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Causation Issues in Medical Malpractice: A United Kingdom Perspective*

*Marc S. Stauch***

INTRODUCTION

For the purposes of this paper, I shall offer the following broad working definition of medical malpractice: any unjustified act or failure to act on the part of a doctor or other health care professional that results in harm to the patient.

Though my major concern will be with the latter part of this definition—the problem of showing that the harm results from the malpractice as opposed to the patient’s underlying medical condition—it may be helpful to set this concern in context by first looking briefly at the potential forms of action available in the United Kingdom with respect to such malpractice.

On the face of it, there are three possibilities open to the patient: to sue in tort, either in battery or negligence, or to mount an action for breach of contract. In practice, however, it is the second option, the tort of negligence, that offers the only appropriate channel for most malpractice claims. The first option, battery, which forms the civil analogue to the crime of assault, only arises as a possibility in those rare instances where treatment is carried out without consent; it is of no use to the patient who, having given the doctor the go-ahead, suffers injury, however poor the treatment.¹ As for the third option, breach of contract, though it is of some relevance within the growing private sector of medical provision, it is not available to the majority of patients in the United Kingdom who continue to be treated under the National Health Service scheme and provide no consideration in return for the services they receive.²

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1. *Chatterton v. Gerson*, [1981] 1 All E.R. 257 (Q.B.).
2. *Appelby v. Sleep*, [1968] 2 All E.R. 265 (Q.B.).

I. MEDICAL NEGLIGENCE

To succeed in a claim under the tort of negligence, a plaintiff must show three things: first, that the defendant owed the plaintiff a duty of care; second, that the defendant breached this duty; and third, that the breach caused damage to the plaintiff.

In the context of a medical malpractice claim, there is rarely any difficulty in establishing the existence of a duty of care on the part of the doctor. The latter falls squarely within Lord Atkin's neighbour principle from *Donoghue v. Stevenson*, the case upon which the whole of the modern law of negligence is founded:

You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer seems to be—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 and omissions which are called in question.³

To establish that the doctor has breached this duty of care in a given instance is undoubtedly more difficult. Here we are within the province of the well-known "*Bolam test*," a test that, since it was first formulated by Mr. Justice McNair in 1957 in the case of *Bolam v. Friern Hospital Management Committee*, has gained almost universal acceptance in the field of medical negligence. According to the test,

[a doctor] is not guilty of negligence [in other words, does not breach his duty of care] if he has acted in accordance with the 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 negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.⁴

This approach has, of course, frequently attracted criticism for being too *laissez faire*. Doctors are effectively left alone to evolve their own standard of what constitutes acceptable patient care, and, despite the odd judicial muttering to the contrary, the courts will rarely, if ever, intervene. On the other hand, it may be argued that the test at least has the virtue of encouraging an open and pluralistic attitude within the medical profession towards novel forms of treatment, and has perhaps inhibited the

3. [1932] All E.R. 1, 11 (H.L.) (appeal taken from Scot.).

4. [1957] 2 All E.R. 118, 122 (Q.B.).

development of “defensive medicine” as practised (so, at any rate, we are told!) in the United States.

Be that as it may, in the remainder of this paper I will assume that the patient has succeeded in overcoming the particular hurdle represented by *Bolam*. For, as I mentioned at the beginning, my main concern here is with the third of the three elements making up the tort of negligence—the requirement that the defendant doctor’s breach of duty should have caused the patient’s loss.

II. ESTABLISHING CAUSATION

This element, the need to show causation, constitutes the link between the defendant’s fault—the breach of duty—and the harm suffered by the plaintiff. On the face of it, this might seem simple enough. To give an example, if a surgeon’s knife slips during delicate spinal surgery and severs the spinal cord, it may be obvious enough that this was the cause of the patient’s subsequent paralysis. However, in many instances, especially where a complex and unpredictable disease holds sway, it is often by no means so straightforward to separate out the various contributing factors and to say that it was a breach of duty on the doctor’s part and not one of those other factors that caused the patient’s disability or death.

Establishing causation is, in fact, a two-step process. First, in identifying an event “A” as a candidate for the label “the cause” of another event “B,” we normally alight upon, from the total set of antecedent conditions necessary and sufficient to produce “B,” just one member of the set—that which, from our perspective, strikes us as the deviation from the norm. For example, in saying that the cause of the fire was a cigarette carelessly discarded in the wastepaper basket, we ignore the many other background conditions—for example, the presence of paper in the basket, the lack of a sprinkler system, the presence, for that matter, of oxygen in the air—all necessary and together sufficient for the result. Since the latter are normal features of the situation, their presence is usually simply taken for granted.⁵

Second, to then confirm, for the purposes of the tort of negligence, that the candidate condition, the discarded cigarette, is truly “the cause” of the fire, the familiar “but for” test will usu-

5. See H.L.A. HART & TONY HONORE, *CAUSATION IN THE LAW* (Clarendon Press, 2d ed. 1985).

ally be employed. The test poses the following hypothetical question: "But for" the discarded cigarette (that is, supposing that it had not in fact been discarded), would the fire have taken place anyway? Where, on the balance of probabilities, the answer is "no," then it was the presence of the cigarette that made the difference to the outcome. The cigarette can be regarded as the cause in the sense of a "condition sine qua non" of the fire.

III. APPLYING THE "BUT FOR" TEST IN MEDICAL NEGLIGENCE

The "but for" test works best in these simple, linear instances of causation, in other words, when there is only one obvious contender for the label "the cause of the damage."

As hinted earlier, its application is potentially more problematic, certainly from the patient's point of view, in medical malpractice cases. Here, it has to be shown that "but for" the doctor's breach of duty, the patient would have avoided injury. However, usually the whole point of going to see a doctor is that one is already ill, and the illness, in representing a deviation from the norm, itself displays causal features. This moves us immediately into the realm of multiple, as opposed to linear, causation. That is to say, there are two contenders, the prevailing illness as well as the doctor's breach, vying for the title of "the cause" of the patient's disability. It is therefore always open to the doctor to claim that the admitted breach of duty did not make any difference because the patient would have suffered the same injury in any event. A good illustration of this is provided by the case of *Barnett v. Chelsea & Kensington Hospital Management Committee*.⁶ Here, three night watchmen presented to the defendant's casualty department complaining of violent vomiting after drinking some tea. The receptionist in the department telephoned for the doctor on duty to come and examine the men, but the doctor, in breach of his duty of care, failed to do so and the men were sent away untended. One of the men died of, as later learned, the effects of arsenical poisoning. In the subsequent action brought against the hospital by the dead man's widow, she was unable to recover damages in respect of his death. The reason was that there was no causation. Relying on expert testimony, the court found that even if the man had been treated promptly, his condition (given its rar-

6. [1968] 3 All E.R. 1068 (Q.B.).

ity) would have been diagnosed too late to administer an effective antidote (in other words, he would have died anyway).

The sine qua non, or “but for,” approach to causation also makes life difficult for those patients alleging that their loss resulted from the failure of the doctor to inform them of the risks involved in treatment. What they have to show, assuming that the doctor’s failure amounts to a breach of duty, is that had the doctor told them of the risk, they would not have gone ahead with the treatment. Often, this will be impossible to do, especially if there was no real alternative to the treatment. A case that illustrates this point very clearly is *Smith v. Barking, Haverling & Brentwood Health Authority*.⁷ Here Miss Smith suffered from a condition that was likely to render her tetraplegic within a year unless she underwent surgery. However, the operation itself carried a twenty-five percent risk of immediate tetraplegia, of which the surgeon failed to warn her. In the case, she did become tetraplegic following the operation, but damages were limited to cover her shock and depression. With regard to her immediate tetraplegia, the surgeon’s failure to tell her of the risk was not the cause since the court found that she would have had the operation even had she been told of the risk.

The patient’s cause has not been helped by the manner in which the majority of the Court of Appeal applied the “but for” test in *Bolitho v. City & Hackney Health Authority*.⁸ In this case, a doctor, in breach of duty, failed to attend to a baby with breathing difficulties, and the baby subsequently suffered brain damage. The doctor claimed, however, that even if she had attended the baby, she would not have instigated the one procedure (intubation) that could have avoided the damage. This contention was backed up by evidence that a body of other doctors, when attending babies exhibiting symptoms similar to the plaintiff’s, would not intubate. Lord Justices Dillon and Farquharson saw this as an opportunity for importing the *Bolam* test into the arena of causation. They held that, in light of *Bolam*, the doctor’s failure to attend (her admitted breach of duty) made no difference since had she attended she need not have intubated (in the sense that the failure to do so would not have been a breach of duty); thus, her breach did not cause the baby’s brain damage. As commentators have pointed out, “this deci-

7. Unreported (Queen’s Bench Division, July 29, 1989) (LEXIS, UK library, ALLCAS file).

8. 13 B.M.L.R. 111 (C.A. 1992).

sion confuses the issue of what should have been done (a breach of duty question) with what would have probably been done (a causation question)."⁹ The court should not be asking itself what other doctors might have been justified in doing in the hypothetical scenario, but simply what this particular doctor as a matter of fact would probably have done.

IV. LIMITATIONS TO THE "BUT FOR" TEST

As mentioned already, medical negligence cases by their nature usually involve questions of multiple causation. At least two causal factors (the illness *and* the doctor's failure to treat properly) are normally present in the circumstances leading to the patient's injury. The "but for" test will normally continue to produce a result, as in the above cases, so long as the scientific evidence available is sufficient to enable us to separate out the role of such factors and subject each of them to the test in turn. What happens, though, when the evidence is insufficient to allow judges to discriminate between the different factors in this way, rendering them unable to say that in the absence of one or the other factor no injury would have occurred? The courts had to deal with this type of difficulty, outside the medical negligence context, in the case of *McGhee v. National Coal Board*.¹⁰

In *McGhee*, an employee of the coal board brought an action alleging that his dermatitis had come about due to his employer's failure (in breach of duty) to provide him with proper washing facilities. This meant that he had to cycle home with the brick dust, to which his work unavoidably exposed him, still caked to his skin. Here, there was no doubt that brick dust caused the plaintiff's injury. The problem was determining whether the "guilty" dust (in other words, the dust that continued to stick to him on his ride home) had made any difference. The House of Lords' solution was to assert that in this type of case it was open to a court to infer, as a question of fact, that the defendant's breach had *materially contributed* to the plaintiff's injury, even though it could not be shown that "but for" the breach no injury would have occurred. Accordingly, the House of Lords allowed recovery. Indeed, in one of the judgments, Lord Wilberforce appeared to go further and suggest that once the plaintiff has established that the defendant's breach created

9. IAN KENNEDY & ANDREW GRUBB, *MEDICAL LAW* (Butterworths, 2d ed. 1994).

10. [1972] 3 All E.R. 1008 (H.L.).

a risk of harm, the onus of proving that the breach did not in fact materially contribute to the harm falls upon the defendant.

The House of Lords had the opportunity to apply this approach in the sphere of medical negligence in the case of *Wilsher v. Essex Area Health Authority*.¹¹ The facts of this case concerned a premature baby who became virtually blind following treatment in the defendant's postnatal unit. It was established that due to a breach of duty by hospital staff, the baby had been oversaturated with oxygen in the first weeks of his life. However, whilst this might, according to some of the evidence, have contributed to the injury, there were four or five other natural conditions, all of which had affected the baby, that could equally have had the same effect. Lord Bridge delivered the unanimous view of the House of Lords: in these circumstances, it would not be appropriate to bridge the evidential gap by invoking the doctrine of material contribution. He went out of his way to repudiate Lord Wilberforce's suggestion in *McGhee* that the onus of proof shifts to the defendant in such cases. Instead, he endorsed the distinction drawn by the Vice Chancellor, Sir Nicholas Browne-Wilkinson, in the Court of Appeal:

The position [in *Wilsher*], to my mind, is wholly different from that in *McGhee*, where there was only one candidate (brick dust) which could have caused the dermatitis, and the failure to take a precaution against brick dust causing dermatitis was followed by dermatitis caused by brick dust. In such a case, I can see the common sense, if not the logic, of holding that, in the absence of any other evidence, the failure to take the precaution caused or contributed to the dermatitis. . . . I do not consider that the present case falls within [this] reasoning. A failure to take preventative measures against one out of five possible causes is no evidence as to which of those five caused the injury.¹²

Arguably, *Wilsher* limits the ability to get around the "but for" test, by simply showing a *material contribution* to the loss, to those cases in which the overall risk of such loss was produced in the first place by the defendant. After all, in *McGhee*, all of the brick dust emanated from the defendant's brick kiln, even though only some of it represented a breach of duty. In such cases, and in default of clear evidence that "but for" the breach the plaintiff would have avoided loss, it may be acceptable, on policy grounds, to make the defendant liable simply for

11. [1988] 1 All E.R. 871 (H.L.).

12. *Id.* at 873.

the failure to mitigate a risk of the defendant's own creation. In a medical negligence action, by contrast, the original risk of harm to the patient is usually not of the doctor's making, but stems from the patient's illness. The most that can be said against the doctor who, for example, makes a faulty diagnosis is that the doctor has failed to ameliorate that risk.

If this is right, *Wilsher* offers little encouragement to the patient who is unable, due to the overcomplexity or lack of clarity of the available evidence, to show that in the absence of the doctor's breach of duty, a full recovery from illness would have been made. On the other hand, in many instances, especially where a doctor's failure to make a prompt or proper diagnosis is at issue, the patient *will* have evidence as to the effect this has had upon the chances of recovery, at least in the form of statistical probabilities. In this respect, the implications of *Wilsher* in medical malpractice actions may come to be seen as far less important than those of another case decided by the House of Lords around the same time, *Hotson v. East Berkshire Area Health Authority*.¹³

V. *HOTSON* AND LOSS OF CHANCE

In *Hotson*, the plaintiff, a thirteen-year-old schoolboy, fell from a rope from which he was swinging and severely damaged his hip. Despite the boy's prompt attendance at the defendant's hospital, the seriousness of his injury was not diagnosed until five days later, as a result of the hospital's breach of duty in failing to carry out a proper x-ray. By this time, however, it was too late to avoid permanent disability. The medical evidence suggested that prompt and proper diagnosis and treatment would have given the plaintiff a twenty-five percent chance of avoiding this disability.

At first instance, Mr. Justice Simon Brown accepted the plaintiff's argument that the loss of the twenty-five percent *chance of recovery* was itself something that could be actionable in negligence and awarded the plaintiff a quarter of the full damages available for that type of injury. This, on the face of it, provided a neat solution to the problem of causation. Rather than having to prove that the defendant's breach was the cause of the disabled hip itself—something that the plaintiff was, on the balance of probabilities, all too obviously unable to do in the teeth of the

13. [1987] 1 App. Cas. 750 (H.L.).

statistical evidence that the disability was seventy-five percent likely to occur in any event—he instead got away with demonstrating that the breach had caused him to lose the residual twenty-five percent *chance of recovery*. This decision was unanimously endorsed by the Court of Appeal, which was attracted by the greater potential for fairness embodied in such an approach. In the words of Sir John Donaldson, the Master of the Rolls,

[a]s a matter of common sense, it is unjust that there should be no liability for failure to treat a patient, simply because the chances of a successful cure by that treatment were less than fifty per cent, nor by the same token can it be just that if the chances of a successful cure only marginally exceed fifty per cent, the doctor or his employer should be liable to the same extent as if the treatment could be guaranteed to cure.¹⁴

In the light of the growth in private health care, the Court of Appeal also saw merit in bringing the law of negligence in this respect into line with the law of contract where, following the case of *Chaplin v. Hicks*,¹⁵ in which a plaintiff succeeded in recovering damages for her wrongful exclusion from a beauty contest, loss of chance has long been recognised as providing a viable cause of action. As the Master of the Rolls continued:

Equally, I am quite unable to detect any rational basis for a state of the law, if such it be, whereby in identical circumstances [doctor] A who treats a patient under the national health service, and whose liability therefore falls to be determined in accordance with the law of tort, should be in a different position from [doctor] B who treats a patient outside the service, and whose liability therefore falls to be determined in accordance with the law of contract¹⁶

VI. THE FATE OF LOSS OF CHANCE IN THE HOUSE OF LORDS

The House of Lords, however, overturned the decisions of both lower courts and found against the plaintiff on the basis that he had failed to prove causation. It rejected the notion that a negligence claim could be couched in any terms other than the actual damage that resulted, and asserted that the trial judge's finding that Hotson's disability was seventy-five percent likely in any event was tantamount to finding that the original fall had

14. *Id.* at 759-60.

15. [1911] 2 K.B. 786.

16. *Hotson*, [1987] 1 App. Cas. at 760 (C.A.).

been the sole cause of the injury. The analogy between Hotson's tortious action for his lost chance of recovery and a claim for loss of chance in contract, which had impressed the Court of Appeal, was found "superficially attractive" but ultimately spurious.¹⁷ Instead, the Law Lords reiterated the traditional requirement of proving causation on the balance of probabilities.

On the other hand, the Lords stopped short of saying that there could never be recovery of damages in tort for a loss of chance. They did not say when such recovery would be allowed, but, from Lord Mackay's judgment, it appears that they may have been thinking of the *McGhee* type of situation where, as a matter of policy, it is desirable that defendants should be penalised for failure to mitigate risks of their own making. Liability should not be excused on the basis of statistics showing that the plaintiff was likely to have suffered loss even supposing that risk mitigation had taken place.

VII. A ROLE FOR STATISTICAL INFERENCE?

Arguably, much of the House of Lords' reluctance to accept a loss of chance as a viable cause of action in tort stemmed from its lack of confidence in the use of statistics. This aspect again comes across most clearly in the speech of Lord Mackay in which he looked, at some length, at the decision of the Supreme Court of Washington in *Herskovits v. Group Health Cooperative of Puget Sound*.¹⁸ In that case, the plaintiff was suing on the basis that had his malignant tumour been properly diagnosed initially, he would have had a thirty-nine percent chance of recovery. By the time it was diagnosed, his chance of recovery had fallen to twenty-five percent. Lord Mackay was clearly impressed by arguments canvassed in the minority judgment of Justice Brachtenbach:

[Justice Brachtenbach] warned against the danger of using statistics as a basis on which to prove proximate cause and indicated that it was necessary at a minimum to produce evidence connecting statistics to the facts of the case. He gave an interesting illustration of a town in which there were only two cab

17. [1987] 1 App. Cas. 750 (H.L.) (per Lord Bridge). No satisfactory reason was given for this view. Lord Ackner referred to the theory that the plaintiff in *Chaplin* had lost "a right of . . . value, one for which many people would give money . . ." *Id.* at 792 (H.L.) (quoting *Chaplin v. Hicks*, [1911] 2 K.B. at 797). Presumably, though, in a hypothetical market of individuals fated to suffer hip disabilities, people could be found who would pay for the 25% chance of avoiding such disability.

18. 664 P.2d 474 (Wash. 1983).

companies, one with three blue cabs and the other with one yellow cab. If a person was knocked down by a cab whose colour had not been observed it would be wrong to suggest that there was a 75% chance that the victim was run down by a blue cab and that accordingly it was more probable than not that the cab that ran him down was blue and therefore that the company running the blue cabs would be responsible in negligence for the running down. He pointed out that before any inference that it was a blue cab would be appropriate further facts would be required as, for example, that a blue cab had been seen in the immediate vicinity at the time of the accident or that a blue cab had been found with a large dent in the very part of the cab which had struck the victim.¹⁹

Recovery for the loss of a less than even chance of avoiding loss has also been rejected, this time unequivocally, by the Canadian Supreme Court in *Lawson v. Laferrière*.²⁰ Nevertheless, in academic terms, the debate is set fair to continue.²¹ The increasing availability of statistical probabilities as evidence in medical malpractice claims poses an ongoing challenge to traditional conceptions of causation. Lord Mackay is undoubtedly right that normally care must be taken in using naked statistical evidence to arrive at inferences in individual cases. A court faced with a plaintiff who, on the facts of the example just given, sued the blue cab company would be fully entitled to say: "You're going to have to do better than that!" The point about *Hotson*, however, is that there were only bare statistics: the hospital's negligence had deprived the plaintiff from the outset of any possibility of showing that he, personally, was one of the twenty-five percent of patients who, given proper treatment, would have avoided injury.

CONCLUSION

Let me propose, by way of conclusion, the following analogy as an antidote to the one canvassed in *Herskovits*. The plaintiff department store has its sprinkler system installed by the city's fire department. The installation is carried out negligently, with the result that when a fire occurs, the system fails to operate and

19. *Hotson*, [1987] 1 App. Cas. at 789 (H.L.).

20. 1 S.C.R. 541 (Can. 1991).

21. See, e.g., Jane Stapelton, *The Gist of Negligence: Pt II: The Relationship Between Damage and Causation*, 104 LAW Q. REV. 389 (1988); Timothy Hill, *A Lost Chance for Compensation in the Tort of Negligence by the House of Lords*, 54 MOD. L. REV. 511 (1991); Mark Lunney, *What Price a Chance?*, 15 LEGAL STUD. 1 (1995).

the store burns down. The only evidence available is that when similar fires have occurred in other department stores of roughly the same design, on a quarter of occasions sprinklers have saved the building. Is there really any reason in policy or logic why the plaintiff should not recover a quarter of the damage from the defendant in such a case?