, this is often the most thorny issue, mainly because patients are already unwell before they become involved with a medical professional, and separating out the consequences of their existing illness, any long-standing or constitutional problems, and the breach of duty in question, can often be a difficult matter.

• Nevertheless, the principle is clear: once a breach of duty has been established, the injured party is only entitled to recover compensation for the consequences of the breach of duty, and not otherwise.
VICARIOUS LIABILITY

Vicarious liability is a concept of great importance to Allied Healthcare Professionals, many of whom function within an institutional framework and under the auspices of the NHS.

- Vicarious liability means that the institution (often the NHS Trust or the PCT) will be directly liable to the patient for the negligence of its employees committed in the course of their employment.

- There are usually three relevant issues:
  - has the individual been negligent?
  - is the individual an employee of the institution?
  - was the individual negligent in the course of his employment?
CONTRIBUTION

• The law of contribution between tortfeasors deals with the situation where there has been a breach of duty by more than one party. A typical example might be where an Independent Prescriber incorrectly prescribes a drug which is contra-indicated, but a reasonable and prudent pharmacist should have noticed the error, but failed to do so.

• In these circumstances, the patient suffering the loss and damage might well sue the doctor, the pharmacist, or both and the court may well be called upon to apportion the extent to which each clinician contributed to the loss.