Causation in Cases of Delayed Medical Diagnosis or Treatment

a paper by Kristina Stern

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Contents

Introduction ....................................................................................................................1
Causation after Bolitho .................................................................................................4
Causation in cases of delay ..........................................................................................8
Conclusion ...................................................................................................................16
Causation in Cases of Delayed Medical Diagnosis or Treatment

Introduction

Causation in clinical negligence cases is well known to be an area of considerable difficulty. Problems which arise in other contexts are apparently amplified in clinical negligence cases, in particular, where one is considering allegations of omission to provide a particular form of medical treatment, or where one is considering a delay in reaching an appropriate diagnosis and/or in providing proper medical treatment. The assumption, often ill founded in a court of law, that those who have been victims of negligent treatment should receive compensation for their injuries, is in some senses undermined in clinical negligence cases where it is often intuitively felt that those who have been helped (even if not as successfully as one would have hoped) by the medical profession should really not come to court to complain.

Moreover, and probably of more significance when considering how a court responds to a claim in negligence, in cases of alleged clinical negligence there are a number of features which complicate issues of causation:

1. even in cases where it is established that a particular defendant was negligent in the treatment which was provided, it is the burden of the court in a clinical negligence case to ascertain what standard of treatment would, or ought, to have been provided if there had been no negligence. This is the problem which formed the subject matter of the appeal to the House of Lords in Bolitho v City & Hackney Health Authority¹ – namely, how is the court to approach the question of determining the “but for” position in cases where the “but for” position requires an assessment of how an individual would or should have responded in the hypothetical circumstances under consideration.

Examples to consider of such problems include:

- a GP fails to identify that a patient has had protein in her urine and the question is how a hospital department would or should have responded if they had been informed of this feature. The situation is complicated if there is no evidence of the “would have” position.

¹ [1998] AC 232 (HL)
• a midwife wrongly construes a trace as normal, and it is accepted that, on that particular night, an extremely cautious registrar was on call and would have performed a caesarean section promptly, even though it would not have been negligent to have continued to observe the woman rather than to intervene

2. most clinical negligence cases involve claimants who were already ill (and likely to become more ill) when they first came into contact with their defendant. Many illnesses, even with exemplary medical treatment, will have an uncertain outcome. The task for the court is, therefore, to form a judgment as to how the Claimant’s illness would have responded to proper medical treatment – and that judgment may be plagued by uncertainties and imponderables.

Examples to consider:

• a patient attends a hospital and it is not appreciated that he is then suffering from a severed nerve – the question is how that severed nerve would have responded if promptly treated

• a patient has advancing renal failure which is not identified, but it is uncertain what effect prompt treatment would have had

3. the human body, and its workings, remains a subject of some mystery even to the medical profession. Much analysis in reports on the question of causation is reliant upon statistical, or anecdotal, analysis because there is in fact no clear understanding of why, in some cases a successful outcome is achieved whereas it is not in others. That leads to a particular difficulty in cases of clinical negligence where, the question for the court is, as in Hotson v East Berkshire Health Authority, what would have happened to this particular patient if his condition had been diagnosed when it ought to have been. The inadequacy of statistics to provide a reliable basis for an assessment of how any one individual would have responded in the circumstances was a matter of some concern to the House of Lords in Hotson.

Examples to consider include

2 [1987] AC 750 (HL)
• a claimant who has in fact survived in a way which is not consistent with statistical evidence before the court, or which suggests that for an unknown reason the claimant falls within one statistical category rather than another

• a man who undergoes two operations rather than one, on account of negligence, and suffers a known complication of the surgery. It is not known precisely why he suffered from that complication, but it is known that the risk of the complication during the second operation, was increased from 2% to 4% because he had already undergone one failed procedure.

4. the relative lack of knowledge about the workings of the human body also causes problems in cases where there are a number of possible causes operating, and only one of them is the result of clinical negligence.

Examples to consider include:

• the baby in Wilsher v Essex Area Health Authority\(^3\) who was born blind where there were a number of different possible causes of the blindness.

5. The vagaries of the human body are such that, in some cases, negligence can be identified in that a doctor negligently exposed a patient to risk A, whereas in fact, Risk B materialized.

6. Much will depend on the way in which evidence is presented, and medical experts (particularly those who have not previously been exposed to legal proceedings) are more comfortable using clinical vocabulary, than using the terms and approaches foisted upon them by lawyers. Thus many doctors are reluctant to express their opinions in terms of percentage chances, given that it is not their usual practice to do so. Also, clinical experience may prompt doctors to be more concerned with the future than with ascertaining precisely the causation of a particular sign or symptom. However, the success or failure of a clinical negligence claim (or defence) will generally depend upon the clinician fitting his knowledge into precise legal formulations (balance of probabilities,

\(^3\)[1988] AC 1074 (HL)
material contribution, acceptable medical practice) in a way which is capable of being justified and explained to the court.

In this paper I consider two particular problems arising in cases of causation:

1. cases in which the task for the court is to assess the hypothetical chain of human conduct following an incident of negligence; and

2. cases of delayed diagnosis and/or delayed provision of treatment, in circumstances where the task of the court is to assess the effect of the delay.

**Causation after Bolitho**

Bolitho confirmed that where the chain of causation between the alleged negligence and the ultimate injury or damage involved a hypothetical chain of human conduct, the Defendant should not escape liability where he could show that he (or, possibly, a third party) would not in fact have prevented the claimant’s injury, but his failure to do so would have involved a lack of reasonable care. This approach to causation can be described as the “two bites at the cherry” approach, i.e. the claimant can succeed if he can show either that with reasonable care the defendant would on a balance of probabilities have prevented his injury, or that the failure so to act would have been negligent (on the Bolam v Friern Hospital Management Committee\(^4\) test).

Subsequent cases have sought to apply this approach to causation with varying degrees of success. In Wisniewski v Central Manchester Health Authority\(^5\), the Court of Appeal considered a case which was factually analogous to Bolitho, i.e. where the negligence was a failure to attend a woman in labour and the question arose what the doctor would or should have done if he had so attended. The Court of Appeal held that the trial judge, although incorrect in his findings in relation to some of the medical expert evidence, was entitled to find on a balance of probabilities that a

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\(^4\) [1957] 1 WLR 583
\(^5\) [1999] Lloyd’s LR Med 223 (CA)
doctor who attended the claimant would probably have ruptured the membranes and would therefore have detected meconium which in turn would have indicated the need for a caesarean section. Accordingly, in theory at least, the case was decided on the balance of probabilities test and not upon the Bolitho “two bites of the cherry” approach.

The case was, however, complicated by the complete lack of any explanation of what would in fact have been done from either the doctor who would most likely have attended or from anyone else at the hospital. In such circumstances, Brooke LJ said (at p.243):

“It must be remembered that the first limb of the Bolitho test, as it has now been explained by Lord Browne-Wilkinson, does not require a court to make a finding of fact as to what a doctor actually did, but as to what a doctor would have done in the hypothetical situation the court is required to envisage. In those circumstances it may be easier for the plaintiff to set up an affirmative case on that issue which is liable to be strengthened if, for no good reason, the doctor is unwilling to submit him/herself to questioning before the judge as to what he/she would probably have done.”

A further issue in Wisniewski arose from the fact that, narrowly construed, the risk from which the doctors owed a duty to protect the fetus, i.e. to protect the fetus from oxygen starvation in the womb, was different from that which actually eventuated, i.e. strangulation because the umbilical cord was wrapped around his neck and had a knot in it which gradually tightened. Brooke LJ had little difficulty in rejecting the defendant’s argument that this was sufficient to give rise to a problem of “unrelated
risk” such as to preclude the claimant’s right to damages. Brooke LJ affirmed the approach of the trial judge (Thomas J) that

a) there was a foreseeable risk of damage caused by hypoxia,

b) the fetus suffered damage by hypoxia,

c) in those circumstances, it was immaterial that the precise causal mechanism, i.e. a knot in the umbilical cord, could not have been foreseen.

Also of note is Brooke LJ’s suggestion that in any case in which the two bites of the cherry approach causation is to be relied upon, it should specifically be pleaded in order to give the Defendant the opportunity properly to answer the allegation.

A second case in which the Bolitho approach to causation received judicial consideration was Hallatt v North West Anglia Health Authority. In that case the doctors treating a pregnant woman had decided not to administer a glucose tolerance test when she presented at 34 weeks of pregnancy. She subsequently gave birth to a child who suffered from catastrophic brain injury and damage to the left brachial plexus, caused by complications during an attempted vaginal delivery which in turn were caused by his mother having suffered from gestational diabetes. The critical issue in the appeal was whether or not the doctors had been negligent in having failed to perform a glucose tolerance test.

The trial judge had held that it was not negligent not to perform such a test, notwithstanding that she criticised the doctor’s reliance upon the results of random blood tests to exclude gestational diabetes as illogical. The plaintiff argued that the

6 [1998] Lloyd’s LR Med 197 (CA)
judge, having found that the process of reasoning of the doctors was illogical, should have then approached the question as one of causation, i.e. what would the doctors have done if their reasoning had not been so flawed. In effect, the plaintiffs were arguing for a fragmented approach to negligence which focussed upon the stages of reasoning rather than the actual actions of the defendants. Such an approach could, if taken to its logical conclusion, lead to a vast array of allegations of negligence ranging from a failure to be better informed to a failure to consider alternative hypothesis in any given case.

Unsurprisingly the Court of Appeal rejected the Plaintiff’s argument. They affirmed the importance of focussing on the correct issue, i.e. whether or not the actual decision not to administer a glucose tolerance test was negligent (at p.206). Provided that decision was not negligent, it mattered not that the reasoning process was not beyond reproof. It is the decision, and not the process of reasoning, which must withstanding scrutiny. Buxton LJ, in particular, was critical of the unnecessary complication introduced by arguing the case on Bolitho lines. In his view, the case was clearly distinguishable on two bases:

a) there was no causal issue in this case as it was accepted that if a glucose tolerance test had been carried out the result would have been that gestational diabetes would have been identified; and

b) the criticism which was made of the doctors was not failure or omission but ignorance, i.e. it was not a failure to do anything to protect the claimant. It was simply a failure to be aware of the limitations of the random blood test. It is not everything which can
properly be described as a “failure” which constitutes a legally significant omission.

**Causation in cases of delay**

One of the continuing difficulties in clinical negligence litigation is ascertaining the correct test for causation in cases involving delays in diagnosis. In particular, confusion arises as to whether or not it is appropriate to treat a particular case as one requiring proof on a balance of probabilities, or as one in which an assessment of the chance of a better or worse prognosis will suffice. *Hotson* (above) establishes that where the evidence does not allow any individual assessment of the likelihood of an individual having achieved a better outcome if there had been no negligence, then damages should not be awarded on the basis that the Claimant had a chance of avoiding personal injury. However,

a) *Hotson* does not apply to cases where some personal injury can be established on the balance of probabilities, and the question is whether or not the consequences of that personal injury are all attributable to the negligence.

b) Equally, in cases where there are other evidential factors which enable an application of generalised statistics to the individual case, *Hotson* does not prevent a finding that causation has been established on a balance of probabilities where it is possible to infer on a robust and pragmatic approach to causation, that on balance an individual Claimant was more likely to fall into one particular statistical category than another; and

c) In cases falling within the ambit of the principle established by *Fairchild v Glenhaven Funeral Services Ltd and others*\(^7\) (and query whether this could apply where a patient suffered injury which was caused by either or two negligently created risks, but it is not possible to identify which risk eventuated in the circumstances), a material increase of risk will be sufficient to establish causation.

\(^7\) [2002] 3 WLR 89 (HL); [2002] Lloyd's LR Med 361
A second difficulty with causation in cases of allegedly negligent delay was identified in Tahir v Haringay, namely that the evidence must in fact establish an identifiable injury caused by the negligence, and it is not sufficient merely to lead evidence to the effect that the negligence “made matters worse”. In Tahir, the Deputy Judge had awarded damages representing a proportion of the total value of the claim, on the basis that the delay had led to a somewhat worse result. The court of Appeal, however, held that in circumstances where there is no finding as to precisely what effect a period of delay had, then the correct result is that the Claimant has not proved his case. Damages cannot be awarded unless the Claimant can prove his injury.

Up until recently one of the few cases to consider the correct approach to causation in cases of alleged negligent delay was Judge v Huntingdon HA. Somewhat surprisingly in Judge, the Claimant recovered 80% of the damages he would otherwise have recovered on the basis that at the time of the negligent delay in diagnosis of his cancer he only had an 80% prospect of a normal life expectancy.

Four recent cases have considered this problem

1. Pearman v North Essex Health Authority was a case involving an admitted delay in diagnosis of an acute disc prolapse. The only issue was causation. Butterfield J. noted in his judgment that in such a case the law was not in dispute, namely, causation is a question of past fact to be decided on a balance of probabilities. The evidence as found by the judge in the case was surprising, namely that whilst overall in patients who suffer from compression of the cauda equina by a central profusion of lumbar disc as evidenced by retention of urine 70% recover some bladder control and 30% do not, time of surgery does not have any impact upon the outcome. Accordingly, he found that the outcome for this Claimant would have been the same even if he had been operated upon 2 days previously as regards bladder control. The claim succeeded, however, as regards the more minor components of damage, namely perineal sensory loss and numbness down the left leg.

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8 [1998] Lloyd’s Law Reports Med 104
9 (1995) 6 Med LR 223
10 [2000] Lloys Rep Med 174 (Butterfield J.)
In that case it does not appear to have been suggested that any loss of a chance analysis could apply. In any event, given the judge’s findings of fact, the Claimant did not lose even a chance of recovery.

2. In Smith v NHSLA\textsuperscript{11} the court considered a claim arising out of an alleged delay in diagnosing that the Claimant had a congenitally displaced hip. The alleged negligence was in failure to carry out an Ortolani-Barlow examination. It was agreed however, that it was possible for such an examination not to detect congenitally displaced hip even if there were no negligence. Further, the judge found that even if treated before the child is 8-12 weeks old, there was only a 70% chance of the treatment being successful. Accordingly the causation question was, in part, whether or not the appropriate test to apply was that of balance of probabilities, or loss of a chance, and if the appropriate test was the balance of probabilities, how should the court approach this task. The court considered these questions notwithstanding its finding that there was in fact no breach of duty in the circumstances.

The approach of the judge was as follows:

a) He found that where the chain of causation depended upon how a defendant would have acted if he had not been negligent, i.e. here how an examination would have been carried out if one had been carried out, it should be assumed that the defendant would act in accordance with his obligations to the claimant but it should also be assumed that the Defendant will not have gone beyond his duty. Accordingly, that the doctor would have carried out an examination with proper skill and care but not an especially thorough or able examination.

b) Thereafter, it would be appropriate to assess the damage resulting from the failure to examine on a loss of a chance basis. In so finding, the judge relied upon the reasoning of the Court of Appeal in Allied Maples v Simmons & Simmons\textsuperscript{12}.

\textsuperscript{11} [2001] Lloyds Rep Med 90
\textsuperscript{12} [1995] 1 WLR 1602
c) In assessing this, the court must assess the likely condition of the Claimant’s hip at the time of the examination on the balance of probabilities.

d) There was therefore a 25% chance of detection and successful treatment of the congenitally displaced hip had a neonatal examination been carried out.

e) There was also a 15% chance of detection and successful treatment of the congenitally displaced hip had a 6 week examination been carried out.

3. In Hardaker v Newcastle Health Authority\textsuperscript{13} the question arose as to whether damages were recoverable for an alleged delay in treatment of decompression illness by recompression. According to the judge, the evidence showed that there was a real possibility that the delay affected the claimant’s chances of a full recovery and that his permanent symptoms would have been less serious if there had been no such delay. However, none of the experts could quantify the chances that a speedier entry into the chamber would have led to a better result and none could identify in what respects his permanent symptoms would have been different if compression had begun earlier. Accordingly he held that the case was indistinguishable from that of Hotson and Tahir v Haringay and Pearman (above), and that authority precluded him from awarding damages for the loss of a chance of a full or better recovery. He also specifically disapproved of the decision in Smith v NHSLA (above) as not representing the law. Rather, the claimant must establish what injury has been caused, or what aggravation to his injuries has been caused on the balance of probabilities (see paragraphs 69-71).

4. More recently, in Gregg v Scott\textsuperscript{14}, the Court of Appeal considered the problem of a 9 month delay in diagnosis of a lymphoma. In that case:

\begin{itemize}
\item[a)] The statistical evidence in the Claimant’s initial expert’s report had to be altered to take account of further published research, and the fact
\end{itemize}

\textsuperscript{13} (15th June 2001, Stanley Burnton J)
\textsuperscript{14} [2002] EWCA Civ 1471
that the Claimant had in fact survived which suggested that he had a
better prognosis than the norm; and

b) the judge found that: of 100 patient such as the Claimant, at the time of
the alleged negligence, 55 would achieve remission, 42 would
ultimately survive of whom 35 of which would not have had to
undergo high dose chemotherapy with stem cell treatment, i.e. that it
was more likely than not that prompt treatment would have led initially
to remission, but it was not more likely than not that prompt treatment
would have produced a better long term outcome.

c) At the time of the trial the Claimant had a 25% prospect of disease free
survival for 5 years. Accordingly, there had been a 17% diminution in
the chance of long term survival.

d) The trial judge found that the question of how the Claimant’s condition
would have developed in the period up until the trial was one of past
fact and was not properly described as hypothetical so as to put it in the
category of quantification. He said that the question of how the tumour
would have developed was identical to that of how the doctor who
ought to have attended would have treated the patient in Bolitho.

e) The trial judge found that the Claimant had failed to prove that the
outcome for him, viewed as at the date of the trial, would have been
any different.

Latham LJ held that the present case could be distinguished from Hotson
because of the all or nothing nature of the avascular necrosis in Hotson, i.e.
because in Hotson, it was accepted that either the avascular necrosis would or
would not have happened, and the evidence in Hotson was that, given the
finding as to the state of the Claimant’s hip at the time of his admission to
hospital, the avascular necrosis was inevitable. The present case, however, was
one in which there was a question of degree (as the tumour grew the chances
of successful treatment diminished), and that in those circumstances an all or
nothing approach was not just. This analysis suggests that where, as in this
case, at the time of the negligence it would not have been possible to predict
how the Claimant’s condition would develop, the all or nothing approach is not appropriate.

Latham LJ also concluded that Hotson was not authority for the proposition that damages could not be awarded for loss of a chance in clinical negligence claims. He held that the case should be determined by an analysis of the scope of the duty of care. That, he found, was to exercise such care as would reduce the risk of an undiagnosed cancer spreading and becoming less amenable to treatment. A further factor of relevance to Latham LJ was that the spread of the cancer, and the reduced chances of recovery, were in this case, inextricably interlinked (unlike the pain and the lost chance of recovery of the boy in Hotson). Thus, he held that the damages for the lost chance of recovery were properly analysed as a consequence of the personal injury, which the Claimant had proved on a balance of probabilities. His conclusion was expressed as:

“where an injury that has been sustained carried with it a significant reduction in the chance of a benefit which would otherwise have been available, the judge is required to evaluate the value of that lost chance. I say significant because it seems to me that otherwise it will be too marginal or speculative to amount to an injury capable of being recognised as damage”.

Mance LJ viewed the question as being whether or not the relaxation of the rules of causation in cases where scientific proof of “but for causation” is not possible (as in Fairchild, Bonnington15, and McGhee16 as explained in Fairchild) should be extended to cover the present circumstances. Mance LJ held that the present case was different from that of Fairchild, Bonnington, and McGhee, in part, because in those cases the Defendant was the source of the risk, whereas in the present case the Defendant’s breach was in failing to ameliorate the consequences of an existing risk. Accordingly, he held that there was no room for a material contribution analysis.

He recognised the difficulties in the case as stemming from a simple problem:

“No-one suggests that the statistical diminution in life expectancy relied upon by the appellant can sensibly be treated as minimal. Anyone would regard a

15 Bonnington v Castings & Wardlow (1956) AC 613
16 McGhee v National Coal Board (1973) 1 WLR 1
42% chance of survival as, at any rate, a fair, though not of course a good, chance of survival, whereas a 25% prospect, although the drop is “only” 17%, falls into the category of a poor chance of survival. On the other hand, quite apart from the respondent’s negligence, the appellant had cancer, which at least as a matter of statistical probability meant that he was anyway going to suffer a curtailed life, so that there cannot be a simple attribution, to the respondent’s negligence, of all the devastating effects on him of his cancer.”

Mance LJ analysed the case as not falling precisely within any other previously defined category. He distinguished the case from Fairchild on the basis that, in the context of clinical negligence, the policy considerations which militated in favour of recovery in the employer’s liability context were missing. Thus, whilst in the employer’s liability context there were the problems of a range of defendants introducing a risk, and the difficulty of a wrong going unremedied, in a clinical negligence case the policy considerations pointed the other way.

According to Mance LJ, although the evidence did not actually speak to this, it was possible that the Claimant’s prognosis depended at least in part upon factors which were present (although not identifiable) at the time of the negligence. Thus, he said, factors relating to the precise characteristics of the tumour, and precise characteristics of the Claimant, may have determined whether or not the Claimant fell within the 58% or the 42% statistical likelihood of remission. In some senses, therefore, he held that this case was like Hotson where the statistical analysis itself depended upon a past fact, namely the number of blood vessels left intact following the boy’s fall. However, he held that the analogy was not complete as it could not be known whether or not past facts themselves determined the prognosis. A second reason for distinguishing this case from Hotson was that in this case the question of prognosis was only presented in evidence as a matter of statistics. The question was, therefore, whether or not the approach in Hotson should be taken where the evidence does not allow any finding of past fact to be made regarding the position of the Claimant at the point of the negligent event, and where it is not clear that the Claimant’s statistical prospects depend upon matters of past fact.

Mance LJ suggested the following response:
a) English law should not allow a claim for loss of a chance _simpliciter_, i.e. where there is no personal injury and the claim is purely for a loss of a chance. The example of this which he gave was someone exposed to a risk who did not yet know whether or not it would eventuate.

b) A claimant should not be able to succeed merely by showing that there is a chance that negligence may have caused his injury. For example, the Claimants in Wilsher and Bolitho could not succeed merely by showing that there was a possibility, as opposed to a probability, that the negligence caused their injury.

c) That ultimately it was a question of policy whether or not to treat a case such as the present as one in which the Claimant had to prove the probability that his loss in life expectancy was caused by the negligence, or as one in which recovery should be allowed for the loss of prospect of recovery.

d) His conclusion was that, as a matter of policy, claims based upon statistical possibilities rather than upon probability itself, should not be allowed. He felt that it would open the gates to a wide variety of claims, and introduce difficult distinctions, were such claims to be allowed.

e) He rejected the Claimant’s claim for diminution of life expectancy as a consequence of the enlargement of the tumour not in principle, but because as a matter of probability at the time of the negligence the Claimant would have suffered this loss in any event. Thus, for this “substantive head of loss” the Claimant had not proved his loss as a matter of probability. He distinguished this case from a case of acceleration of, for example, back pain as in such a case the loss, in terms of acceleration, would have to be proved on a balance of probability.

Simon Brown LJ agreed with Mance LJ that as a matter of policy the rules of causation should not be relaxed in health claims. Ultimately, however, he based his judgment upon the similarity between this claim and that in Hotson.
Leave has been granted to appeal to the House of Lords in *Gregg v Scott*. It seems likely that the policy arguments which found favour in the Court of Appeal will equally sway the House of Lords. The factors identified in the introduction to this paper are powerful arguments in favour of a restrictive approach to causation in clinical negligence cases, particularly where the character of a background risk is left unchanged by the clinical negligence, and the difference is simply one of degree.

**Conclusion**

Whilst for the present it is safe to say that in the clinical negligence context, there will be no relaxing of the rules of causation save to the extent that *Bolitho* permitted the two bites of the cherry approach, some of the analysis adopted by the Court of Appeal in *Gregg v Scott* has left the law in an unsatisfactory state, in particular, in that:

a) The distinction adopted by Mance LJ between a negligently caused cancer, for which damages may be reduced to take account of a pre-existing risk of developing cancer, and a negligent failure to diagnose a cancer with the result that there was an increased risk of curtailed life expectancy, is a distinction for which it is difficult to find a principled justification. Surely if there is to be permitted a comparison between a negligently caused risk and a non-negligently caused risk then it should be a comparison which is allowed in any case in which negligence has caused a significant increase in risk. Why should there be a difference between a claimant who is negligently exposed to a carcinogenic leading to a 42% risk of dying within 5 years from cancer, but who already had a 17% risk of developing cancer – and the Claimant in *Gregg v Scott*.

b) The distinction adopted by Latham LJ between a case where there is scientific knowledge as to causation as a matter of past fact, and a case such as *Gregg v Scott* where there was no such knowledge, it again difficult to justify as a matter of principle. It leads to an anomalous situation where the less known about the scientific aetiology of the Claimant’s condition, the better.
c) A Claimant who can show a diminution of life expectancy on the statistics, rather than a statistical diminution of 5 year life expectancy, is more likely to succeed in a claim for damages. Thus, it is preferable for a Claimant’s medical evidence to be framed in terms of diminution of life expectancy, and in the more conventional medical phraseology of probability of 5 year survival.

As these cases show, the Courts are still clearly unwilling to expand the categories of recovery in clinical negligence cases by adopting more flexible approaches to causation. What is a favourable development, however, is the willingness of the judges in English courts to express their conclusions as being based upon policy, rather than upon legal analysis. Such an openness allows the true premise of the decisions to be debated, and resists the temptation to hide policy behind a mask of legal principle, thereby clouding the debate. After Gregg v Scott the true question to be addressed is whether or not, as a matter of judgment and ethics, our courts should allow those who come into the health service with an illness, should be treated in the same way as those who are injured by extraneous causes, such as cars, noxious fumes, or the vagaries of the workplace.

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Multiple Tortfeasors in Clinical Negligence: The Influence of Fairchild

a paper by Dr. Vikram Sachdeva

18 March 2003 at 39 Essex Street

Contents

Introduction.................................................................................................................... 2
Material Contribution to the Damage. ................................................................. 4
Material Contribution to the Risk. ................................................................. 6
Multiple Tortfeasors in Clinical Negligence: The Influence of Fairchild

Introduction
1. Care is needed with the concept of causation in Clinical Negligence law. The legal concept of causation is distinct from the scientific meaning: for instance in the case of an adverse drug reaction to penicillin in a patient who is allergic and has been documented as such. The scientist would say that the reaction was caused by the combination of a pre-existing susceptibility, which has numerous possible causes, both genetic and environmental, coupled with the administration of penicillin by the medical professional. However a philosopher might be more concerned with the conduct of the medical professional, seeking to enquire why he acted as he did, seeking to evaluate his conduct. In law, the function of the concept of causation is to attribute legal responsibility for damage, which involves asking whether (1) factual and (2) legal causation has been satisfied.

2. The “but for” test of causation in Clinical Negligence has been regarded by some as a prerequisite of liability. The function of the test, in asking “would the damage of which the Claimant complains have occurred but for the wrong of the Defendant”, is to eliminate irrelevant causes. If the damage would have occurred in any event the Defendant’s conduct is not a “but for” cause.

17 See Clerk & Lindsell on Torts (17th Ed, 2000) para 2-06.
18 In Barnett v Chelsea & Kensington Hospital Management Committee [1969] 1 QB 428 the Plaintiff’s husband was sent home from a hospital casualty department after complaining of acute stomach pains and sickness. He died later the same day of what turned out to be arsenic poisoning. The hospital admitted negligence in failing to treat the man promptly. However his widow’s claim under the Fatal Accidents Act failed because of evidence that, had he been treated promptly, he would still have died from the poison. Similarly in Robinson v Post Office [1974] 1 WLR 1176 a doctor’s omission to test for an allergic reaction to an anti-tetanus vaccination was not causally related to the patient’s subsequent reaction, because the test would not have revealed the allergy in time.
3. If the Defendant’s conduct satisfies the “but for” test, the next stage is legal causation, whose purpose is to determine the legally effective cause(s), and therefore legal responsibility.

4. It is clear that an action in tort requires that a Claimant advance sufficient convincing expert scientific evidence that the condition of which he complains was caused by the Defendant’s wrongdoing. The quality of the expert scientific evidence is all-important.19

5. Causation is frequently the focus of dispute in Clinical Negligence claims, due to both the difficulty in establishing scientifically the aetiology of disease, and to the complexity of the legal rules of causation. In reality there are a number of events which may be implicated in the Claimant’s increased ill health, and the process of selecting one (the Defendant’s breach) and elevating it to the status of the cause of the Claimant’s ill health can be problematic.

6. For instance, the Claimant’s increased ill health may be due to the natural progression of the disease; the Defendant’s breach may be only one of a number of independent causal agents, as in Wilsher, or, most controversially, the current state of medical science may be unclear as to the exact aetiology of the Claimant’s condition. In Loveday v Renton20, where the issue at stake was the relationship between the pertussis vaccine and brain damage, the experts properly disagreed as to the aetiology of the Plaintiff’s condition, and so the

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claim failed. Other examples include the effects of passive smoking or radiation.  

7. The difficulties of proving causation in certain cases have persuaded the court to relax the causal rules in some instances, particularly where the difficulty of attributing causes is a product of scientific uncertainty. There are two distinct levels which the courts have been prepared to go.

**Material Contribution to the Damage.**

8. The first, less controversial, stage which the courts have gone to is to state that the Claimant does not have to prove that the Defendant’s breach of duty was the sole, or even the main, cause of the damage, provided that he can prove that it made a material contribution to the damage.

9. In *Bonnington Castings Ltd. v Wardlaw* the House of Lords was faced with the problem of a Plaintiff having contracted pneumoconiosis from inhaling air containing silica dust at his workplace. The main source of the dust was from pneumatic hammers (for which the employers was not in breach of duty, hence “innocent” dust) but some dust came from swing grinders (for which they were in breach of duty for failure to maintain, hence “guilty” dust). However there was no evidence as to the proportions of innocent and guilty dust inhaled by the Plaintiff; what evidence which did exist indicated that most came from the innocent dust.

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21 See also *Kay v Ayrshire and Arran Health Board* [1987] 2 All ER 417 (Plaintiff failed to prove that an overdose of penicillin could cause deafness).

10. Although on the evidence the Plaintiff could not prove but for the inefficient working of the dust extraction equipment he would not have contracted the disease, the House of Lords drew a factual inference that the guilty dust was a contributory cause. The employers were thus held liable for the full extent of the loss. The Plaintiff did not have to prove that the guilty dust was the sole or even the most substantial cause if he could show, on a balance of probabilities, the burden of proof remaining with the Plaintiff, that the guilty dust had materially contributed to the damage. Anything which did not fall within the principle *de minimis non curat lex* would constitute a material contribution. This inference was made in a case where the connection between the guilty dust and the Plaintiff’s medical condition was in reality little more than speculation.23

11. However this extension of the but for principle will not avail a Claimant where it is medically impossible to prove a link between a “guilty” cause of the damage and an innocent one. This situation will occur where the nature of the possible causes is such that the damage could have been due to one or other of them, but not due to the cumulative effect of a combination of factors. This conundrum is the root of the further relaxation of the but for requirement such that, in certain restricted circumstances, it is sufficient to prove that the party in breach has made a material contribution to the risk of the damage occurring.

23 In *Nicholson v Atlas Steel Foundry & Engineering Co. Ltd.* [1957] 1 WLR 613 on virtually indistinguishable facts, the House of Lords held the Defendants liable for an employee’s pneumoconiosis even though it was (according to Viscount Simonds) “impossible even approximately to quantify” the respective contributions of guilty and innocent dust.
Material Contribution to the Risk.

12. This test is one stage further back in abstraction. The principle arose in *McGhee v National Coal Board*[^24^]. The Plaintiff, who worked at the Defendants’ brick kilns, contracted dermatitis as a result of exposure to brick dust. The employers were not at fault for the exposure during working hours, but they were in breach of duty by failing to provide adequate washing facilities. This increased the period of exposure to brick dust. It was agreed that the brick dust caused the dermatitis, but the current state of medical knowledge could not say whether it was probable that the Plaintiff would not have contracted the disease had he been able to take a shower after work: the but for test in respect of the guilty exposure could not be satisfied. At best the failure to provide washing facilities materially increased the risk of the Plaintiff contracting dermatitis. Nevertheless the Plaintiff succeeded in full, on the basis that it was sufficient for the Plaintiff to show that the Defendant’s breach of duty increased the risk of the Plaintiff contracting dermatitis.[^25^]

13. The principle established by *McGhee* had the potential to constitute a significant departure from the requirement of “but for” causation. If it were applied to other areas it might have had implications for the ambit of liability in Tort law, for it appeared to be permitting recovery for a new type of damage – the increase in risk of injury, rather than injury itself.

[^24^]: [1972] 3 All ER 1008.
[^25^]: Per Lords Reid, Simon, and Salmon. Lord Wilberforce appeared to favour an approach reversing the burden of proof so that it was borne by the employer, while Lord Kilbrandon inferred that the Pursuer’s injury had been contributed to by the Defender’s breach of duty.
14. Then came *Wilsher v Essex Area Health Authority*. The question was whether *McGhee* could be applied to a case where there were up to five different causes of the Plaintiff’s injury, any one of which might have caused the damage. The Plaintiff was a premature baby who, as a result of the Defendants’ negligence, received an excessive concentration of oxygen. He subsequently contracted a condition known as Retrolental Fibroplasia ("RLF") in which the retina is damaged, resulting in blindness. One possible cause of RLF was exposure to excessive oxygen while premature; however RLF can occur in the absence of excessive oxygen, and there were four other documented risk factors for RLF from which premature babies also suffered.

15. The majority of the Court of Appeal\(^\text{26}\) held that the principle in *McGhee* applied; however Sir Nicholas Browne-Wilkinson VC dissented, holding that “a failure to take preventive measures against one out of five possible causes is no evidence as to which of those five caused the injury”.

16. The House of Lords approved the decision of the Vice-Chancellor, holding that *McGhee* did not establish any new principle of law; that the burden of proof remained with the Plaintiff, who must prove that the breach of duty was at least a material contributory cause of the harm (applying *Bonnington Castings*); and that (per Lord Bridge)\(^\text{27}\) the House of Lords in *McGhee* merely adopted a robust and pragmatic approach to the undisputed primary facts of the case and draw a legitimate, commonsense inference of fact that the additional period of exposure to brick dust had probably materially contributed

\(^{26}\) [1986] 3 All ER 801.

to the Plaintiff’s dermatitis. This explanation, although unconvincing, appeared to signal the end of the road for the argument that a material contribution to the risk was sufficient to prove causation in certain cases.

17. *Fairchild*\(^{28}\) has now overturned that view of *McGhee*. The case involved three consolidated appeals in which mesothelioma, a cancer of the mesothelial cells of the lung, had been developed by workers after negligent exposure to asbestos fibres at work. Mesothelioma is invariably fatal, but can be latent for up to 40 years. There are approximately 1500 cases per year in the United Kingdom, perhaps 50 of which occurring in the absence of exposure to asbestos. Thus the likelihood is that the employees’ mesotheliomas had resulted from occupational exposure.

18. The problem for the Claimants in *Fairchild* was that all of them had worked for more than one employer who had negligently exposed them to asbestos; and with the current level of scientific knowledge about mesothelioma no Claimant could identify which employer had caused the disease.

19. Mesothelioma, being a form of cancer, is a disease which arises from a single (mesothelial) cell which undergoes malignant transformation. The cell loses control of cell division and multiplies uncontrollably, resulting in a tumour, which appropriates the body’s resources to itself, starving normal cells of nutrients.

20. It is not a cumulative disease: although the risk of mesothelioma rises with increasing exposure to asbestos, the severity of the cancer and the resulting disability do not depend on the dose. Further exposure to asbestos, once the cancer has arisen, does not exacerbate the condition. Thus if there has been more than one employment involving asbestos exposure, it is currently impossible to determine in which employment the disease-causing fibre(s) were inhaled.

21. The Court of Appeal\(^{29}\) had held that the Claimants failed to establish causation, because they could not prove on a balance of probabilities that the “guilty” fibres were the result of any particular Defendant’s breach of duty. The court stated that \textit{McGhee} could be distinguished because in that case there was only one causative agent and only one possible tortfeasor; and in the light of \textit{Wilsher}, which had held that an inference of causation could not be drawn where there was more than one causative agent, it was not possible to rely on \textit{McGhee} where there was more than one tortfeasor and the damage was not cumulative.

22. The central injustice left by such a decision was that recovery depended on the completely arbitrary distinction between cases where the Claimant remained with the same (negligent asbestos-exposing) employer, and where the Claimant worked for more than one such employer. In the first case he could recover his full loss; in the second, he could not.\(^{30}\) The most extreme case is where he works for two employers, both of whom expose him to asbestos, but


\(^{30}\) Although there would be social security payments available.
only one of whom does so negligently. The injustice of such a situation is obvious.

23. The crucial issue on appeal was whether, in the special circumstances of the case, principle, authority, or policy requires or justifies a modified approach to proof of causation \(^{31}\), and in particular whether there ought to be insistence on the “but for” rule. The House of Lords allowed the Claimants’ appeals, on the basis that, in the special circumstances of this type of case, there should be a relaxation of the normal rule that a Claimant must prove that but for the Defendant’s breach of duty he would not have suffered the damage. It was sufficient that each Defendant’s breach caused a material contribution to the risk of the Claimant developing mesothelioma.

24. In principle a mechanical approach to causation was discouraged;\(^ {32}\) Lord Bingham opined that it seemed contrary to principle to insist on application of a rule which appeared to yield unfair results.\(^ {33}\)

\(^{31}\) Per Lord Bingham at para [2].

\(^{32}\) In so stating Lord Bingham approved citations from two important opinions of Lord Hoffmann:

“The first point to emphasise is that common sense answers to questions of causation will differ according to the purpose for which the question is asked. Questions of causation often arise for the purpose of attributing responsibility to someone, for example, so as to blame him for something which has happened or to make him guilty of an offence or liable in damages. In such cases, the answer will depend upon the rule by which responsibility is being attributed” (Environment Agency (formerly National Rivers Authority) v Empress Cars (Abertillery) Ltd [1999] 2 AC 22, 29
25. Despite the views of Lord Bridge in Wilsher, the decision of the House in that case, as interpreted by the House in Fairchild, did not rest upon a “robust and pragmatic” approach to the drawing of an inference of fact. Rather, McGhee decided a question of law “whether, on the facts of the case as found, a pursuer who could not show that the defender’s breach had probably caused the damage of which he complained could nonetheless succeed”\(^\text{34}\). The ratio of McGhee, according to Lord Bingham, was “that in the circumstances no distinction was to be drawn between making a material contribution to causing the disease and materially increasing the risk of the pursuer contracting it”\(^\text{35}\). This was not because the burden of proof was reversed\(^\text{36}\).

26. Wilsher was also seen as being decided correctly on its facts. Lord Bingham distinguished it from McGhee and Fairchild by stating that there were a

> “There is therefore no uniform causal requirement for liability in tort. Instead, there are varying causal requirements, depending upon the basis and purpose of liability. One cannot separate questions of liability from questions of causation. They are inextricably connected. One is never simply liable; one is always liable for something and the rules which determine what one is liable for are as much part of the substantive law as the rules which determine which acts give rise to liability” (Kuwait Airways Corpn v Iraqi Airways Co (Nos. 4 and 5) [2002] UKHL 19; [2002] AC 883, 1106 para [128].

\(^{33}\) At para [13].

\(^{34}\) Per Lord Bingham at para [21].

\(^{35}\) At para [21].

\(^{36}\) Per Lord Hoffmann at para [65].
number of noxious agents which could have caused the damage, by contrast to
a single agent.\textsuperscript{37} However this distinction is questionable. Its logical
consequence appears to be that, where two employers negligently expose a
person to two different noxious agents, each of which could singly cause the
damage of which complaint is made, the Claimant would fail, unless there is
something special about the Employment context as opposed to the Clinical
Negligence context. There seems no good reason why the injustice which
\textit{Fairchild} seeks to remedy should be restricted to a single noxious agent.
Indeed, Lord Hoffmann in \textit{Fairchild} disagreed.\textsuperscript{38} He preferred to support the
distinction between the result of \textit{McGhee} and \textit{Wilsher} on policy and pragmatic
grounds related to the distinction in subject matter between an employer’s
liability claim and the national health service’s duty to take medical care.\textsuperscript{39}

27. A more logical distinction was that in \textit{Wilsher} the other potential causes were
innocent. But if all employers bar one were not negligent in exposing the
Claimant to asbestos, would \textit{Fairchild} apply? Lord Bingham thought not;\textsuperscript{40} but
Lord Rodger reserved his position.\textsuperscript{41} In my view Lord Bingham’s view would
probably prevail.

28. It might be suggested that \textit{Fairchild} creates a general, and widely applicable,
principle that whenever the Claimant has difficulty establishing causation, but

\textsuperscript{37} At para [22]. See also Lord Hutton at para [118], and Lord Rodger at para [149].
\textsuperscript{38} “What if [the Claimant] had been exposed to two different agents – asbestos dust and some other
dust – both of which created a material risk of the same cancer and it was equally impossible to say
which had caused the fatal cell mutation? I cannot see why this should make a difference” at paras [71
– 72].
\textsuperscript{39} See below.
\textsuperscript{40} At para [34].
\textsuperscript{41} At para [170].
it can be shown that the Defendant’s breach of duty increased the risk of harm to the Claimant, the rules of causation should be relaxed.

29. Lord Bingham limited it to mesothelioma due to asbestos exposure from multiple employers. Lord Hoffmann also limited it to employees exposed to asbestos. However Lord Rodger’s conditions were at a higher level of generality. Lord Nicholls stated that considerable restraint was called for in

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42 He listed six conditions: (1) C was employed at different times and for differing periods by both A and B, and (2) A and B were both subject to a duty to take reasonable care or to take all practicable measures to prevent C inhaling asbestos dust because of the known risk that asbestos dust (if inhaled) might cause a mesothelioma, and (3) both A and B were in breach of that duty in relation to C during the periods of C’s employment by each of them with the result that during both periods C inhaled excessive quantities of asbestos dust, and (4) C is found to be suffering from a mesothelioma, and (5) any cause of C’s mesothelioma other than the inhalation of asbestos dust at work can be effectively discounted, but (6) C cannot (because of the current limits on human science) prove, on the balance of probabilities, that his mesothelioma was the result of his inhaling asbestos dust during his employment by A or during this employment by B or during his employment by A and B taken together” at para [2].

43 “What are the significant features of the present case? First, we are dealing with a duty specifically intended to protect employees against being unnecessarily exposed to the risk of (among other things) a particular disease. Secondly, the duty is one intended to create a civil right to compensation for injury relevantly connected with its breach. Thirdly, it is established that the greater the exposure to asbestos, the greater the risk of contracting that disease. Fourthly, except in the case in which there has been only one significant exposure to asbestos, medical science cannot prove whose asbestos is more likely than not to have produced the cell mutation which caused the disease. Fifthly, the employee has contracted the disease against which he should have been protected.” at para [61]

44 Lord Rodger’s six conditions were: (1) the principle is designed to resolve the difficulty that arises where it is inherently impossible for the Claimant to prove exactly how his injury was caused. It applies, therefore, where the Claimant has proved all that he possibly can, but the causal link could only ever be established by scientific investigation and the current state of the relevant science leaves it uncertain exactly how the injury was caused and, so, who caused it. McGhee and the present cases are examples. (2) part of the underlying rationale of the principle is that the Defendant’s wrongdoing has materially increased the risk of injury to a class of persons but that it actually created a material risk of injury to the Claimant himself. (3) it follows that the Defendant’s conduct must have been capable of causing the Claimant’s injury. (4) the Claimant must prove that his injury was caused by the eventuation of the kind of risk created by the Defendant’s wrongdoing. In McGhee, for instance, the risk created by the Defender’s failure was that the pursuer would develop dermatitis due to brick dust on his skin and he proved that he had developed dermatitis due to brick dust on his skin. By contrast, the principle does not apply where the Claimant has merely proved that his injury could have been caused by a number of different events, only one of which is the eventuation of the risk created by the Defendant’s wrongful act or omission. Wilsher is an example. (5) this will usually mean that the Claimant must prove that his injury was caused, if not by exactly the same agency as was involved in the Defendant’s wrongdoing, at least by an agency that operated in substantially the same way. A possible example would be where a workman suffered injury from exposure to dusts coming from two sources, the dusts being particles of different substances each of which, however, could have caused his injury in the same way… (6) the principle applies where the other possible source of the Claimant’s injury is a similar wrongful act or omission of another person, but it can also apply where, as in McGhee, the other possible source of the injury is a similar, but lawful, act or omission of the same Defendant. I reserve my position as to whether the principle applies where the other possible source of
any relaxation of the but for test, which required good reason, and that policy questions would loom large to justify taking this “exceptional” course.45

30. However it is difficult to see why the principle ought to be limited to the relationship between employer and employee, let alone to mesothelioma caused by exposure to asbestos dust.

31. Do these principles permit the application of a new approach to clinical negligence cases? No member of the House ruled out any extension of the test; Lord Hoffmann’s view was that the distinction was justified by policy grounds, and in particular the special relationship of employment:46

“It is true that actions for clinical negligence notoriously give rise to difficult questions of causation. But it cannot possibly be said that the duty to take reasonable care in treating patients would be virtually drained of content unless the creation of a material risk of injury were accepted as sufficient to satisfy the causal requirements for liability. And the political and economic arguments involved in the massive increase in the liability of the National Health Service which would have been a consequence of the broad rule favoured by the Court of Appeal in Wilsher’s case are far more complicated than the reasons

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45 At para [43].
46 At para [69].
given by Lord Wilberforce [in McGhee] for imposing liability upon an Employer who has failed to take simple precautions.\textsuperscript{47}

32. There may be a role for the *Fairchild* principle in some medical contexts: for instance:

(1) where an unstable spinal fracture is successively handled negligently by different healthcare providers and the patient develops paraplegia, but cannot show at which stage of his treatment the damage was done; or

(2) where a drug was successively and negligently provided by several healthcare providers.

33. In any event, there remain further issues relating to the application of *Fairchild* to cases of multiple tortfeasors.

(1) The principle clearly applies when there are multiple tortfeasors and all add to the risk of damage by the same noxious agent.

(2) Where there are eg 4 “innocent” causes and 1 guilty cause, and the causes are not cumulative (so that McGhee does not apply), the principle does not apply (*Wilsher*).

\textsuperscript{47} Support for the distinction between the Clinical Negligence and Employment contexts was further added by Mance LJ in *Gregg v Scott* [2002] EWCA Civ 1471 at para [59].
(3) Where multiple tortfeasors add to the risk of the same damage but via different noxious agents, but by a similar mechanism – the principle is inapplicable according to Lord Bingham, but may apply, according to Lords Hoffmann and Rodger.

(4) Where a single tortfeasor and an innocent party are alleged to have caused damage, and the tortfeasor adds to the risk of damage by the same mechanism as the innocent party, the principle is not applicable by Lord Bingham’s criteria, but Lord Rodger reserved his opinion on the matter.

34. In conclusion, it is clear that a more flexible approach may be used for causation in certain difficult contexts; but whether those contexts extend beyond the case of multiple employers negligently causing mesothelioma by asbestos exposure remains to be seen.

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