# AN UPDATE ON THE LAW RELATING TO CLINICAL DISPUTES

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**The Duty of Care**

1. *ABC v St George's Healthcare NHS Trust* [2017] EWCA Civ 336.

   A doctor's duty of care to his patient does not extend to informing the patient of confidential information of the of another patient.

   1.1. Facts. C's father was also under the care of D, having been convicted of the manslaughter of C's mother. The father was diagnosed with Huntingdon's disease, which is a hereditary disease affecting his behaviour. D counselled him to let his family be informed of his condition for their benefit, but he refused, although he voluntarily informed his brother. The family, including C engaged in "family therapy" for the father and arranged by D. The family were not informed of the father's condition. C became pregnant and went on to have a baby, but soon after one of D's staff in error informed C of her father's disease. C claimed that D breached its common law duty to her and art.8 ECHR (right to respect for private and family life) in not informing her of her father's disease and the risk that she and her baby had a 50% chance of having the disease. C claimed that had she known she would have terminated the pregnancy and now with the prospect of a child with Huntingdon's disease she had suffered psychiatric injury and expense in caring for the child.

   1.2. D applied to strike out the claim and Nicol J held that it was not fair, just and reasonable to impose upon D a duty to inform C of facts, which were confidential to another patient. Neither was art.8 breached because the balance favoured the father's right to confidentiality. Professional guidelines as to the duty of patient confidentiality were discussed and the fact that the guidelines do not say that the duty of confidentiality is absolute. The main basis of the decision was that this was an act of omission and imposing an obligation to disclose confidential information of another would be an extension of the duty of care which was not warranted.

1.3. The case went to appeal and the CA allowed the appeal holding that C's argument that the clinicians owed her a duty of care in relation to information held about another patient's condition was properly arguable. It was noted that the duty of patient confidentiality was not an absolute one and that the balancing exercise between maintaining that confidentiality and its potential effect on another patient could only be undertaken if a duty to the other patient existed. It must be noted that the CA only prevented C's claim from being struck out summarily, it did not decide that C's claim should succeed. Nonetheless, the case is important because clinicians will have to consider whether others should be informed of another patient's condition if it could affect the other's health.

2. *Darnley v Croydon Health Care Services NHS Trust* [2017] EWCA Civ 151.

D did not have a duty to provide accurate information as to waiting times in it's A&E department.

2.1. Facts. Judgment after trial. C had been assaulted and suffered a head injury. He attended A&E and alleged he had been told that the wait would be 4-5 hours. He left after 19 minutes. Later he suffered a deterioration in his head injury resulting in left-sided hemiplegia. D's staff could not recall his attendance but said that if asked he would have been told that he would be seen by a triage nurse within 30 minutes. NICE guidelines say that a patient should have a preliminary assessment (triage) at A&E within 15 minutes. C alleged it was a breach of duty not to make a preliminary assessment before he left and in failing to give him an accurate estimate of when he might be treated and that had he been given accurate information as to when he would be seen he would have remained and been treated and not suffered left-sided hemiplegia.

2.2. At first instance the Judge held that the NICE guidelines were just guidelines and subject to exigencies. The experts felt that with exigent circumstances the guideline time might reasonably not be met, but the preliminary assessment must take place within 30 minutes. Since C left A&E after 17 minutes D was not in breach of duty. The CA by a majority upheld the Judge's reasoning. So far the case is only remarkable as an example of professional guidelines not being determinative of breach of duty.

2.3. In relation to the unqualified receptionist, who had allegedly given the 4-5 hour wait time the first instance Judge held that she was not under a duty to inform patients that they would be given a preliminary assessment within 30 minutes. The receptionist's function was to complete registration forms and was only administrative. It was not fair just and reasonable to impose a duty to provide information as to likely waiting times, it had been done purely as a matter of courtesy. In the CA it was said that the question of the imposition of

a duty of care was not a binary one giving a yes or no answer, rather one had to consider the scope of the duty contended for and the range of consequences for which D was to be responsible upon breach. Although previously ambulance control staff had been held to owe a duty to give accurate information[1] the situation with an A&E receptionist was different. The majority of the CA held the receptionist's task was only to record details of new arrivals and it was not fair, just and reasonable to impose a duty on them a general duty to provide accurate information as to waiting and times. Even if it did, that duty did not extend to a responsibility for the consequences of someone walking out of A&E without telling staff he was about to leave.

2.3. The case is important as regards the duties of unqualified non-clinical staff and they are to be judged. Also the extent of D's non-delegable duty to provide information. This case is also under appeal to the SC.

3. *Lane v Worcestershire Acute Hospitals NHS* Trust [2017] EWHC 1900.

The accepted test for breach of duty in clinical disputes is the well known case of *Bolam*: D will only be in breach if its conduct could not be supported by a responsible body of medical practitioners of that discipline. But the equally well known case of *Bolitho* established that a Judge was not bound to reject a claim because D's expert opined that a responsible body of clinicians would support D's conduct. The case of *Lane* is a recent exploration of the tension between the two cases. The Judge held that a doctor could not avoid liability simply by calling evidence from a respectable expert supporting his practice. That would be to delegate the court's decision to the expert. The court had to go further and consider whether the practice supported by such defence expert was reasonable, responsible and logical following Bolitho. However, *Bolitho* was not a licence for a judge to prefer one expert's opinion over another. The question was not whether the patient could have received a better standard of care or whether, with hindsight, things could be been done better, but whether the treatment was supported by a responsible body of medical opinion that withstood logical analysis. The correct approach was set out in *C v North Cumbria University Hospitals NHS Trust* [2014].

4. *Shaw v Kovac* [2017] EWCA Civ 1028.

4.1. One of the pitfalls of only dabbling in clinical disputes is a failure to be aware of or understand the differences peculiar to this area of practice. Whilst *Bolam* is consistent with duties in professional negligence in other areas *Montgomery v Lanarkshire* (SC 2015) established that the duty is different when advising a patient during the consenting process. The reason the SC made an exception to the *Bolam* test was to preserve the sanctity and importance of consent to what is done to one's body. It is for the same reason

[1] *Kent v Griffiths no.3* (2001).

that the HL modified the rule in relation to causation following breach of duty in failing to warn of the risks of surgery in *Chester v Afshar*. The common law on assault had failed to provide sufficient protection because English law held that so long as C knew broadly of the procedure intended there could be no assault; the American doctrine of "informed consent" without which consent was vitiated had no place in English law (*Chatterton v Gerson* 1984). As a result the tort of assault is rarely pleaded in clinical disputes and its impact in terms of causation and measure of damages is open to argument.

4.2. In *Border v Lewisham* [2015] EWCA Civ 8 the CA held that a failure to obtain consent ipso facto amounted to a breach of duty, but did not then have to consider potential arguments on how success in the alternative claim of assault may have yielded a different result.

4.3. In *Shaw* the deceased was subject to pioneering heart surgery but died and the claim was brought on the basis that the true nature of the risks of the surgery were not explained and had they been C would never have consented to the surgery. This claim succeeded and damages at c.£16,000 were awarded. C claimed an additional amount for breach of the duty to provide informed consent, or for invasion of the body", or "vindicatory award", which was put at about £50,000. The CA said that there was no separate cause of action of "failure to obtain informed consent" and in any event damages had to be compensatory. In a particular case it may be appropriate to take into account C's knowledge that an operation had been performed without his informed consent, but this was not as a result of a free-standing cause of action and nor should there be a conventional award for this.

4.4. *Shaw* was not a case concerning the tort of assault. The extent to which advantage may be gained in the exceptional cases of pleading assault in addition to breach of duty in the detail of the consenting process is still untested. In an appropriate case a successful claim of assault is more likely to lead to an award of aggravated damages, but the extent to which there may be an advantage in proving causation over and above *Chester v Afshar* is unclear.

**Secondary victims**

5. There has been a real change over the ability of secondary victims to recover damages in the clinical negligence context. The test for a duty being owed to potential secondary victims was set out in *Alcock v Chief Constable of West Yorkshire Police* [1992] AC 310 with the following basic requirements:

(1) A particularly close relationship of love and affection;

(2) Propinquity in time and space to the incident or its immediate aftermath;

(3) A sufficiently horrifying event.

Older cases had allowed cases to succeed, which would probably be decided differently today, e.g.

- *Sion v Hampstead HA* [1994] 5 Med LR 170. A father sat with his son, who had been injured in a motorcycle accident until his death 14 days later, it was then discovered that the hospital had failed to diagnose and treat internal bleeding. The case was struck out because there was no evidence of nervous shock, but there were observations from Peter Gibson LJ on the argument that a course of events over 14 days could not be regarded as a relevant event, saying:
*"I see no reason in logic why a breach of duty causing an incident involving no violence or suddenness, such as where the wrong medicine is negligently given to a hospital patient, could not lead to a claim for damages for nervous shock, for example where the negligence has fatal results and a visiting close relative, wholly unprepared for what has occurred, finds the body and thereby sustains a sudden and unexpected shock to the nervous system."*
- *North Glamorgan NHS Trust v Walters* [2003] PIQR 232. As a result of negligent misdiagnosis a baby suffered an epileptic fit, which was witnessed by his mother and led to coma and then death in his mother's arms 36 hours later. The CA said that a pragmatic view had to be taken as to what amounted to a necessary "event".

6. In *Taylor v A Novo* [2014] QB 150 CA concerned what amounted to a necessary "event" in circumstances where C did not witness the accident at work by which the primary victim suffered injury, but did witness the primary victim's later death as a result of pulmonary embolism caused by the original accident and injury. As a matter of policy the later death could not be permitted to be the relevant event or its immediate aftermath. A number of cases show how difficult it is to recover as a secondary victim in the context of clinical treatment, both because pain and suffering in the controlled environment of a hospital may not be a sufficiently horrifying event, but also because the event evolves and there may not be a coincidence between the original breach of duty and injury and what later causes psychiatric injury to the secondary victim.

- *Wild v Southend University Hospital NHS Trust* [2016] PIQR 16. A father's claim, as a secondary victim, for psychiatric illness caused by witnessing midwives determine that his baby had died in his wife's womb, could not succeed where he had experienced a growing and acute anxiety starting at a time when the baby had already died, rather than witnessing horrific events leading to a death or serious injury.
- *Shorter v Surrey & Sussex Healthcare NHS Trust* [2015] EWHC 614. A claim by a victim's sister, who learned of the primary victim's deterioration mainly by telephone over a period of 2 days, but who also attended hospital and saw the primary victim in pain and distress on a trolley and later on a life support machine could not recover. Being told of events by telephone was not sufficiently proximate and one must witness the shocking or horrifying events. Further, seeing the victim on a trolley in distress or on life support was not a sufficiently horrifying event and seeing the victim

on a life support machine was not a sudden shock but part of the gradual unfolding of events.

- *Liverpool Women's Hospital v Ronayne* [2015] EWCA 588. Here the CA overturned a finding of liability in favour of a husband, who witnessed his wife's deterioration and distress after negligent surgery over a period of 36 hours and in particular on 2 occasions. The CA stated that the 36 hours could not be regarded as a seamless single event and the occurrences within that period were not sufficiently shocking or horrifying, but were informed by information received in advance from clinicians. The CA said that the circumstances fell "far short" of what was recognised as founding liability for secondary victims.
- *Owers v Medway NHS Foundation Trust* [2015] EWHC 2063. A husband was unable to recover after witnessing his wife's deterioration after a failure to diagnose stroke at the Emergency Department, from which she later died after admission to another hospital. Whilst distressing, witnessing a failure to diagnose and treat was not a sufficiently horrifying event.
- *Wells v University Hospital Southampton* [2015] EWHC 2376. Obiter: if the mother's claim for death of her child during birth had succeeded then she would have been the primary victim, but the father would not have been able to recover as a secondary victim, although he was present at the birth, saw the baby delivered and the attempts to resuscitate the baby. Such events were not sufficiently shocking and horrifying although they were clearly distressing.
- *Morgan v Somerset Partnership NHS* 29.2.16 HHJ Denyer. C's husband attempted suicide by locking himself in his garage and cutting his wrists and was attended to by D. He was not admitted to psychiatric hospital but only medicated, which was alleged to be negligent. Six days later he did the same and was found by C in pools of blood and taken to hospital and survived. C claimed to have suffered an adjustment disorder as a result of discovering her husband in the garage at the second suicide attempt. D admitted negligence in relation the treatment of the primary victim following the first suicide attempt. The claim was struck out due to the lack of proximity between the negligence in the treatment immediately following the first suicide attempt and the horrifying events 6 days later when C discovered her husband in a pool of blood.
- *Baker v Cambridgeshire NHS* [2015] EWHC 609. Another case by a secondary victim after discovering the primary victim's body following suicide, the allegation being that D should have taken the primary victim into psychiatric care earlier. Breach of duty was not proved, but the Judge said that even if it was C would not be able to recover as a secondary victim because of the lack of proximity between the negligent acts and the later events witnessed by C.

7. Slightly bucking the trend is the recent decision of Master Roberts in *Werb v Solent NHS Trust* (15.3.17) in which the primary victim had been released from a psychiatric hospital and committed suicide by jumping from a bridge into the path of a train. The primary victim's case was settled with breach of duty and causation being accepted. The secondary victim was the father who saw body parts on the railway line some 25 minutes after the incident, but did not realise it was his son until later that day he was

telephoned and told that his son had committed suicide. He then returned to the scene and saw the remains of what he knew to be his son. The Master refused to strike out the claim and held that the father's claim as a secondary victim was properly arguable.

**Causation**

8. In clinical negligence causation is established by proving on the balance of probability what the clinical outcome would probably have been had the breach of duty not occurred. This can sometimes be a speculative exercise and one in which medical science may struggle to provide an answer. This is particularly so where there are a number of causal factors affecting the outcome. In *Bailey v MoD* [2008] EWCA Civ 803 Waller LJ said:

*46 In my view one cannot draw a distinction between medical negligence cases and others. I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. Hotson's case exemplifies such a situation. If the evidence demonstrates that "but for" the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that "but for" an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the "but for" test is modified, and the claimant will succeed.*

Those words appeared to suggest that "material contribution" was insufficient unless medical science was unable to establish what would have occurred on the balance of probability. Yet earlier cases on industrial diseases showed that material contribution was sufficient where multiple agents, innocent and wrongful, operated concurrently to cause injury. Further there was uncertainty as to whether consecutive causes of injury were sufficient.

9. The approach in *Bailey* was criticised in *Williams v Bermuda Hospitals Board* [2016] AC 888. It had always been accepted that where several factors caused or contributed simultaneously to an indivisible injury it was sufficient if one of those factors was D's breach of duty. In *Bermuda Hospitals* it was held that the "material contribution" did not apply only in cases where the factors operated simultaneously, but also where they operated consecutively. In that case where delay in operating upon a burst appendix led to complications, some of the delay was innocent, some the result of a breach of duty. D was liable for the whole injury. The SC said that the CA was wrong in *Bailey* to say that the trial judge had departed from the "but for" test, rather the case is properly understood as being an application of the but for test, albeit that there were a number of causes of the claimant's weakened state, which led to her aspirating on her own vomit and suffering ischaemic brain injury. It is not a

case of exceptionally departing from the ordinary proof of causation on the balance of probability by introducing a lower test of material contribution; rather material contribution is always sufficient.

10. There may still be some debate as to whether the "but for" test and "material contribution" test are distinct alternatives or integral parts of the same test. In *Heneghan v Manchester Dry Docks* [2016] 1 WLR 2036 ( a case decided before the SC judgment in *Bermuda Hospitals*) the CA said:

*23 There are three ways of establishing causation in disease cases. The first is by showing that* but for *the defendant's negligence, the claimant would not have suffered the disease. Secondly, where the disease is caused by the cumulative effect of an agency part of which is attributable to breach of duty on the part of the defendant and part of which involves no breach of duty, the defendant will be liable on the ground that his breach of duty made a "material contribution" to the disease:* Bonnington Castings Ltd v Wardlaw [1956] AC 613 *. The disease in that case was pneumoconiosis which is a divisible disease (ie one whose severity increases with increased exposure to the agency). Thirdly, where causation cannot be proved in either of these ways, for example because the disease is indivisible, causation may be established if it is proved that the defendant materially increased the risk of the victim contracting the disease: the Fairchild exception. Mesothelioma is an indivisible disease.*

See also *John v Central Manchester & Manchester Childrens Hospital NHS Trust* [2016] EWHC 407, decided after both *Heneghan* and *Bermuda Hospitals* in which Picken J felt that they may well be an application of the same test, saying at para.89:

*… whether "material contribution" represents a departure from the "but for" test (as Waller LJ considered in the Bailey case) or application of the "but for" test (as Foskett J in the Bailey case and Lord Toulson JSC in the Williams case considered). It is this distinction, as drawn by Mr Kennedy, to which I refer in what follows when referring, on the one hand, to the "but for" test and the "material contribution" test, even though, consistent with the approach adopted by Foskett J in the Bailey case and Lord Toulson JSC in the Williams case, strictly speaking the latter may very well entail application of the former.*

11. There is no doubt that since *Bermuda Hospitals* causation is easier to prove, but it still has its limitations. The following cautionary words were said by the SC:

*39. The sequence of events may be highly relevant in considering as a matter of fact whether a later event has made a material contribution to the outcome (as* Hotson [1987] AC 750 *illustrates), or conversely whether an earlier event has been so overtaken by later events as not to have made a material contribution to the outcome. But those are evidential considerations. As a matter of principle, successive events are capable of each making a material contribution to the subsequent outcome.*

*40. A claim will fail if the most that can be said is that the claimant's injury is likely to have been caused by one or more of a number of disparate factors, one of which is attributable to a wrongful act or omission of the defendant: Wilsher v Essex Area Health Authority … In such a case the claimant will not have shown as a matter of probability that the factor attributable to the defendant caused the injury, or was one of two or more factors which operated cumulatively to cause it.*

12. Further, it will not be sufficient merely to prove that the breach of duty materially increased the risk of the injury occurring. There is a distinction between material increase in risk to something occurring and an agency being proved to have actually contributed materially to an injury occurring. If there was no such distinction then the *Fairchild* exception as applied in *Heneghan* would have no need or place in the law. Further, it is notable that in *Bermuda Hospitals* the court considered the extent to which a proven increase in the risk may be evidence of actual material contribution to the cause of injury. Argument had been made of the use of a "doubling of risk" as a useful tool to prove causation in fact. The SC commented at para.48:

*If it is a known fact that a particular type of act (or omission) is likely to have a particular effect, proof that the defendant was responsible for such an act (or omission) and that the claimant had what is the usual effect will be powerful evidence from which to infer causation, without necessarily requiring a detailed scientific explanation for the link. But inferring causation from proof of heightened risk is never an exercise to apply mechanistically. A doubled tiny risk will still be very small.*

The recent case of *Murphy v MoD* [2016] EWHC 3 explores the way in which temporal association between an untoward event and an injury can be relied upon to prove causation even though medical science has a difficulty in explaining the causal mechanism reliably.

13. There are a few examples in the reports of how *Bermuda Hospitals* makes a difference in practice. *Haughton v Dr Patel* [2017] EWHC 2316 was a case of negligence against a dentist. C suffered periodontal disease and did so for many years but it went undiagnosed by her dentist D. Her chronic adult periodontitis ("CAP") continued and no treatment plan was put in place. The progression of the disease caused her to suffer abscesses one of which caused a rare complication of an abscess on the brain, which was serious. Breach of duty was admitted, the issue was causation. In particular, smoking is a risk factor for CAP and makes treatment of it less effective. Even at trial and after all events C was till smoking and professed that once the stress of the litigation was over she would quit. After hearing C in evidence and experts for both parties the Judge found that properly advised and warned C would probably have addressed her smoking and oral hygiene and followed a treatment plan and avoided the progression of CAP and the brain abscess. Thus C succeeded without reliance on the material contribution test, but the Judge also found in the alternative that D's breach of duty made a material contribution to the progression of C's CAP and cause of the brain abscess.

## Limitation

14. *Pennine Acute Hospitals NHS Trust v Simon de Meza* [2017] EWCA Civ 1711.

C was overweight and diagnosed with hypothyroidism and in 1981 and prescribed testosterone by the Hospital for hypogonadism but stopped taking it. In 1983 he consulted a doctor privately and was again prescribed testosterone for hypothyroidism but stopped taking it and no reviews took place. Nothing happened until 2011 when he consulted another doctor and was prescribed testosterone which was effective for his hypothyroidism. He then brought a claim in 2015 against the Hospital as an institution and against the doctor, whom he consulted privately, who was now in his late 70s and retired. The basis of the claim was failure to recall and review C and advise on the taking of the medication. On determination of limitation as a preliminary issue the Recorder found that C had the requisite knowledge to bring a claim in 1983 so the claim was time barred. Upon C's application to disapply the limitation period under s.33 LA the Recorder refused to disapply against the doctor, but disapplied against Hospital. The Hospital appealed. The CA held that the Recorder had erred in the exercise of his discretion in two ways:

(a) Failing to take into account the merits of C's claim. The Recorder felt he had to assume the claim had merit when in fact it was inherently weak on causation because C had twice been prescribed testosterone and had failed to adhere to it.

(b) The Recorder was wrong to draw a distinction between the doctor as an individual, who would have to face the stress of litigation at his age, and the Hospital as an institution. The difference between an institution and an individual was not itself something which could affect the exercise of the discretion.

Having found the Recorder's reasoning to be flawed the CA exercised the discretion afresh and had no difficulty in refusing to disapply the limitation period due to the long period of delay and the fading of memories and that the complete medical records for the relevant period were no longer available.

## Procedure

15. *Peterborough & Stamford Hospitals v McMenemy* [2017] EWCA Civ 1941.

In conjoined appeals the CA determined how the recovery of ATE premiums in clinical negligence claims to which C would have the benefit of QUOCS protection. The CA was concerned with cases where solicitors to took out ATE insurance at the same time as entering into a CFA and the claim settled before the issue of proceedings and before any expert reports had been obtained. The ATE premiums were typically about £6,000, whilst the claims settled very early for relatively modest sums even as low as £2,500. The CA held:

(a) The CPR applied to the recovery of ATE premiums, it was not something that Parliament had left to market forces as C submitted;

(b) The trumping principle of proportionality in the recovery of costs in CPR 44.3 applied;

(c) D's argument that ATE premiums could not be recoverable in QUOCS protected claims was not upheld, it remained the position as before QUOCS that the reasonableness of taking out ATE insurance was to be considered on a case by case basis. The ATE insurance was not only against liability for D's costs but also his own disbursements on expert fees.

(d) The ATE premiums appeared high, but they were a basket and similar premiums covered cases of higher value with high expert fees. In general it was reasonable for solicitors to enter into ATE insurance at the same time as a CFA.

(e) The Rules Committee was invited to reconsider its view that guidance on the recovery of ATE premiums in clinical disputes was not necessary.


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