Healthcare
July 2012

CLYDE&CO

Health Law News

Injecting some reality into the prospects of appealing a GMC Fitness to Practice Panel determination

The recent decision of Mrs Justice Lang highlights the hurdles a doctor faces in seeking to successfully appeal a decision of the GMC's Fitness to Practice Panel ('FPP'). It also emphasises a general reluctance of the courts to interfere with determinations of the FPP.

The case

Dr Cornish, a consultant anaesthetist at Yeovil District Hospital, had been struck off the register. The FPP had found that his fitness to practice was impaired on a number of grounds including a previous conviction for theft of drugs from his employer, misconduct (for taking drugs from the hospital and administering them on Trust premises and at home) and his adverse physical or mental health (he had abused medicinal drugs such as Fentanyl and Morphine, obtained in the course of his employment, for many years and had also been diagnosed with Opioid Dependence Syndrome).

Dr Cornish appealed against the FPP's determination that his name be erased from the medical register, and against the FPP's determination on the facts. He did not contest the FPP's finding that his fitness to practice was impaired on the grounds of his previous conviction, his misconduct or his adverse physical and mental health. He did, however, appeal against the FPP's determination that he self-administered drugs within the hospital buildings of Yeovil District Hospital.

At the hearing, he admitted to self-administering drugs in the hospital car park, in his car and at his home, but he disputed the finding of fact that he had also self-administered within the hospital itself (in his evidence to the FPP, Dr Cornish accepted that if he was found to be taking drugs whilst at work in the hospital buildings, it would impact on his future employability).

The FPP's finding of fact

The FPP concluded that it did not consider Dr Cornish to be a credible witness given that he had consistently lied about his drug history. Furthermore, and by his own admission, Dr Cornish had told the FPP that at one stage his drug taking had become chaotic and there were times where he could not wait 20 minutes to get home to self-administer drugs. In light of this, the FPP considered that he could not have had the self-control not to self-administer drugs within the hospital. Dr Cornish had also been found to be storing drug paraphernalia in his hospital locker.

The FPP was therefore satisfied that it could reasonably infer, on the balance of probabilities, that Dr Cornish had self administered drugs within the hospital building.

The FPP's sanction of erasure

The FPP had determined that, in light of his previous conviction and misconduct, erasure was the appropriate sanction for Dr Cornish. Dr Cornish appealed on the grounds that the decision was excessive and disproportionate. He made a number of submissions including the fact the FPP had failed to attach any weight to evidence from colleagues that he was a well-regarded, competent practitioner and there had been no formal or informal complaints about his work with patients during his 15 years of opioid dependence.

The High Court decision

Mrs Justice Lang rather unsurprisingly dismissed both grounds of Dr Cornish's appeal in this particular instance. In doing so, she considered the High Court's jurisdiction on appeal from a determination by the GMC in light of two recent Court of Appeal cases.

In the first of those cases[1], Auld LJ stated that it is plain from the authorities that the court must have in mind and give such weight as is appropriate in the circumstances to the following factors:

(i) the body from whom the appeal lies is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect

(ii) the tribunal had the benefit, which the court normally does not, of hearing and seeing the witnesses on both sides, and

(iii) the questions of primary and secondary fact and the overall value judgment to be made by the tribunal, especially the last, are akin to jury questions to which there may reasonably be different answers

In the second of those cases[2], Laws LJ took the view that consideration should be given to the difference in function of the FPP in imposing sanctions from that of a court imposing retributive punishment. Where professional discipline is at stake, the relevant committee is not concerned primarily with the punishment of the practitioner concerned, but rather the reputation or standing of the profession. The consequences of a sanction (such as erasure) may be deeply unfortunate for the individual concerned (i.e. an inability to continue practicing) although, in light of the reasoning above, does not necessarily make the sanction wrong. It seems therefore that the court considers the reputation of the profession more important than the fortunes of any individual member.

Mrs Justice Lang stated that the above principles constitute the essential approach to be applied by the High Court on appeal. Interestingly, she went on to say that such approach does not necessarily emasculate the High Court's role in the appeal process. The court will, for example, correct material errors of fact and law and it will exercise judgment, albeit distinctly and firmly as a secondary judgment as to the application of the principles to the facts of the case.

In this particular case however, Mrs Justice Lang considered that the FPP had set out an impressive summary of the evidence prior to its conclusions and that its reasons were fully and clearly stated. She considered the FPP was entitled, on the basis of the evidence before it, to conclude Dr Cornish had self-administered within the hospital buildings. Furthermore, and in her judgment, Mrs Justice Lang considered the FPP had correctly concluded erasure was the appropriate sanction, particularly bearing in mind the seriousness of Dr Cornish's misconduct.

In Mrs Justice Lang's view, the FPP had correctly directed itself on the relevant law and guidance, fairly assessed the evidence, and reached conclusions which were justified on the evidence before it. In light of this, she came to the same conclusions as the FPP such that any degree of deference to the more specialist tribunal, in her view, was irrelevant.

Comment

Perhaps the facts of this particular case are not the best example of how one might go about successfully appealing a FPP determination. The judge did not even need to stray into questions of deference as eluded to above, for example.

The case does, however, give a succinct view of what a High Court Judge has in mind when considering whether or not a FPP has come to the correct decision. The principles referred to by Mrs Justice Lang appear, on their face, unproblematic. On closer inspection however, the hurdles that must be overcome are difficult.

[1] Meadow v General Medical Council [2007] QB 46s
[2] Raschid v General Medical Council [2007] 1 WLR 1460

The court acknowledges for example, if the FPP has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of the court which cannot deploy those factors when assessing the position. Furthermore, the court appears quick to defer to the FPP on issues which are relevant to the profession (issues of medical practice and the standing of the profession for example).

There is hope for any potential appeals however, and consideration should be given to whether or not the FPP has made material errors of fact, law and/or judgment. In these circumstances, the court should be more ready to overrule a determination.

Stuart Wallace
Associate
T: +44 (0)20 7876 6091
E: stuart.wallace@clydeco.com

E-disclosure: survival guide

The new rules on electronic disclosure affect healthcare providers as the widespread use of technology in hospitals, surgeries and clinics means electronic documents have become a key source of disclosure materials. This article provides some practical guidance for healthcare providers on what to expect in the future.

The requirement to consider e-disclosure now applies in all cases where proceedings started on or after 1 October 2010.

Does it really apply to my case?

Yes, the rules on e-disclosure set out under Practice Direction 31B of Civil Procedure Rules apply to multi-track cases with any cause of action which began on or after 1 October 2010. To-date there have been both clinical negligence cases and product liability cases which have been the focus of e-disclosure.

What is an e-document?

A 'document' is anything in which information of any description is recorded. This broad definition now includes email, text messages, voicemails, word documents, radiographs, photographs and metadata.

Perhaps the biggest surprise to some is the fact this includes deleted items or 'metadata' as it is known. This will include documents stored on servers and back up systems. Therefore, it is important to ensure preservation of documents as soon as litigation is contemplated (i.e. at the inquest or complaint stage).

How will the rules affect my cases?

The new rules may cause some concern over the escalating costs of complying with e-disclosure. However, the e-disclosure rules are not intended to increase the cost burden on the parties and there are ways of managing the costs.

The Practice Direction encourages and assists the parties to reach an agreement in relation to the disclosure of electronic documents in a proportionate and cost-effective manner.

It is also good to remember that the rules on standard disclosure remain unchanged but the scope of 'documents' which a party must consider has been extended. Therefore, a party is still only required to make a reasonable search for documents that support his case or adversely affect or support another's case.

The general principles of e-disclosure balance the duty to disclose information with (a) the nature and complexity of proceedings; (b) the significance of any document that is likely to be located during the search; and (c) the volume of documents involved.

These considerations must be borne in mind by both parties and should specifically be considered during pre-case management conference discussions. If agreement cannot be reached between the parties the case should be referred to a judge for directions.

Conclusions

Given the ever-increasing volume of electronic data that is created in the workplace the new rules on e-disclosure will have far-reaching consequences.

The best way to be prepared for e-disclosure is to ensure these electronic documents are manageable and easily searchable. Therefore, it is recommended a policy is adopted and applied throughout the workplace for preserving documents (including emails) and filing electronic documents. This will make any search more manageable in the future.

Finally, those who create documents in the workplace need to be aware that these documents may need to be disclosed if litigation is subsequently contemplated. In particular, many have been trapped by the informality of emails which later have been disclosed. Adopting a strict policy now can save problems later.

Charlotte Krol
Associate
T: +44 (0)20 7876 6008
E: charlotte.krol@clydeco.com

When will a doctor's negligent acts or omissions attract criminal liability?

We have advised recently on a number of incidents where it is alleged that a doctor was criminally responsible for the death of his/her patient. Rachel Morse examines the current law behind gross negligence manslaughter allegations and offers some practical points.

Imagine the scenario. It is the end of a busy shift in A&E when patient A is admitted. The attending doctor reaches a rapid conclusion that the patient is, sadly, in the process of dying and that intervention would be futile. The attending relatives are upset with that decision. Patient A dies shortly thereafter.

Two months later, the doctor receives a request from the police to attend a formal interview under caution. The family has obtained evidence to suggest that A's presentation was treatable, the decision not to treat was negligent, basic medical tests were not undertaken and the independent expert providing that evidence considers the doctor's decision fell below basic medical care.

While this picture is, thankfully, uncommon, it does arise from time to time. The effect on the individual doctor subjected to these investigations is catastrophic, they are faced with potential criminal charges which may result in a custodial sentence and would, in any event, endanger their registration and livelihood.

The law

The case of *R v Adomako* (1995) sets down the current test for gross negligence manslaughter. The defendant was a locum anaesthetist at an operation to correct a detached retina. He failed to notice that a tube had become dislodged during the course of the operation which resulted in the patient being deprived of oxygen. The patient suffered a cardiac arrest and died. The defendant was convicted of manslaughter and appealed to the House of Lords (as was) on the basis that gross negligence was not the correct test for involuntary manslaughter. The House of Lords dismissed his appeal and held that gross negligence is the correct test.

To be convicted of gross negligence manslaughter, a doctor must have breached a duty of care owed by them to the patient causing death and the breach of the standard of care must be '*so grossly negligent as to justify a criminal conviction*'. The standard of care demanded of the doctor is the standard of the reasonably skilled and experienced doctor in the doctor's particular field of medicine. It is ultimately a question of fact for the jury to determine whether the standard of care provided was so badly negligent that it can properly be condemned as criminal.

In Dr Adomako's case, he failed to notice for over four minutes that the tube administering oxygen to the patient had become disconnected. One prosecution expert described his standard of care as abysmal and said that any competent anaesthetist should have recognised complete disconnection of the tube within 15 seconds. The jury found the standard of care fell so far below the standard of the competent anaesthetist they were persuaded Dr Adomako's conduct went beyond a civil breach of his duty of care and should attract the sanctions of the criminal law. He was accordingly convicted of gross negligence manslaughter.

In *R v Prentice and R v Sullman* (1993) two junior doctors were acquitted of manslaughter on appeal after they wrongly injected vincristine intrathecally into the patient's spine when the cytotoxic drug should have been administered intravenously. This resulted in the patient's death. It was held that the question for the jury to answer in relation to a charge of gross negligence manslaughter was whether, in the case of each doctor, the jury was sure that the failure to ascertain the correct mode of administering the drug was negligent to the point of criminality. The jury should be directed to have regard to all of the circumstances of the case. The case ultimately turned upon the fact there were many mitigating circumstances in the case and the jury found although the doctors had acted negligently, they had not acted grossly negligently.

In practice

Whether or not a jury will find a doctor's actions to be 'grossly' negligent as opposed to negligent is dependent on the individual facts and circumstances of a specific case and on whether the jury decides to attach sufficient weight to any mitigating factors put in evidence before them so as not to render the doctor's acts or omissions criminally liable. Although it is ultimately a matter for the jury whether or not an individual practitioner's acts or omissions are so culpable as to attract criminal liability, there are certain things doctors can do to minimise the risk of committing negligent acts that may or may not be deemed 'grossly' negligent.

As demonstrated by *R v Prentice and R v Sullman*, when delegating tasks to other doctors, the delegating doctor should always check that the individual is competent to a reasonable standard and communicate any tasks effectively. The delegating doctor in this case failed to check whether Dr Prentice was competent to give cytotoxic drugs intrathecally and the supervising doctor, Dr Sullman, thought that he was only there to supervise the use of the needle to make the lumbar puncture but had no responsibly over the administration of the cytotoxic drugs. Had there been clear communication between the delegating doctor, the supervising doctor and Dr Prentice, the negligent administration of vincristine would not have occurred, the patient would not have died and there would have been no charges of gross negligence manslaughter. The case also illustrates that delegated duties should not be accepted unless the doctor is confident of completing them to a reasonable standard.

Keeping accurate and detailed medical records is essential because this may be the only record or evidence that a jury or a police investigation has to support the doctor's version of events. Inadequate or muddled notes and lost records may lead to an inability to rebut the prosecution's case. Best practice is to ensure all clinical developments are noted together with investigations undertaken, action on results and notes on future management, referral and follow up in a patient's medical notes.

In order to reduce the risk of undertaking acts or omissions which a jury may find as being grossly negligent, medical practitioners should ensure they keep up to date with current medical practice within their own speciality and keep within the limits of their own expertise. Where there are standard protocols or guidelines for dealing with particular conditions and these guidelines are not followed, individuals must be prepared to justify their own management by reference to a responsible body of medical opinion.

Police investigations are traumatic, both for the relatives of the deceased and for the doctor concerned. It is, ultimately, for the CPS to decide whether or not to prosecute bearing in mind the prospects of securing a conviction and the public interest. The quality of the notes, the adherence to policies and the awareness of competency are factors which would weigh heavily in the CPS decision.

Rachel Morse
Trainee Solicitor
T: +44 (0)20 7876 4767
E: rachel.morse@clydeco.com

Practice points

- Trusts should, so far as possible, be prepared to offer the individual doctor as much legal and professional support as possible. While, strictly, the allegations do not affect the Trust and may be characterised as matters on which the individual's defence organisation should assist, it would be preferable for the Trust to be involved with the investigations
- A successful defence would be predicated on the clarity, accuracy and coherence of the original medical records
- The process is likely to be protracted. Depending on the nature of the allegations, Trusts will need to reassure themselves that there are no adult or child protection issues raised by the allegations which would suggest the individual should not undertake front-line duties in the interim
- It is unlikely the police or the CPS will have access to the same in depth understanding of medicine or hospital practice; by offering an understanding of local and national procedures, the Trust can seek to inform the nature and scope of the investigation

Health and Social Care Act 2012

Regardless of any political view the lay observer may hold, it must be common ground that the Health and Social Care Act 2012 has, after a somewhat tortuous journey, taken huge steps to reinvent the landscape of healthcare provision. Comprising 309 sections and 23 schedules, the Act has implications for the entire NHS. The rationale for the change, and the effectiveness of the provisions now in force, remain a matter of debate; the Government would appear not to have made the case for change as compellingly as perhaps they would have wished.

It would be impracticable to attempt to summarise the workings of the Act within a few short paragraphs, never mind to try to reconcile the reactions and implications of the Act, particularly where key issues on the implementation of the Act remain unclear. A short account of the key points, however, may be of assistance:

- The Act seeks to define the duties attendant on the Secretary of State, Monitor, clinical commissioning groups, NICE and other bodies within the new NHS. The extent to which those duties can be easily reconcilable is perhaps a moot point; pertinently, there would seem to be an inevitable tension within the expanded remit of Monitor both to control price and efficiency and to maintain or improve quality
- PCTs and SHAs are in the process of being abolished. In their place, the Act establishes clinical commissioning groups to provide a nationwide network of commissioners answering to the NHS Commissioning Board. Some may say that in order to achieve effective bargaining leverage, a critical patient density and to attract suitable experienced commissioners, the new CCGs will in effect simply be old PCTs reinvented
- The Board itself is subject to a range of duties, including those to promote innovation and quality of care, reduce inequality and promote the interests of the individual. Again, there may be a tension between the various duties, and it would also appear that showing compliance with those duties will be burdensome
- NHS Trusts are to move towards foundation trust status, allowing greater financial flexibility in the provision of healthcare and the promotion of public health. Failure provisions are set out
- Monitor's remit is expanded to a general duty to promote effective, economic and efficient healthcare services. It carries ongoing oversight, licensing and tariff responsibilities for both NHS and private providers and is under a positive duty to eliminate anti-competitive practices. Provisions are made to ensure that providers cannot simply cherry pick the most desirable or profitable patients or services, and to ensure reasonable and transparent consistency of pricing. Monitor and the Care Quality Commission are also required to work together in a step towards the Government's goal of a comprehensive health and social care system
- Patient representation is sought to be enhanced through local Healthwatch organisations reporting to Monitor, the Secretary of State and other bodies

The legislation is imposing in its breadth. It seems remarkable that, despite the physical size of the Act, there remain questions as to how it will in fact work; guidance documents setting out how Monitor will exercise its functions are awaited, for example.

Andrew Lansley stated that his aim was to *"...deliver power to clinicians, … put patients at the heart of the NHS, and...reduce the costs of bureaucracy"*.

In a time of financial crisis, with Trusts struggling to make financial savings and with clinical and nursing morale seemingly heading towards an all time low, it can only be safely said that the costs of reorganising the NHS will be considerable. The benefits of change, and whether Mr Lansley's aims have in truth been achieved, still remain somewhat undefined.

Sam Holden
Senior Associate
T: +44 (0)20 7876 6041
E: sam.holden@clydeco.com

Legal issues arising from claims concerning negligence in relation to the diagnosis of renal failure

High blood pressure (hypertension) is extremely common in western societies. In England alone approximately 34% of women and 37% of men have high blood pressure. Hypertension, on its own, is the second most common cause of end-stage renal failure (next to diabetes) and it is customary for all types of chronic kidney disease to eventually cause hypertension. As such, routine blood pressure management forms an integral part of the prevention and detection of these conditions and clinical negligence claims alleging a delay in the diagnosis of progressive renal failure are becoming more widespread.

This article considers trends in the legal issues associated with these claims.

> Complaints often concern the adequacy of blood pressure control and/or a failure to monitor renal function and/or a failure to act on results.

The British Hypertension Society (BHS) Guidelines advocate a minimum of three blood pressure readings spread out over some months before considering a diagnosis of hypertension and it is recommended that once a diagnosis of hypertension is made (after several elevated readings) routine investigations should include urine analysis (Dipstix) and the measurement of serum electrolyte and urea (U&Es) or creatinine concentrations. Analysis of claims relating to a failure to diagnose and/or monitor renal function suggests that claimant lawyers frequently rely on a failure to act on a single elevated blood pressure result as evidence of negligence often at the same time overlooking subsequent entirely normal readings. In order to defend allegations of this nature it will be necessary to demonstrate sufficient attempts were made to follow up a potentially 'rogue' result otherwise a practitioner is likely to be vulnerable.

There is some evidence from the late 1990s that GPs omitted to carry out urinalysis in newly hypertensive patients, however, notwithstanding this, the general consensus amongst expert opinion is this was not an acceptable practice (the guidance has been in operation since 1993) and claims of this nature will be difficult to defend. When considering what constitutes an abnormal result it is important not to apply today's standards to the past and what may be considered an abnormal creatinine level now may not unreasonably have been considered essentially normal several years ago. Furthermore, the normal range for serum creatinine is variably quoted depending on the reporting laboratory and elevated creatinine levels do not necessarily mandate referral to a renal physician provided there is evidence of recurrent follow-up.

> Recurring allegations centre around the instigation and/or adjustment of treatment in order to reduce risk factors and delays in arranging referral for specialist opinion.

For patients who have high blood pressure and kidney disease ACE inhibitor (ACEi) and angiotensin II receptor blocker (ARB) drugs lower blood pressure and protect the kidneys from further damage. As such, allegations of negligence may concern an alleged failure or delay in the instigation of this treatment. Whilst ACEi and ARB drugs were being widely used to treat hypertension by the mid 1980s (particularly ACEi) they were recommended by the BHS as 'second line' agents (after thiazide diuretics and beta blockers) until the introduction of the 'AB/CD' algorithm in 2004. Consequently, it may be possible to defend these allegations prior to this date. ACEi can rarely cause serum creatinine to rise after starting or increasing dosage in some patients and, therefore, the British National Formulary recommend that U&Es are measured before and after starting treatment and at periodic intervals thereafter. A failure to adhere to this guidance is likely to constitute a breach of duty. Further, it is now accepted that the prescription of non-steriodal anti-inflammatory drugs (NSAIDS), such as ibuprofen, may worsen renal function and, accordingly, their prescription is contraindicated in some patients with kidney disease. This has not always been the case and any allegations of negligence relating to the prescription of NSAIDS should be analysed in the context of the medical knowledge available at the time and without the benefit of hindsight.

> Patients tend to develop symptoms of renal failure only when the disease is relatively far advanced and patients will often seek legal redress for what they feel must have been a diagnostic delay resulting in recourse to a lifetime on dialysis or transplantation. Kidney disease is rarely cured by medication and, therefore, the chain of causation may be weak and it may be possible to restrict quantum.

Although there is evidence that good blood pressure control with ACEi can retard the progression of renal failure, it is important to determine if earlier intervention would have avoided the development of renal failure or if earlier diagnosis could have led to measures to slow the progression of renal disease or prepare patients for renal replacement therapy. This is often difficult to predict with certainty. There is a tendency for claimant lawyers not to investigate causation by obtaining independent expert evidence and to assume that the instigation of effective therapy at an earlier stage would have avoided the development of renal failure altogether. The allegations of

causation are often poorly particularised and sometimes demonstrate a careless analysis of the medical records. For instance, any subsequent normal serum creatinine and urinalysis results will act to undermine any assertion that renal function would have been abnormal before this time insofar that renal function rarely improves with the passage of time. In addition, ACEi may have been instigated indirectly to control hypertension rather than as a direct response to renal failure and, as such, its effect on preserving renal function may have been overlooked. It is, therefore, crucial to obtain expert opinion on causation since more often than not it is possible to demonstrate that a diagnostic delay has exacerbated the onset of a patient's requirement for renal replacement therapy rather than having actually caused it. This has significant implications for the assessment of quantum insofar that in this instance it will be possible to argue that the mainstay of any claim for special damages would have been incurred in any event (albeit at a later stage).

> If a claimant can demonstrate that, but for the alleged negligence, he would have avoided the development of renal failure, then his claim is likely to sound in a significant claim for damages.

Whilst for the majority of the time prior to the need for renal replacement therapy patients will remain relatively well from a renal perspective, once renal function has fallen below 20 ml/min it is generally accepted that they will become symptomatic. Beyond this point claims for loss of earnings and care/assistance are likely to succeed.

Patients undergoing dialysis require haemodialysis three times a week in a hospital or satellite unit or, potentially, by home dialysis. Home treatment may entail a claim for accommodation to enable the installation of a clean room or the costs of treatment in the private sector. Where transplantation is anticipated, given the uncertainty as to the availability of donor grafts, compensation for an extended period of dialysis will be sought in order to take account of this. The median survival of living and deceased donor grafts is approximately 20-25 years and 14 years respectively. Therefore, the costs of more than one transplantation in a claimant's lifetime (or further recourse to dialysis) may be sought. In this instance it will be important to consider if a claimant has any comorbidities, since is maybe arguable that by the time a replacement transplant is required the claimant's anticipated life expectancy has been exceeded.

Conclusion

In conclusion, it will be necessary to obtain expert evidence early on to investigate both breach of duty and causation. As a number of these cases are defensible (or partly defensible) on causation (i.e. expert evidence suggests the claimant will establish an exacerbation of his/her condition rather than causation in full), consideration should be given to an early Part 36 offer in order to limit litigation costs.

Kate Erskine
Associate
T: +44 (0)20 7876 6031
E: kate.erskine@clydeco.com

NHS strike action

Doctors staged their first industrial action since 1975 over the ongoing debate on pensions. Sarah John of Clyde & Co's employment team considers steps Trusts could take in the event of further action.

On Thursday, 21 June 2012, British Medical Association (BMA) members across the UK commenced strike action for a 24-hour period in a dispute over pensions. Under the terms of the strike, all participating doctors were told to attend their place of work so that they were available in the event they were needed to provide urgent and or emergency care. However, they were not to undertake their normal day to day duties.

In the event, the disruption to services feared by many did not materialise; NHS London, for example, reported to the BBC that 11% of non-urgent operations were cancelled and 6% of outpatient appointments were required to be rearranged. Whether the scale of the action met the BMA's anticipation and whether it had any practical effect on the ongoing pension debate, are moot points. It remains to be seen whether the BMA will propose further industrial action.

What is strike action?

Strike action is 'a concerted stoppage of work by workers with the purpose of disrupting the employer's business'. It is the most serious form of industrial action open to employees, and can cause considerable disruption in the workplace. This is in contrast to 'action short of strike', which can take a number of forms, including an overtime ban, 'go-slow', working to rule and withdrawal of cooperation.

What can an employer do?

So, what are the options open to employers when faced with a striking workforce, and what risks should an employer be aware of when attempting to deal with strike action?

Withholding pay

The core principle in an employment contract is that an employee is paid for work done. Where an employee refuses to work during their contracted hours he or she is not therefore entitled to be paid, and in most cases will be in breach of his or her employment contract.

An employer is therefore entitled to withhold an employee's pay for the time during which they did not work. If an employee is paid on an hourly basis, and his or her employment contract specifies normal working hours, deductions should be calculated by reference to the hours lost. Where employees are salaried, unless stated differently in the employee's contract, salary is deemed to accrue from day to day, and this means calendar day, not working day, and salary should be deducted on this basis.

In this instance, where doctors attended their workplace but did not carry out work unless it was urgent or emergency care, determining what an employee is entitled to be paid is not a straightforward process. Furthermore, NHS employees are employed on a range of atypical arrangements including flexible hours of work and rota arrangements, making it harder to establish whether an employee has been involved in strike action and for what period of time.

Care should be taken to ensure consistency of treatment of full-time and part-time staff when deciding how to calculate the level of pay to be withheld. It is good practice to seek to agree an 'Interruption of Work During Periods of Industrial Action' Policy Statement for dealing with these issues to avoid disputes arising when strike action commences.

Dismissal?

There is a certain amount of protection afforded to employees who are partaking in strike action. However, the rules relating to whether a dismissal that occurs while an employee is taking industrial action is 'automatically unfair' are complex and should be reviewed on a case by case basis.

The legal position of employees will depend on whether the action they are taking part in is:

- Unofficial – not authorised or endorsed by a union
- Official – authorised or endorsed by a union but not protected
- Protected – official action which is taken in response to a valid trade dispute and following a properly conducted ballot and proper notification of the employer and the participating employees

Where strike action constitutes 'protected industrial action' as in the case of the recent BMA action, employees would be entitled to take industrial action for a minimum of 12 weeks without being dismissed.

Employees do not however enjoy the same protection against unfair dismissal if the statutory notification requirements have not been complied with.

The limited nature of the action at this stage may not be sufficient for Trusts to consider whether or not to take steps against those involved in the dispute. In the event of further action, however, Trusts may be required to respond.

Sarah John
Associate
T: +44 (0)20 7876 6219
E: sarah.john@clydeco.com

Practice points

- Action was aimed at disrupting non-urgent services; Trusts and the public should be reassured that urgent care would still be provided
- Trusts should work with affected patients and clinicians to rearrange as soon as practicable cancelled operations and clinics
- Liability for incidents arising due to insufficient staff on duty during the period of the action is unlikely to be avoided; Trusts still retain their duty to provide reasonable care to patients
- Careful legal advice would be recommended in the event any Trust seeks to take steps against doctors involved in protected industrial action
- Consider introducing a clear policy statement regarding pay if further action is likely to occur

Death is the only certainty in life, so why has the law on assisted dying been branded 'inadequate and incoherent'?

This article examines the recently published report by the Commission on Assisting Dying and discusses the implications of its proposed new legal framework for assisted suicide on doctors and other healthcare professionals.

On 5 January 2012, the Commission on Assisted Dying, which was set up in September 2010, published its report on the current law on assisted suicide. From the perspective of health and social care staff involved in end of life situations, the Commission concludes that the law is unclear and should not continue. It sets out a proposed framework on assisted dying, should such a system be implemented in the UK. This places a striking emphasis on health and social care professionals upholding and promoting suggested safeguards to prevent the abuse of vulnerable groups, whilst strictly defining the circumstances in which terminally ill patients would be assisted in dying.

Criminality

Under current legislation, encouraging or assisting another person's suicide or attempted suicide is illegal in England and Wales, and is punishable by up to 14 years' imprisonment. However, the report sets out that there has been no prosecution of offences since the publication of the Director of Public Prosecutions' policy on assisted suicide in February 2010. Despite this, it remains at the discretion of the Director of Public Prosecutions to prosecute, which shrouds an ostensibly entrenched legal position in uncertainty. In turn, this provides great difficulty for doctors who must act in their patients' best interests and champion confidentiality, under the threat of criminal prosecution. This is especially pertinent in light of the Commission's conclusion that health and social care professionals are more likely than other members of public to be prosecuted for providing assistance with suicide. The overwhelming conclusion is that this issue needs to be addressed.

Neutrality

In a recent move, the British Medical Journal has called for the adoption of a neutral stance on assisted dying for the terminally ill by doctors' organisations. This coincides with the launch in February 2012 of the General Medical Council's (GMC) consultation on guidance for its decision makers when considering allegations about a doctor's involvement in encouraging or assisting suicide. The GMC is clear that nothing in the guidance should be taken to imply that the GMC supports or opposes a change in the law, but that greater clarity for its decision makers is required.

Clarity

So what would a clearer framework on assisted dying look like? The Commission's report places responsibility for implementing a set of safeguards to protect patients from abuse on health and social care professionals. This would include ensuring that certain eligibility criteria are met and that the patient has been fully informed of all available options for treatment and care.

Inevitably, such a system would need to be underpinned by improvements to health and social care services including adequate training and supervision, guidance and codes of conduct for the professionals involved. Consideration would also need to be given to the inherent concern of doctors that legalising assisted dying would have a detrimental effect on the doctor/patient relationship, which is built on trust between practitioner and individual. Whilst such concerns highlight the endemic tension between providing greater clarity on the law for doctors and other professionals, and moving to a situation where doctors are at the forefront of change on an issue which raises legal, ethical and professional issues, the Commission has ultimately concluded that, should legislative change be implemented, it should not be a crime for a doctor to assist a person to take their life, if that person has an advanced, progressive, incurable condition that is likely to lead to their death within the next 12 months, and if the correct safeguards and procedures are observed.

Finally

In March 2012, Tony Nicklinson, a man with 'locked-in syndrome', won the right to ask the court to make a declaration that it would not be unlawful, on the grounds of necessity, for a doctor to terminate or assist with the termination of his life. As his case is due to be heard by the High Court, we can only speculate on the impact of a change in the law on assisted dying. What is clear, however, is the lack of clarity surrounding such an important issue as doctor assisted dying is inadequate and should not continue.

Lucy Stevenson
Associate
T: +44 (0)20 7876 6084
E: lucy.stevenson@clydeco.com

Rabone No 2

This case was reviewed in previous editions of Health Law News. We reported that the Court of Appeal's conclusion that NHS Trusts did not owe a positive obligation to safeguard the lives of voluntary patients, must provide some comfort to increasingly beleaguered NHS Trusts. Unfortunately, that comfort proved somewhat illusory as the Supreme Court has now reversed that decision. In this article, we examine the implications for all NHS Trusts of this important judgment.

The facts

The background of the case will be familiar, but by way of reminder, the deceased, Melanie Rabone, was admitted to Stepping Hill Hospital on a voluntary basis following a severe episode of a recurrent depressive disorder. Despite objections raised by her parents, the claimants to the action, the deceased was allowed home leave, during which time she committed suicide.

Procedural position

A claim for negligence was compromised in the sum of £7,500, but the claimants also brought a claim for damages pursuant to the Human Rights Act 1998, alleging breach of Article 2, the right to life. Furthermore, they argued that they were victims of the breach, and were therefore entitled to compensation. The claim failed both at first instance and on appeal; although it was found on the facts of the case that had an operational obligation been owed it would have been breached. The claimants appealed to the Supreme Court, and here, they were successful.

Supreme Court ruling

In the leading judgment, Lord Dyson held the Trust was under a positive duty to safeguard the life of the deceased. Although a voluntary patient, the deceased was vulnerable and posed a real suicide risk; she was under the control of the Trust which had assumed responsibility for her.

Having thus established an operational obligation was owed, it came as little surprise that the Supreme Court found it had been breached. This was, after all, the conclusion previously reached by the Court of Appeal. Previous cases had established that the risk of death had to be 'real and immediate'. The evidence of the psychiatrist who gave evidence for the Trust, and whose evidence was preferred at first instance, described a risk of suicide as between 5-10%. This was accepted both in the Court of Appeal and by Lord Dyson as reflecting a 'real' risk of suicide, thus satisfying the first qualifying limb. The Trust's argument that the risk had to be 'imminent' was rejected, with Lord Dyson preferring to interpret 'immediate' to mean 'present and continuing'. Having reached the conclusion that the risk of the deceased attempting suicide was real and immediate, the decision to allow her home was described as one which 'no reasonable psychiatric practitioner would have made'. Breach was established.

The question of whether the claimants enjoyed victim status within Article 34 of the European Convention on Human Rights was dealt with in short order. Lord Dyson was able to point to a clear line of European Court of Human Rights decisions which provided that relatives of the deceased were able to claim in their own right.

Finally, the Supreme Court was required to consider whether the claimants would forfeit that status if they had already been awarded compensation in a negligence claim. The parties accepted that victim status would have been forfeited if the State has provided 'adequate redress', and 'acknowledged either expressly or in substance the breach of the Convention'. The Trust argued that both conditions had been met, and therefore the claimants were not entitled to further compensation.

That argument was rejected by the Supreme Court. The damages paid to the claimants in the civil claim were in respect of losses to the Estate under the Law Reform (Miscellaneous Provisions) Act 1934. The claimants had received no compensation for their loss as the Fatal Accidents Act 1976 did not permit parents of an adult child to make such a claim. Thus, they had not received 'adequate redress'. However, the Supreme Court did go on to find that although the claimants retained their status as victims as a result, the fact the Trust admitted breach of duty was evidence of an admission of breach of Article 2.

Keep calm and carry on!

Whilst there is no doubt this is an unwelcome judgment, the important point to remember is that it does not impose additional burdens on treating clinicians; who remain under a duty to provide reasonable care to their patients. What it does mean is, if that duty is breached, then the consequences of that breach so far as a Trust is concerned are potentially greater, depending on the facts of the case. If the case involves a psychiatric patient, whether detained or not, then breach of duty of care will also invoke the operational obligations of Article 2, which could mean payment of compensation in addition to an award of damages in a civil claim.

Whether the operational duty will be imposed only in cases of psychiatric patients is unclear. Lady Hale did emphasise that, in deciding the case in favour of the claimants, the Supreme Court was not attempting to make *"an exception to the general rule that the State is not responsible for the deaths of hospital patients"*. However, given the parents of adult children have no means of seeking redress for their loss, claimant lawyers will doubtless redouble their efforts to persuade her otherwise.

A more immediate practical effect may be seen in the realm of inquests. While it has been reasonably settled ground that investigations into the death of a compulsorily detained mental health patient would be subject to the wider Article 2 investigations, the position regarding **informal** patients has often been the subject of some discussion. Similarly, there was uncertainty regarding the status of investigations where a mental health patient dies in an acute setting (e.g. suicide after admission to CDU). The thrust of the Supreme Court's decision now suggests that in the presence of a real and immediate risk of suicide and where the patient has been admitted under the care of an NHS Trust, the wider investigation responsibilities may well be triggered. In truth, however, it is our experience that even prior to the Supreme Court's decision coroners were inclined to act as if Article 2 was engaged – to that extent, therefore, there may be no practical difference in coronial practice.

Sian Fisher
Senior Associate
T: +44 (0)20 7876 6033
E: sian.fisher@clydeco.com

Further information
If you would like further information on any issue raised in this newsletter please contact:

Claire Petts
Partner
claire.petts@clydeco.com

Sam Holden
Senior Associate
sam.holden@clydeco.com

Clyde & Co LLP
The St Botolph Building
138 Houndsditch
London EC3A 7AR

T: +44 (0)20 7876 5000
F: +44 (0)20 7876 5111

Further advice should be taken before relying on the contents of this summary.

Clyde & Co LLP **www.clydeco.com**