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UNTIL PLATYPUS MILK SAVES THE WORLD, HOW TO MINIMISE CLAIMS EXPOSURE FOR SUPERBUG INFECTIONS

27 MARCH 2018 | HEALTH SECTOR

Australian researchers have identified a protein in platypus milk that may hold the key to winning the fight against antibiotic-resistant superbugs. The monotreme's milk has antibacterial properties that scientists are hoping to synthesise and eventually use to save lives.[1] Until then however, medicine has a very real fight on its hands.

Claims relating to infections are on the rise with the increase in treatment-resistant superbugs, due to both the volume of patients affected and the severity of the injuries caused by the bugs. Many of the claims will involve Methicillin-resistant Staphylococcus Aureus (MRSA), Clostridium-difficile (C-diff) or Carbapenem-resistant Enterobacteriaceae (CRE) as these tend to be the most prevalent superbugs occurring in a hospital setting. These resistant strains are on the rise due, in large part, to the overuse of antibiotics which can in turn cause infection strains to mutate and become resistant.

Claims can be made for nosocomial, or hospital acquired infections (HAI), and also for failures or delays in treating pre-existing infections. Some patients will have life-changing injuries such as the loss of a limb or paralysis. Where a patient has been left severely disabled as a result of an infection, and the organisation is found liable, the damages awarded can be significant.[2] Here we look at what your organisation can do minimise the chances of a successful claim being made against you.

POLICIES AND PROTOCOLS

Organisations should have written policies on infection control, requiring all staff (whether employed or contracted) to adhere to best practice infection control measures[3] as a condition of work.

Lines of responsibility should be made clear, and regular audits (for instance, into hand-washing) should be conducted. Staff who fail to comply with policies should be appropriately sanctioned. Many organisations will also have a dedicated infection control lead to look at human and systemic contributions to infection, and how to minimise these factors.

Policies can of course represent a double-edged sword for organisations – a failure to adhere to its own policies is not definitive of negligence on the part of an organisation but can be indicative of it. Claimant solicitors can (and do) ask for copies and will examine the policies to

determine whether there has been any divergence in practice.

DOCUMENTATION AND RECORDS

It is absolutely crucial that records are stored safely and retained for sufficient periods of time.

For instance, many organisations test for certain infections, such as MRSA, on admission. The general population can carry the infection on skin or inside their noses with no ill effects, however in a patient who is otherwise ill, and particularly where there is an open wound, MRSA can gain a foothold and may even prove fatal. It is essential not only that the patient's medical records but also the initial screening records be securely held, bearing in mind that a claim can be brought several years after the treatment is concluded (and in the case of minors, up to 18 years later). If a patient can be shown to have been infected on admission the hospital needs to be able to produce its records and show what it did in response to such infection to defend a claim that it caused or contributed to the infection.

Retention of cleaning rosters, equipment checks and sterilisation treatments should also be ensured as part of best practice.

LIABILITY OF OTHER PARTIES

Although a health organisation will generally have a non-delegable duty of care to its patients (and hence remain an appropriate defendant in a claim for medical negligence) it may be that contribution or indemnity can be sought from another party in certain circumstances, such as:

- Contracted cleaners who fail to clean properly.
- Contracted medical staff who fail to adhere to infection guidelines, including rigorous handwashing and 'bare below the elbows' requirements.
- Manufacturers of faulty equipment that cannot be properly cleaned. [4]

THE FUTURE – CLAIMS FOR OVER-PRESCRIPTION OF ANTIBIOTICS?

Most claims relating to delayed or failed treatment of infections involve an allegation that the antibiotic regime used to tackle the particular infection was inadequate. Will there however be claims made in the future based on over-prescription and over-use of antibiotics? Will healthcare providers be open to allegations that a patient had been given antibiotics when they were not indicated such that when they *were* needed, the patient had built up resistance to them?

A recent NSW decision[5] may be indicative of the way in which courts will view wider antibiotic policy arguments. The claim did not involve a HAI but rather a gangrenous infection in a boy's hand. The hospital argued that a washout and low-grade antibiotic had constituted reasonable treatment in the circumstances. Its expert stated in evidence that the use of the lower grade antibiotic was justified in part due to the antibiotic resistance crisis. This argument received short shrift, with Judge Levy SC noting:

> *'It appears that* [the doctor's] *views on the appropriate antibiotic therapy for the plaintiff's circumstances were based on general epidemiological considerations and standardised treatment regimes of general rather than specific application, and which appeared to have involved policy considerations, and what he described as both a national and a worldwide antibiotic stewardship by which specialists in his discipline are trying to reduce the inappropriate use of antibiotics because of the "huge issue" of antibiotic resistance... It fails to adequately explain how the relative risk to the patient, and the patient's specific antibiotic needs, is balanced against the principles of antibiotic*

stewardship in cases where a clinician gives consideration to the pros and cons of administering an antibiotic to which stewardship considerations might ordinarily apply.'[6]

The hospital was found liable for not tailoring the antibiotic regime to the claimant's needs. The decision indicates that, for now at least, doctors may still be safer erring on the side of caution and over rather than under-prescribing.

While we wait and hope that developments (perhaps involving our duck-billed friend) mean that the cataclysmic predictions about the future of healthcare do not eventuate, organisations must ensure that they have measures in place to prevent and treat infections (where possible), and also keep scrupulous records of the infection control steps they have taken.

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[1] https://www.csiro.au/en/News/News-releases/2018/Saving-lives-with-platypus-milk
[2] Figures from the UK dating back to almost 10 years ago show that significant payments were being made by the NHS for claims involving superbugs: https://www.telegraph.co.uk/news/health/news/5167338/Millions-paid-to-superbug-victims-new-figures-show.html
[3] NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010)
[4] For example pseudomonas on medical equipment: http://www.fieldfisher.com/personalinjury/case-studies/medical-negligence/surgery-claim/kidney-surgery/settlement-for-near-fatal-superbug-infection-at-guys-hospital
[5] *Gould v South Western Sydney Local Health District* [2017] NSWDC 67
[6] Ibid, paras 406 - 407

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