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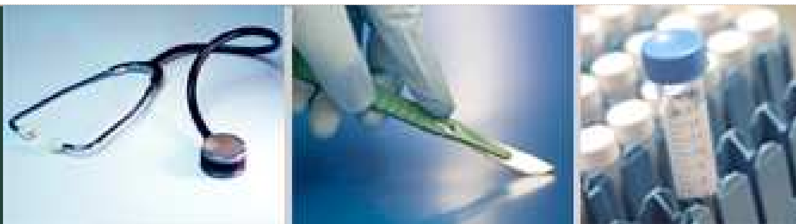


Healthcare Update
Issue 16

July 2010

Arbitration Act 2010

The recently enacted Arbitration Act 2010 repealed and replaced the current Arbitration Acts and applies to all domestic and international arbitration agreements from 8 June 2010. This means that arbitration clauses in existing agreements will continue to operate under the old legislation with arbitration agreements entered into after 8 June 2010 operating under the new Act. The Act incorporates UNCITRAL Model Law on International Commercial Arbitration which has been adopted by more than 50 countries and covers all stages of the arbitral process.

HIQA poll on safety and quality in healthcare

The Health Information and Quality Authority carried out an opinion poll on safety and quality in healthcare (ahead of starting its consultation on the Draft National Standards for Safer Better Healthcare) and published the results on 8 July 2010. When the standards are completed and approved, they will apply across all health sectors and will be significant in driving quality and safety for people using the health service.

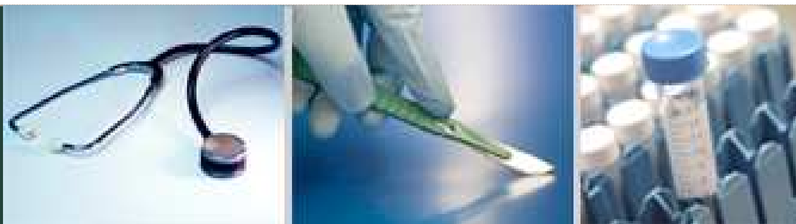
99% of people said that they wanted to be informed if something went wrong in treatment and that providers should take steps to prevent mistakes and ensure learning takes place across the system to improve healthcare quality. Despite the fact that the majority of people (95%) felt it important that senior staff take responsibility for the quality and safety of services, the majority (86%) said they did not feel this was currently the case.

Advance Healthcare Decisions Bill 2010

There is currently no legislation on advance care directives (ACDs) in Ireland. The Law Reform Commission on 16 September 2009 published a report on bioethics: advance care directives which recommended that legislation be introduced and included a draft Mental Capacity (Advance Care Directives) Bill.

The Advance Healthcare Decisions Bill 2010 was introduced into the Dail recently. However it is not government sponsored; it is a private member's Bill so therefore may never be enacted. It provides for the making of medical treatment decisions, in advance, by competent persons, and with the intention of those decisions subsequently providing for the provision or withholding of care at a time when the person loses competence to make treatment decisions. It proposed to amend the Powers of Attorney Act 1996 to allow attorneys to take healthcare treatment decisions.

A framework will have to be introduced to regulate advance care directives and even if this Bill fails it may encourage the Government to bring forward its own legislation on this issue.



Medical treatment of vulnerable adults

Case: DH NHS Foundation Trust v PS [2010] EWHC 1217

Facts. The 55 year old defendant patient has "a significant impairment in intellectual functioning as a consequence of a learning disability". Although she agreed to undergo surgery for a life threatening cancerous tumour, she then failed to attend the hospital for treatment. The NHS in the UK applied for declarations to permit special arrangements (including, if necessary, non-consensual sedation and the use of force to administer it) in order to ensure that she had the operation and stayed in hospital until she recovered.

Decision. The medical evidence before the court concluded that the patient did not have capacity within the meaning of the English Mental Capacity Act 2005 to make decisions concerning her future medical treatment. Accepting this evidence the President of the High Court in England ruled that it would be lawful to impose treatment on the cancer patient, despite her refusal to consent. This is because it is in the patient's best interests that she had the operation and stayed in hospital during her post-operative recovery.

Comment. Currently in Ireland where a person is considered incapable of managing his affairs an application to court must be made to make that person a ward of court. In 2008 the Government approved proposals for a Mental Capacity Bill but it is yet to be introduced into the Dail. The legislation would presume that a person had capacity and the person would not be treated as unable to make a decision unless all practicable steps to help that person make a decision had been taken without success.

In the interim if a similar situation arose in Ireland the courts would most likely follow the guiding principles set out in *Fitzpatrick & Anor v K & Anor* where the High Court ruled that the Coombe Women's Hospital acted lawfully in giving a blood transfusion to a woman, a Jehovah's Witness, who refused the treatment having had a post partum haemorrhage (*[2008] IEHC 104*).

The relevant principles applicable to the determination of capacity are as follows:

1. An adult has the capacity to refuse treatment, but it is a rebuttable presumption.
2. The patient's cognitive ability must be so impaired that he does not sufficiently understand the nature, purpose and effect of the treatment and the consequences of accepting or rejecting it, in light of all the choices available.
3. The cognitive ability will have been impaired to the extent that he is incapable of making the decision to refuse by reason of the following factors:

    - The patient has not comprehended and retained the treatment information and the consequences likely to ensue from their refusal;
    - The patient has not believed the treatment information, in particular, that death may be the likely outcome;
    - The patient has not weighed the treatment information, the alternative choices and the likely outcomes, in the balance in arriving at the decision.

4. The clinician is under a duty to impart information as to the medically advised appropriate treatment and the risks and consequences and the choices available to the patient.
5. The clinician must look out for and consider the patient's misunderstanding and misperception of the treatment information, which may be evidence of a lack of capacity. An irrational decision or a decision made for irrational reasons is irrelevant to the assessment.
6. Regard must also be had to the gravity of the decision and the consequences which are likely to ensue.

Books of Pleadings: new rules

The rules relating to setting cases down for trial in the High Court have been changed. Previously when setting a case down for trial parties were required to lodge a book of pleadings in the Central Office together with the duly stamped Notice of Trial with service indorsed, and the setting down docket. Since 10 June 2010, as a result of an amendment to Order 36 of the Rules of the Superior Courts, the book of pleadings no longer has to be presented in the Central Office in this way but must be handed in to the court registrar on the assigned hearing date.

New Supreme Court judge

The Hon Mr. Justice Liam McKechnie has been nominated by the Government for appointment by the President to the Supreme Court. The vacancy arises from the retirement in May of the Hon. Mr. Justice Hugh Geoghegan.

Working group on medical negligence litigation

We anxiously await the proposals of the above group being chaired by the President of the High Court. It is anticipated that its recommendations will be available no later than 30 November 2010.

Recent cases

Needle stick injuries

One of the significant matters relied on and with positive results, when defending needle stick cases on behalf of employers is the experience of the employee at the time of the incident. The Healthcare Department were recently in a position to assert a significant element of contributory negligence, thereby reducing the value of the claim.

In this Circuit Court case we defended on behalf of a large Dublin hospital, the plaintiff's claim arising out of a "needle stick injury" was settled at a level below the Circuit Court jurisdiction. While the plaintiff suffered a puncture wound to the skin and had to wait six months before receiving test results confirming that she did not acquire an infectious disease, there was a significant element of contributory negligence on behalf of the plaintiff due to her level of experience as a cleaner. This assisted us in negotiating a settlement on terms that were agreeable to all.

Third party/co-defendant practice and procedure

The recent case of *Sherry v Primark trading as Penneys and anor* has clarified the appropriate practice and procedure in situations where a plaintiff wishes to join a co-defendant to proceedings, when a defendant is making an application to join them as a third party (*[2010] IEHC 66*). The High Court stated that any application by a plaintiff to do so can only be made following receipt of an authorisation from the Injuries Board. The courts are now unwilling to allow plaintiff's to join a co-defendant without this authorisation.

It would appear that in such applications the courts will either grant the defendant's order to join the third party, putting a stay on such order pending receipt of the plaintiff's authorisation to join them as a co-defendant or adjourn the motion to allow the plaintiff to seek the authorisation.

While it is preferable for the party to be joined as a co-defendant rather than a third party, the defendant should remember that the Statute of Limitations continues to run. Therefore, if time is of the essence, a defendant should seek their order to join the third party and allow the plaintiff to apply to join at a later stage. The plaintiff should also be notified of the requirement for an authorisation well in advance of the motion so that it is to hand on the return date.

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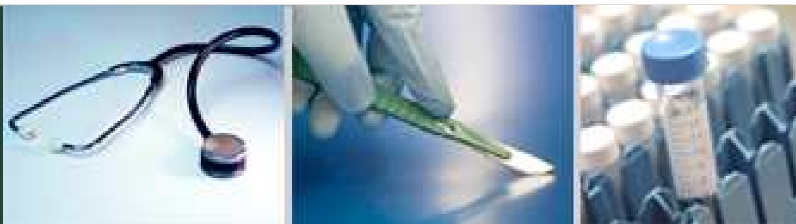

MDU test cases
The third party actions in both MDU "test cases" are now listed for hearing. They are specially fixed to commence in the Dublin High Court on the 30 November 2010 and the 8 February 2011 and are both being case managed by Mr Justice Quirke.

Non-suit application
The Healthcare Department are awaiting judgment from the Supreme Court in an interesting appeal which we recently defended. During the course of the High Court trial in 2005 we made an application for non-suit on behalf of one of three defendants. A non-suit application is an application by a defendant asking the judge to rule that the plaintiff has not and cannot prove its case against the said defendant. We first made our application at the conclusion of the plaintiff's case, and again having cross-examined one of our co-defendants. On the second application we were successful.

Two of the three defendants were successfully allowed out of the case and the plaintiff proceeded against the one remaining defendant who successfully defended the action. The plaintiff did not appeal his case against all defendants, but only the two defendants who were successful in their second application for non-suit. The appeal was brought on two fronts, firstly that the High Court judge erred in law by finding that there was not a *prima facie* case for the said two defendants to answer and the timing of the actual applications for non-suit.

The significance of 'pathology' evidence
In defending cases which involve considering the pathology evidence at the time care was provided to a plaintiff patient it is important that the pathology in question is retained in an appropriate manner so that it can be relied on for further examination. In simple terms this means that it should be stored in an environment that will protects its form for an indefinite period of time. If it is furnished to relevant parties for examination, strict procedures should be adhered to avoid the pathology being mislaid, contaminated or destroyed. In the absence of the relevant pathology, the defence of the action may be seriously compromised as experts cannot be instructed to examine it and therefore it cannot be relied on as evidence.

Cosmetic surgery cases
The number of cases being taken against private cosmetic surgery clinics and consultant plastic surgeons is on the rise. In representing the interests of private cosmetic surgery clinics, we continue to strive to successfully secure indemnities on their behalf and primarily from the consultant plastic surgeon. The grounds for seeking the indemnity are primarily related to the following three factors. First, that the issue of consent is a matter for the surgeon to address and that he/she is responsible for ensuring that the patient is brought through the process adequately. Secondly that the clinic implements and can stand over their appropriate corporate governance policies and procedures. Thirdly that the clinic cannot be held vicariously liable for the alleged negligent clinical actions of the surgeon who is an independent contractor.

The Healthcare Unit
If you have any queries on the contents of this update, or if there are other topics you would like to see us address in future editions, please contact any member of the Healthcare Unit listed below.

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