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Causation in Clinical Negligence Claims

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Informed Consent and Causation

Paul Stagg

The need to obtain informed consent

Montgomery v Lanarkshire HB [2015] UKSC 11, [2015] AC 1430

87. .... An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. ....

The need to prove causation

Shaw v Kovac [2017] EWCA Civ 1028, [2017] 1 WLR 4773

- At trial C proved failure to obtain informed consent and that deceased would not have undergone operation
- C argued that entitled to compensation for loss of personal autonomy: suggested additional award of £50,000
- Court of Appeal dismissed appeal: [50]-[83] no right to damages for mere fact of failure to obtain informed consent.

The need to prove causation

Duce v Worcestershire AH Trust [2018] EWCA Civ 1307, [2018] PIQR P18

- [51] C's submission: causation established if:
  - injury connected with duty to warn
  - duty owed by doctor providing treatment
  - injury was result of risk about which C should have been warned
- [53] submission rejected: would be "a wholesale disapplication of conventional causation principles in consent cases"

The test for causation

Subjective or objective?

- In English law the issue is generally viewed as purely subjective
  - What would C have done?
  - Not: what would the reasonable person in C's position have done?
- cf Canada where test is a 'modified' objective test
- Never apparently tested in case law
- Does not mean that what reasonable person would do is irrelevant to court's consideration

The test for causation

Based on what advice?

- *Montgomery* at [103]

.... The question of causation must also be considered on the hypothesis of a discussion which is conducted without the patient's being pressurised to accept her doctor's recommendation.

- So, wrong to judge issue on basis of doctor's firm belief that caesarian section inappropriate for patients in C's position
- But may be appropriate for advice to have been strong: *Pepper v Royal Free London Trust* [2020] EWHC 310 (QB) at [146]

The test for causation

Chester v Afshar [2004] UKHL 41, [2005] 1 AC 134

- C developed CES following spinal surgery, not warned of 1-2% risk
- C's evidence was that:
  - she would not have proceeded with surgery on the same day and would have sought a second opinion, but
  - she could not say whether she would ultimately have proceeded
- [19], [61]-[62], [94] Majority of House of Lords held that this was sufficient to prove causation, as on another day she would have been subject to the same 1-2% risk and probably would not have developed CES

The test for causation

Chester v Afshar [2004] UKHL 41, [2005] 1 AC 134

- Controversial decision: strongly doubted by Leggatt LJ in *Duce* at [81]-[92]
- Query whether same result would be reached eg where C would be undergoing the same surgery by the same surgeon using the same technique, just on a different date: see *Pomphrey v Secretary of State for Health* [2019] Med LR 424 referred to elsewhere in this webinar

The test for causation

What if advice was only given about some risks?

- *Moyes v Lothian HB* [1990] 1 Med LR 463
  - C told of risk of stroke from angiography but not of fact that risk was higher due to personal medical factors
  - C said would not have proceeded if warned of higher risk
  - Held: causation made out
- *Wallace v Kam* [2013] HCA 19, (2013) 297 ALR 383
  - C warned of risk of neuropraxia, but not of paralysis
  - C said would not have proceeded if warned of both risks
  - C suffered from neuropraxia
  - Held: damage not within scope of D's duty

Factors relevant to causation

Evidence from the claimant

- Essential for C's solicitors to take careful instructions and ensure issue addressed in witness statement
- Must explain:
  - what C would have done
  - why
- Court will examine assertion by C critically due to adverse outcome colouring evidence: see eg *Diamond v Royal Devon & Exeter Trust* [2019] EWCA Civ 585, [2019] PIQR P12 at [21]-[22]
- If C cannot give evidence because dead/incapacitated, evidence from a relative may be considered: *Keh v Homerton UH Trust* [2019] EWHC 548 (QB), (2019) 168 BMLR 117 at [90]-[95]

Factors relevant to causation

Evidence as to what the claimant has said

- C's possible difficulty in having evidence seen as based on hindsight can be obviated by contemporaneous statements
  - in medical records
  - communications with friends/family: text messages, e-mails, social media
  - journals etc
- *Meiklejohn v St George's Healthcare Trust* [2014] EWCA Civ 120, [2014] Med LR 122 at [36]:

.... He told the judge in terms that he trusted [the surgeon] and would have done what she advised ....

Factors relevant to causation

Evidence of the claimant's actions, beliefs and experiences

- *Less v Hussain* [2012] EWHC 3513 (QB), [2013] Med LR 383: C had high risk of miscarriage which she was not advised about, but subsequently saw other gynaecologists in relation to pregnancy
- Cases of previous trauma in labour
  - *Holsgrove v SW London SHA* [2004] EWHC 501 (QB): shoulder dystocia in previous delivery
  - *FM v Ipswich Hospital Trust* [2015] EWHC 775 (QB): previous traumatic vaginal delivery

Factors relevant to causation

Evidence of the claimant's actions, beliefs and experiences

- *Powell v UH Sussex Trust* [2023] EWHC 736 (KB) at [81]-[88]: C had undergone four operations by D previously and there was no evidence that she had ever done anything other than follow his advice
- *Jones v North West SHA* [2010] EWHC 178 (QB), [2010] Med LR 90: Jehovah's Witness would not have opted for caesarian section due to higher risk of bleeding

Factors relevant to causation

Evidence as to what patients generally do

- Court may be prepared to use this as a yardstick against which to test C's evidence
- Sometimes evidence can come from D: eg *Montgomery* at [101]: I don't tell them about risk of shoulder dystocia because they would all want a caesarian section
- So:
  - Ask your expert
  - But ensure that their opinion is based on evidence rather than anecdote

Factors relevant to causation

Evidence as to relative risks/benefits

- Matter for expert evidence
  - Set out each possible course of action
  - Set out risks and benefits of each
  - Consider efficacy, particularly when considering conservative treatment
- *Diamond v Royal Devon & Exeter Trust* [2019] EWCA Civ 585, [2019] PIQR P12 at [21]: in deciding whether C would have proceeded, reasonable to consider rationality of decision

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CNZ – Material Contribution and Apportionment

Ella Davis

CNZ (by her Litigation Friend MNZ) v Royal Bath Hospitals NHS Foundation Trust [2023] EWHC 19 (KB)

The case (under appeal):

- Claim arising out of C's birth on 3 February 1996.
- C's twin born by normal vaginal delivery ("NVD") at 00:01.
- C was delivered by emergency caesarean section at 01:03.
- She had suffered acute profound hypoxic ischaemia ("PHI") and as a result suffered cerebral palsy.
- It was her case that her mother ("M") was never offered elective caesarean section, that requests for a caesarean section ("CS") were refused or delayed and that the eventual delivery by CS was carried out negligently late.

CNZ - breach

- The case contains interesting commentary on the application of Montgomery to historic cases (¶264), the test for whether a treatment is a reasonable alternative (¶265) and in relation to the conversations which should take place in response to a request for CS during labour (¶319).
- While there was a failure to offer elective CS, which was a reasonable alternative treatment, it was found that M would have accepted reasonable advice to proceed with NVD.
- There was a negligent delay in performing the CS of a minimum of 5 minutes and a maximum of 8 minutes, with a mid-point of 6.5 minutes being the most probable delay.

Causation – the easy answer

- The duration of PHI was found to be between 14 and 18 minutes – i.e. with a mid point of 16 minutes.
- The agreed expert evidence was that brain damage only started to accumulate after 10 minutes.
- The likely mid-point of the delay was 6.5 minutes.
- 16 – 6.5 = 9.5 so on the balance of probabilities but for the 6.5 minute delay C would have avoided all of the brain damage.

Causation – the problem

- However, that was based on the mid-point of the delay and the mid-point of the likely duration of PHI.
- What if the delay was 5 minutes and the duration of PHI was 18 minutes?
- 18-5 = 13. Therefore there would be 10 minutes of PHI during which no brain damage was suffered. Up to 3 non-negligent minutes in which brain damage was accumulating and at least 5 negligent minutes in which brain damage was accumulating.
- C would have to prove that the delay caused injury distinct from and beyond injury caused by the non-negligent PHI.

The but for test

- Every minute of acute PHI over the first 10 caused incremental brain cell death. This damage minute by minute was more than de minimis and caused increasing functional outcome injury.
- To that extent the but for test was satisfied.
- C had sustained injury which she would not have done but for D’s breach.

The problem in *CNZ*

- If part of the PHI was caused by negligence, and part would have arisen anyway, what causation test should be applied?
- Should the court apportion quantum and if so how?
- Fairness would seem to say yes - but how when medical science is unable to identify with generality, accuracy or detail the functional effect of each minute of brain cell deaths?

The 5 types of tricky causation issues in scientific gap cases.

1. Multiple causative factors, one negligent and the others non negligent (naturally occurring/idiopathic/genetic/environmental etc.).
2. **One known causative factor, part of which was an innocently inflicted and part of which was caused by the breach.**
3. Multiple different defendants responsible for exposing the claimant to the same causative factor.
4. Multiple known risk factors.
5. **Multiple different outcomes which can occur from one known causal factor.**

Material contribution to injury

- The judge considered *Bonnington v Wardlaw [1956] AC 613* and *McGhee v NCB [1973] 1WLR 1* at some length.
- He took from them the principle that:

"*where the but for test cannot be satisfied due to scientific gap impossibility then the law will apply the material contribution to the injury test. If the Claimant can prove the breach made a material contribution to the Claimant's injury which was more than de minimis then damages are to be awarded against the Defendant. In certain (limited) circumstances material contribution to the risk of causing the injury will be used.*"

Trigger diseases and indivisible injuries

- C’s brain injury was not indivisible.
- It was not like malaria which is caused by a single bite, albeit exposure to more mosquitoes increases the risk.
- Nor was it like lung cancer which might be caused by increasing exposure to smoking, but which once triggered takes its course whatever the exposure.
- The spread of brain damage caused by PHI is wholly dose dependent and in that sense divisible.

The correct causation test

The judge held that the relevant test in brain injury caused by acute PHI is firstly the but for test and then in relation to the functional outcome the material contribution to the injury (not to the risk of injury) approach.

N.B. different tests at different stages.

Apportionment in divisible injury cases

- The judge considered a number of divisible disease cases in which damages had been apportioned to reflect the Defendant's contribution to dose.
- He held that they would support a ruling that a fair way to apportion the damages in a brain damage case caused by acute PHI at birth would be by way of a percentage based on the relative durations of the PHI caused by the breach compared to the PHI which would have been suffered in any event.
- However, he then asked if the evidence was sufficient to permit apportionment.

Causation in clinical negligence cases where there is a scientific gap

- The judge considered *Bailey v Ministry of Defence [2008] EWCA Civ 883*, *Popple v Birmingham [2012] EWCA Civ 1628* and *Williams v Bermuda [2016] UKPC 4*.
- None of them resolved the issue of apportionment in acute PHI brain damage cases where the functional outcome cannot be apportioned or divided.
- The key principle to take from them was the effect of scientific impossibility in modifying the test for causation at each stage.

Impossibility or difficulty of proof for apportionment of functional outcome

- The judge considered *John v Central Manchester [2016] EWHC 407*, in which it was held that if it is not merely difficult but impossible to allot particular loss to a particular cause, apportionment is not appropriate.
- The judge accepted that there is a distinction between impossibility of proof for apportionment of functional outcome and difficulty over proof for apportionment of functional outcome.

The issue of Apportionment in *CNZ*

- Where C's cerebral palsy had been caused by one noxious factor, acute PHI, and every minute of PHI causes brain damage, the scientific gap was how to attribute each minute of brain damage to each or any functional deficit.
- D argued that loss could be apportioned by reference to their expert's Aliquot theory but this was held not to be an acceptable, fair or practicable way to apportion quantum.

Conclusions in *CNZ*

- The material contribution test was not appropriate in relation to deciding whether the breach caused injury. On the balance of probabilities each minute of PHI caused brain injury. The but for test was sufficient and satisfied.

Conclusions in *CNZ*

- As to proof of the quantification of loss, there was a scientific gap in the ability of the medical experts to predict the but for outcome.
- In law the cases showed that if there is **a scientific gap making proof of causation of functional outcome, therefore also quantification, impossible in contra-distinction to merely difficult,** then the Claimant will recover 100% of the damage she has suffered due to the acute PHI, so long as the Claimant can prove that the breach made **a material contribution to the reduced functional outcome** which was more than de-minimis.

Conclusions in *CNZ*

- Had the evidence permitted such an approach, the judge would have ruled that apportionment of quantum is fair on the basis of a percentage tied to the relative duration of PHI.
- However, quantification of C's functional outcome but for each minute of negligently caused acute PHI was impossible and not merely difficult .
- Therefore C will recover 100% of her damages on the basis that the delay made a material contribution to her functional outcome.

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Claims for Loss of a Chance

Susanna Bennett

Causation on balance of probabilities: all or nothing

Causation of loss of a chance: reflects the likelihood that the claimant would have had a better outcome

Hotson v East Berkshire HA **[1987] A.C. 750**

- Claim for 25% loss of chance of avoiding disability.
- C suffered injury to his left hip after falling 12 foot.
- He went to hospital and there was a negligent failure to diagnose his injury for 5 days.
- He suffered avascular necrosis of the joint, resulting in permanent disability.
- If he had been treated competently at the hospital, he would have had a 75% chance of developing avascular necrosis; on account of the negligence he had a 100% chance.

Hotson v East Berkshire HA **[1987] A.C. 750**

- His claim for loss of the 25% chance succeeded in the High Court and Court of Appeal.
- It was overturned in the House of Lords.
- Regarded as a case about causation of the disability: was it caused by the original fall or by the negligence? All or nothing not loss of a chance.
- But the HL left open the possibility that claims could be brought on a loss of chance basis…

Hotson v East Berkshire HA **[1987] A.C. 750**

E.g. Lord Mackay at p 786:

"On the other hand, I consider that it would be unwise in the present case to lay it down as a rule that a plaintiff could never succeed by proving loss of a chance in a medical negligence case…"

Possibly an unfair outcome?

Allied Maples Group Ltd v Simmons & Simmons **[1995] 4 All ER 907 (CA)**

- Not a PI case but helpful guidance on causation.
- Where D has committed some positive negligent act, causation to be treated as a question of historical fact, and determined on the balance of probabilities.
- Quantifying losses based on uncertain future events to be approached on a loss of a chance basis.
- Hypothetical questions about what C would have done to be proved on the balance of probabilities.

Allied Maples Group Ltd v Simmons & Simmons **[1995] 4 All ER 907 (CA)**

- The hypothetical actions of third parties are to be approached on a loss of a chance basis: first C must show that there was a substantial chance the third parties would have acted so as to benefit C, then the likelihood of this is assessed.
- The approach has been endorsed (obiter) for clinical negligence claims by the HC in *Smith v NHSLA* [2001] Lloyd's Rep. Med. 90 and *Hardaker v Newcastle Health Authority* [2001]Lloyd's Rep. Med. 512.

Hypothetical actions of D or those for whom D is responsible are also to be proved on the balance of probabilities: *Gregg v Scott* at [83].

Gregg v Scott **[2005] UKHL 2**

- Claim for 17% loss of the chance of 10-year survival following diagnosis of non-Hodgkin's lymphoma.
- C's GP negligently failed to refer him to a specialist resulting in a 9 month delay in diagnosis.
- According to statistics, C would have had a 42% chance of 10-year survival absent the negligence; this was reduced to a 25% chance.
- He was still alive at the House of Appeal 8 years later.

Gregg v Scott **[2005] UKHL 2**

- C's claim was dismissed at 1st instance and the CA dismissed his appeal.
- C's appeal was dismissed by a bare majority of the HL (Lords Nicholls and Hope dissenting).
- Different reasons given, thus no clear principle arises.
- Lord Hoffman: law treats the world as bound by laws of causality. There should be no exception in this case.

Gregg v Scott **[2005] UKHL 2**

- Lord Hoffman and Lady Hale: potentially enormous consequences of allowing loss of a chance claims in clinical negligence.
- Lady Hale at [218]-[220] addressed the inconsistency with solicitor negligence claims. No clear rationale as to the basis for this inconsistency:

“[218] … So why should my solicitor be liable for negligently depriving me of the chance of winning my action, even if I never had a better than evens chance of success, when my doctor is not liable for negligently depriving me of the chance of getting better, even if I never had a better than evens chance of getting better? Is this another example of the law being kinder to the medical profession than to other professionals?...

[220] It is unfashionable these days to distinguish between financial loss and personal injury. Losing the money one has may not be so different from losing the leg one has. But many claims for financial loss do not relate to the money one has but to the money one expected to have—a prospective financial gain. There is not much difference between the money one expected to have and the money one expected to have a chance of having: it is all money. There is a difference between the leg one ought to have and the chance of keeping a leg which one ought to have. There is perhaps an even greater difference between the disease free state one ought to have and the chance of having a disease free state which one ought to have…”

Gregg v Scott **[2005] UKHL 2**

- Lord Phillips: rejected the findings made regarding C's chances of survival. But accepted the possibility of loss of a chance claims in principle: [191].
- Lord Nicholls (dissenting): categorized loss of a chance claims into those where there was significant medical uncertainty as to what the outcome would have been absent the negligence (as in *Gregg*) and those where there was not (as in *Hotson*). Loss of a chance claims should succeed in the former cases.

Gregg v Scott **[2005] UKHL 2**

- Lord Hope (dissenting): distinguished between loss of a chance claims where the fundamental question of fact relates to a point in time before the negligence (as in *Hotson*) and where it relates to a point in time after the negligence (as in *Gregg* – enlargement of the tumour)

Loss of a chance claims in clinical negligence: where we are now

- Loss of a chance claims in the *Gregg v Scott* type scenario are arguably possible (given that 3/5 of the HL accepted the possibility) but likely to be difficult.
- Striking to compare the position in solicitor negligence claims.
- Difficult to reconcile the decisions of *Barker v Corus* and *Gregg v Scott*. Why was the but for test not relaxed in *Gregg*?
- Look out for cases in which (a) there is significant medical uncertainty as to what the outcome for C would have been absent the negligence and (b) the outcome for C is known.

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Scope of duty in cases where the timing of surgery is the result of negligence

Pomphrey v Secretary of State for Health **[2019] Med. L.R. 424**

- Claim arising from a dural tear which occurred during spinal surgery which left C disabled.
- There was a 10-day delay in C having surgery due to D's negligence.
- Recognised risk of a dural tear during surgery ~5-10%.

Pomphrey v Secretary of State for Health **[2019] Med. L.R. 424**

The Claim was dismissed for 2 reasons:

- If surgery had taken place on a different date, it would have been the same surgeon using the same technique, and dural tear would probably still have occurred.
- (obiter): If that was wrong, the harm suffered by C was not within the scope of the duty breached, being the duty to avoid unreasonable delay, following the CA's decision in *Meadows v Khan*.

Crossman v St George's Healthcare NHS Trust **[2016] EWHC 2878 (QB)**

- C wrongly put on the waiting list for surgery – despite agreeing to conservative treatment.
- During surgery he sustained a nerve root injury, of which there was a less than 1% chance.
- The Judge, HHJ Hughes QC, allowed the claim, purportedly on conventional "but for" causation principles.

“45. In summary, Mr Crossman was unlucky. Had he had the operation on a different occasion, on the balance of probabilities the operation would have been successful.

46. In the light of my finding that the Claimant was not at fault, but for the admitted negligence of the Hospital the Claimant would not have had the operation when he did. Had he had the operation on a different occasion, he would not have been advised that he was at any greater risk, and, although the risk was in fact higher in his case, it was not one which was more likely than not to be realised. Hence, in my judgment, the claim succeeds on conventional “ but for ” causation principles.”

Strongly criticized by the HC in *Pomphrey*:

“290. Given that there was no direct link between the admitted negligence and the risk arising from surgery (which he would have undergone in any event) and no material alteration in that risk had the operation been performed three months later it is difficult to reconcile the learned Judge's approach with the unanimous view of their Lordships [in Chester v Afshar] as to the problems with reliance upon conventional causation in such circumstances

297. It follows from my analysis that given the scope of the relevant duty which was breached in this case (to avoid unreasonable delay) I would have declined Mr Samuel's invitation to follow the reasoning/approach in Crossman and would have found that establishing simple "but for" causation; based solely on the operation taking place on a different day (or Mr Samuel suggested even at a different time on the same day) would not have been sufficient, without more, for the Claimant to establish causation. Indeed to do so would drive a coach and horses through well established causation principles. So even had my conclusion been different on the issue of factual causation the claim would have failed.”

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Thank you for your attention

Questions?

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