But for causation in delayed diagnosis cases

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Overview

- Loss of chance: *Gregg v Scott [2005] 2 A.C. 176*
- Scope of duty: *Wright (A Child) v Cambridge Medical Group (A Partnership) [2011] EWCA Civ 669*
- Exceptions for policy reasons: *Chester v Afshar [2005] 1 A C 134*
- Modified but for test, has something else contributed to the disease or injury (as opposed to the risk of such disease of injury): *Davies v Frimley Health NHS Foundation Trust [2021] EWHC 169 (QB)*

Gregg v Scott

- Delayed cancer diagnosis reduced the claimant's chance of a cure form 42% to 25%, he lost a 17% chance of a cure.
- The majority of their Lordships in the House of Lords found against the claimant on the basis that he could not prove that had there been no breach of duty on the part of his GP, he would have had a better than 50 per cent chance of a cure
- At present , recovery for a loss of a chance in clinical negligence claims of this nature is not permissible.
- This may be particularly problematic in claims against GPs.

Wright (A Child) v Cambridge Medical Group

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- GP was liable for negligent delay in referring 11 month old baby to hospital where diagnosis had also been negligently delayed.
- Could not escape liability by establishing that the hospital would have negligently failed to treat the patient appropriately, even if promptly referred.
- Caution: the Court of Appeal made very clear in obiter dictum in such cases it is likely to be preferable to join the GP and the hospital.
- Court of Appeal suggested that recovery in loss of chance claims should not be considered completely foreclosed in clinical negligence claims, but thought to be an extension of the law that can only be made by the Supreme Court.

Chester v Afshar

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- A doctor failed to warn a patient about the potential risks of a particular operation.
- There was a 1-2% chance of significant adverse injury whenever the operation was performed quite irrespective of the particular circumstances of the patient.
- The risk in fact materialised following the operation
- Had the patient been warned he would still have had the operation but on a different day and there was a very high probability that the injury would not have been sustained on that occasion.
- Majority of 3:2 held that the doctor should be liable.
- Basis of decision was that the obligation to warn was an important protection of patient autonomy which should not be undermined even if it is clear that the patient would have taken the risk of having the operation in any event.
- **Their Lordships rejected the contention that the doctor should be liable on the simple basis that in fact the patient would not have suffered the injury but for the failure to warn. In failing to warn, the doctor had not increased the risk of the operation. It was quite arbitrary when that risk would materialise; the risk was the same whenever the operation occurred. The majority only imposed liability in order to give an effective remedy for breach of the right to warn.**

Davies v Frimley Health NHS Foundation Trust [2021] EWHC 169 (QB)

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- Henry Charles from 12 KBW for the claimant
- The claimant died of acute pneumococcal meningitis,
- The defendant admitted negligent delay in failing to administer IV antibiotics between 10.40 am and 13.20 pm on 25th February 2015.
- The issue was causation.
- Important reminder that:
  - The Court can and should gain whatever insight it properly can from hindsight.
  - Care must be taken when extrapolating from the literature to a particular case: the Court must, or course, read the literature with a critical eye and apply sound methods of reasoning when drawing upon it.
  - What statistics or literature may contribute to the picture in a given case, and how much probative weight can or should be attached to it, is also highly fact-sensitive to the issue at hand.

- *Schembri v Marshall* [2020] EWCA Civ 358
- *Clerk & Lindsell on Torts* (22nd edition, 2018), particularly the last sentence:

> "On the other hand, care should be taken not to take the logic of this reasoning too far in the opposite direction. If the evidence is that, say, 80 per cent of patients survive with prompt treatment, but 20 per cent die even with prompt treatment, the fact that the patient died following delayed treatment does not establish that he probably fell into the 20 per cent category at the outset and therefore the delay did not contribute to the death. **The assessment of causation would turn upon the detailed medical evidence, both as to the overall statistical chances of survival and the particular condition and circumstances of the patient.**"

Facts

- Every disease is different, as is every patient, in *Davies* but for causation was established.
- It is also important to bear in mind that the evidence available and state of knowledge at any given time may be quite different.
- John-Paul Swoboda and Henry Charles cover this topic in some detail in the Head to Toe Talk on Brain injuries, video and slides available:

www.12kbw.co.uk/events/head-to-toe webinar-series/

Material contribution

- *Davies* contains a very useful synopsis of the ongoing difficulties with proving disease related clinical negligence claims where but for cannot be established, leading cases cited include:
  - *Bailey v Ministry of Defence* [2009] 1 WLR 1052
  - *AB v Ministry of Defence* [2010] EWCA Civ 1317
  - *Heneghan v Manchester Dry Docks Limited* [2016] ICR 671
  - *Sinkiewicz v Grief (UK) Limited* [2011] 2 AC 229
  - *BAe Systems (Operations) Limited v Konczak* [2018] ICR 1.

Judge Auerback (sitting as a High Court Judge) in *Davies* concluded that:

"209. I conclude that, while ***Bonnington Castings*** *was viewed in Bailey as establishing a novel principle, later authorities of the Court of Appeal, House of Lords and Privy Council view it as having resulted in an* ***anomalous outcome, for peculiar reasons****, and not as standing for any novel legal principle, distinct from the* ***general jurisprudence on co-contribution to divisible or indivisible harms.*** *This conclusion appears to me to accord with deep principle, and with the prevailing view at the highest level, ever since Fairchild, that it* ***stands alone as an exception to orthodox principles, in a tightly circumscribed type of case.*** *In any event, I am bound to follow what I understand to be the principles emerging from those authorities.*

210. *In the present case Mrs Davies died from a disease which, whilst it involved a process that took its course over a period of time, led to the indivisible outcome of death. The sole task of the Court has been to determine* ***on the balance of probabilities whether, in a but for sense, the failure to start IV antibiotics by 10.40 on the day of admission caused her death or not.***

211. *As I have said, while I fully appreciate that some of the experts felt ultimately unable, on the clinical evidence available in this very difficult case, to answer that counterfactual question in quite that way, the Court is obliged, on the evidence it has, including such assistance as the experts feel able to provide, to do so, as best it can. That I have done. For the reasons I have given,* ***I do not think that any other legal doctrine could have been brought to bear in this case."***

Summary: approach to causation

1. Unsafe to assume that modified causation will apply to a case of late diagnosis.
2. Safe to take a forensic approach to all of the evidence, in order to establish but for causation:
    1. Medical/scientific;
    2. Factual; and
    3. Literature/Statistics.