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Medical Law and Ethics

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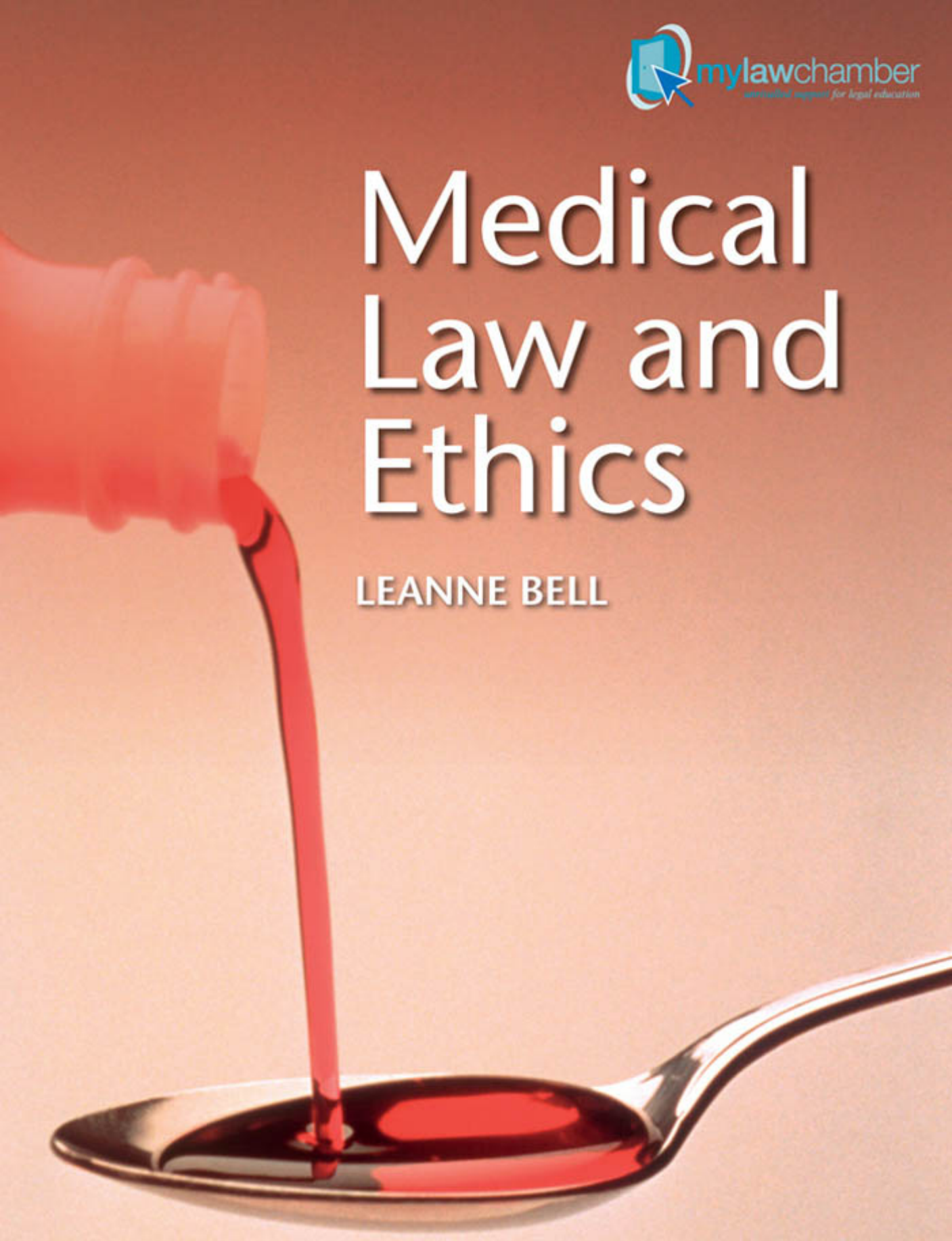

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Medical Law and Ethics

KEY CASE

Fairchild* v *Glenhaven[10]

The claimants in this case had all developed the fatal lung disease mesothelioma. The condition was caused by inhalation of asbestos fibres and each claimant could prove that they had been negligently exposed to such fibres in the course of their employment. However, they had all worked for several employers over the years, all of whom had negligently exposed them to this material and it was not possible to establish which defendant had been responsible for the single fibre that entered the lungs and caused the disease in each of them. The House of Lords held that it could not be argued that each employer materially contributed to the damage because only one fibre could have caused the condition, but said that each employer had materially increased the risk of the claimants developing the disease and therefore it would hold the defendant liable.

Controversially, the claimant was able to recover his entire damages from the defendant despite the fact that several other defendants had also materially increased the risk and, it could be argued, the causal link was not established, as in *Wilsher*. Just because this particular defendant had been negligent did not necessarily mean that his negligent exposure was the precise exposure that led to the crucial fibre being inhaled. The Lords acknowledged that they were basing their decision in *Fairchild* largely on policy grounds, in that it was felt that claimants in this position should have some redress for a situation they found themselves in through no fault of their own:

> The men did nothing wrong, whereas all the defendants wrongly exposed them to the risk of developing a fatal cancer, a risk that has eventuated in these cases. At best it was only good luck if any particular defendant's negligence did not trigger mesothelioma.[11]

While this reasoning has some merit, it is difficult to understand why the same reasoning was not applied in *Wilsher* where, at best, it was only good luck on the defendant's part if their breach of duty did not actually cause the baby's blindness. As Lord Hoffman stated in *Fairchild*: 'When a decision departs from principles normally applied, the basis for doing so must be logical and justifiable if the decision is to avoid the reproach that hard cases make bad law.'[12]

It is submitted that the reasoning behind the approach of the Lords in the *Fairchild* case is not entirely logical and justifiable and reflects more the keenness of the courts to provide a remedy to those people affected by negligent exposure to asbestos, which occurred on such a massive scale in the UK for many years. Also

[10] [2002] UKHL 22.
[11] ibid above at 116.
[12] n. 10 above at 70.

relevant is the identity of the defendant. Lord Hoffman specifically distinguished *Wilsher* from *Fairchild* and *McGhee* by stating that: 'The political and economic arguments involved in the massive increase in the liability of the National Health Service . . . are far more complicated that the reasons given by Lord Wilburforce [in *McGhee*] for imposing liability upon an employer who has failed to take simple precautions.'[13]

Not only were they willing to impose that liability in *Fairchild*, they were not prepared to limit the extent of the defendant's liability to reflect his relative contribution to the risk. It has since been argued that this is unfair:

> The defendant was a wrongdoer, it is true, and should not be allowed to escape liability altogether, but he should not be liable for more than the damage he caused and, since this is a case in which science can deal only in probabilities, the law should accept that position and attribute liability according to probabilities.[14]

Some problematic issues with causation

In order to illustrate some crucial problems with the application of the causation tests in clinical negligence, consider the following two cases and, applying your knowledge of the tests, decide whether liability is established in each case.

Case study 1

The claimant visited his GP complaining of a lump under his arm. The GP misdiagnosed the lump as benign and a further year went by before the claimant went to another GP who referred him to hospital for investigation. In fact, he was suffering from cancer of the lymph gland which had by now spread to his chest. He argued that if the first GP had not misdiagnosed him (which it was admitted by the defence was a breach of duty) and he had begun treatment after that first visit, his chance of surviving for 10 years from diagnosis would have been 42%. After the year-long delay, his chance was now 25%.

Case study 2

The claimant suffered from repeated bouts of lower back pain and was referred to a surgeon who specialised in lumbar disc surgery. The surgery was explained to her in some detail, but she was not informed of a small risk (around 1 to 2%) that she would develop a complication called cauda equine syndrome as a result of the surgery. She agreed to the surgery, the complication did, in fact, occur and she was left with significant nerve damage and partial paralysis. She argued not that the surgeon

[13] n. 10 above at 68.

[14] *Barker* v *Corus Plc and Ors* [2006] UKHL 20 – this approach has been overruled in relation to mesothelioma cases by section 3 of the Compensation Act 2006. For earlier cases in favour of apportionment of damages between all potential defendants, see *Thompson* v *Smiths Shiprepairers (North Shields) Ltd* [1984] QB 405 and *Holtby* v *Brigham and Cowan (Hull) Ltd* [2000] 3 All ER 421.

had carried out the operation negligently, but that his failure to fully warn her of the risks was negligent and that if the risks had been properly explained to her, she would not have had the operation on that particular day, she would have waited, considered other options and perhaps sought a second opinion.

Case study 1 – loss of a chance

In the first case,[15] the House of Lords, by a 3:2 majority, confirmed the Court of Appeal decision that the claimant could not recover damages because causation was not established. It is established law in England and Wales that where a claimant is alleging that the defendant's negligence resulted in a loss of a chance of recovery, the claimant must be able to show, on the balance of probabilities, that he would have recovered if not for that negligence. For example, in *Hotson* v *East Berkshire Health Authority*,[16] a 13-year-old boy fell from a tree, injuring his leg. He was taken to hospital and x-rayed, but they found nothing wrong and sent him home. It was only after five days of increasing pain that he was taken back to hospital and a hip injury was discovered and promptly treated. The child went on to develop a condition called avascular necrosis, where blood supply to the area is restricted, leading to joint pain, disability and the development of osteoarthritis in later life. He alleged that there was a 25% chance that if he had received the correct treatment immediately, the avascular necrosis could have been avoided. At first instance, he was awarded full compensation but this decision was quashed by the House of Lords, because he needed to show that it was likely that he would have had a problem-free recovery but for the negligence of the defendant. In this case, there was a 75% chance that he would have developed the avascular necrosis anyway so it was not shown, on the balance of probabilities, that the negligence caused the damage. The effect of this was that in order to recover for loss of a chance, a claimant had to prove that he had a 50% or better chance of recovery to begin with. Lord Donaldson dissented in *Hotson* and expressed the view that such a rule led to an inequitable outcome and should be approached in a similar way to contract claims, where all the claimant needs to show is that he had a *significant* chance in the first place that was then reduced by the actions of the defendant:[17]

> What is the damage that the claimant has suffered? Is it the onset of the avascular necrosis or is it the loss of a chance of avoiding that condition? In my judgment it is the latter . . . I can see no reason why the loss of a chance which is capable of being valued should not be capable of being damage in a tort case just as much as in a contract case . . . it was amply proved in the present case that the choice which the claimant on the judge's finding had was lost by the admitted negligence of the doctor.[18]

[15] *Gregg* v *Scott* [2005] UKHL 2 [2005] 2A. C176.
[16] [1987] 2 All ER 909.
[17] See, for example, *Allied Maples Group Ltd* v *Simmons & Simmons* [1995] and *Stovold* v *Barlows* [1996].
[18] Per Lord Donaldson at 760.

The arguments put forward in *Gregg* supported the view that it comes down to burden of proof and that where the claimant has a fairly low chance of recovery, it is not possible to establish the causal link between the breach of duty and the damage – it is more likely that the underlying condition caused the damage. As Lord Hoffman has observed, we cannot know the exact cause and that lack of knowledge is dealt with by having the burden of proof.[19] However, there is an inescapable effect of such an approach, which is that the law then provides 'a blanket release from liability for doctors and hospitals any time there was a less than fifty per cent chance of survival, regardless of how flagrant the negligence'.[20] In effect, as far as the law is concerned, the patient's chances of recovery simply do not exist unless they are greater than 50%. Any lower than this and the claimant has not shown recoverable loss.

One question raised by this decision is the importance of the way a case is framed. For example, if instead of alleging a loss of 17% of his chance of recovery, Mr Gregg had alleged that the doctor had negligently failed to give him all the necessary information about his condition that he needed, would the case have been decided differently?

Case study 2 – *Chester* v *Afshar*

Here, by a 3:2 majority, the House of Lords found in the claimant's favour, despite the fact that she was not arguing that if she had received a full and complete warning of the risks of the surgery she would not have gone ahead. If that had been her argument, then she might have succeeded on the basis of the 'but for' test. However, she was alleging that if the defendant had not breached his duty, she would possibly still have had the surgery but would have had it on a different day. She succeeded in her claim on the basis that the injury she suffered was the product of the very risk of which she should have been warned and it could therefore be regarded as having been caused by that failure to warn. This is an extremely tenuous argument and possibly a distorted application of the causation tests. The Lords acknowledged that, on a strict application, her claim would fail and that policy played a strong role in their ultimate decision. As Lord Hope stated: 'To leave the patient . . . without a remedy . . . would render the duty useless in cases where it is needed most . . . I would hold that justice requires Miss Chester to be afforded the remedy that she seeks.'[21] Lord Steyn agreed, saying 'This result is in accord with one of the basic aspirations of the law, namely to right wrongs.'[22]

[19] Per Lord Hoffman at 196.
[20] Per Dore J, *Herskovitis* v *Group Health Cooperative of Puget Sound* (1983) 664 P2d 474, 477 quoted by Lord Nicholls in Gregg at 190.
[21] Per Lord Hope at 162.
[22] Per Lord Steyn at 146.

Not surprisingly, the case has come in for a lot of criticism, particularly in the light of the seemingly inequitable outcome in the *Gregg* case. Sarah Green argues that the law of negligence simply cannot accommodate both decisions and that in order to retain some coherence in the law, you either have to take the strict interpretation approach favoured in *Gregg* or you have to look at each case on a broad, equitable basis as demonstrated in *Chester*, but the courts cannot simply choose one of these approaches each time depending on the scenario presented to them.[23] Lord Hoffman observed in *Gregg* that: 'a wholesale adoption of possible rather than probable causation as the criterion of liability would be so radical a change in our law as to amount to a legislative act'[24] but arguably, that is exactly what the Lords did in *Chester*.

Chester is a difficult case to reconcile with the rules we associate with causation and in subsequent cases the courts have been cautious about attaching too much weight to it as a precedent, instead equating it with *Fairchild* as an example of rare cases in which the rules can be modified on policy grounds.[25] Even so, it presents the student of clinical negligence law and the lawyer advising clients in such litigation with a challenge in trying to predict just how a court will deal with the issue of causation in a situation where the long-established tests cannot easily be satisfied. It also brings us back to the question of how you frame a case. If Miss Chester had argued that the surgeon's negligence had resulted in the loss of a chance of pursuing a different treatment or an operation at a different time, would the outcome have been different? Perhaps an even better approach from a legal certainty perspective would have been to argue that the operation itself was carried out negligently because it was done without full and valid, informed consent (for a detailed discussion of the rules on consent, see Chapter 6).

Hypothetical causation

So far, we have been talking about a situation in which there has been some negligent act on the part of the defendant that is, if not the only cause, then a possible, partial or contributory cause of the damage suffered by the claimant. How then will the law deal with a situation where the negligent act is failure to attend? The actual failure to turn up may not be an operative cause, but can failure to administer the treatment that the doctor would or should have given if they had attended be an operative cause of damage in law?

[23] See n. 2 above.
[24] Per Lord Hoffman at 198.
[25] See *White* v *Paul Davidson & Taylor* [2005] PNLR 15.

Bolitho v *City & Hackney Health Authority*[26]

We analysed the *Bolitho* decision in some depth when we considered the *Bolam* test in relation to assessing the appropriate standard of care to be required of healthcare professionals (for a detailed discussion of the facts, see p. 50). Here the admitted breach of duty on the part of Dr Horn was her failure to answer her bleep and attend the child to assess his condition. Clearly the *Bolam* test as modified by Lord Browne-Wilkinson in this judgment is relevant to the assessment of whether failure to answer the call and attend the child was negligent, but should that test play any part in the assessment of whether that failure caused the child's death?

In effect, the defence was arguing that even had Dr Horn not been negligent and had in fact attended Patrick when she was bleeped, the only thing that would have prevented his ultimate respiratory arrest was intubation and she alleged that she would not have intubated him at that stage – in other words, the negligence did not cause the damage because even if she had attended, the outcome would have been the same. Given this argument, the court in *Bolitho* decided that it needed to consider both the factual question of whether Dr Horn would have intubated had she attended Patrick and the hypothetical question of whether it would have been a breach of duty not to intubate. How did the court make that assessment? Well, it made it quite clear that the *Bolam* test has no application to the factual assessment of whether or not she would have carried out the procedure, but it could only resolve the second question by asking what a reasonable, competent doctor would have done in those circumstances.[27] As it turned out, medical opinion was divided, with experts for the claimant advising the court that failure to intubate Patrick at that time given the symptoms he was presenting with would have been a breach of duty and one very eminent medical expert for the defence stating that in that situation, he would not have opted for the invasive, uncomfortable and risky option of intubating such a young child. The House of Lords ultimately decided that a reasonable doctor may not have intubated and therefore, they could take Dr Horn at her word and if indeed she would not have performed the procedure, her breach of duty in not attending had not caused Patrick's death.

The *Bolitho* case raises some interesting questions about how the courts should approach the issue of causation when the defendant doctor's breach is a failure to attend, because realistically, although it may be possible using the *Bolam* test to hypothesise about what they *should* have done if they had been present, it is impossible to say with any certainty what they *would* have done had they not breached their duty and come to the patient's bedside. Should they take the view of Lord Hoffman in *Gregg* v *Scott* that where knowledge is lacking the court must employ

[26] [1998] AC 232.
[27] [1998] AC 232 at 240.