Medicolegal

Negligence through loss of chance

CLARE DYER

Can a plaintiff in a negligence case win damages for the loss of a chance or an opportunity—for instance, a less than 50% chance that quick medical treatment might have prevented permanent disability? Yes, ruled the Court of Appeal last month in *Hotson v East Berkshire Health Authority*, unanimously dismissing the health authority's appeal.

The case, which may go to the House of Lords, raises what the Master of the Rolls, Sir John Donaldson, described as a novel point on damages in the law of tort. Although there are several precedents for awarding damages for the loss of a chance where a claim is based on breach of contract, the health authority argued that there is no authority for doing so where a plaintiff sues in tort.

Nearly 10 years ago, in April 1977, 13 year old Steven Hotson was swinging from a rope when he dropped 12 feet on to muddy ground, landing on his seat. He suffered an acute traumatic fracture separation of the left femoral epiphysis, but this was not diagnosed when he was taken to St Luke's Hospital, Maidenhead, because no radiograph was taken of his femur or hip. A radiograph of his left knee showed no injury, and he was given an elastic knee bandage and told to return in 10 days if necessary. "I draw a veil over the next five days, during which the plaintiff suffered excruciating pain and received scant sympathy and no real treatment from his general practitioner," said the Master of the Rolls in his judgment. His general practitioner, who thought he was exaggerating his injury and trying to avoid school, simply prescribed tablets. The general practitioner and his partners were additional defendants, but the claim against them was settled before the trial.

Five days after the accident Steven Hotson was taken back to St Luke's, where he was re-examined and a radiograph of his hip was obtained. He was given emergency treatment by traction and manipulation under general anaesthesia, and the fracture was reduced and pinned. However, he developed avascular necrosis with resultant distortion and collapse of the epiphysis, producing increasing deformity of the left hip. By the age of 20 there was severe shortening of the left leg resulting from the severe flexion and adduction deformity of the hip; this was causing spinal deformity that was thought likely to become permanent. There was pain and discomfort in the left knee and hip and, increasingly, backache. Osteoarthritis was inevitable.

Expert witnesses disagree

How likely was it that immediate diagnosis and treatment would have prevented permanent disability? The expert witnesses disagreed, but in the high court Mr Justice Simon Brown made four findings of fact, all of which, for the purposes of the appeal, the health authority accepted: that even had there been a correct diagnosis and treatment on the day of the accident there was a 75%

chance that the injury would have followed the same course; that the defendants' delay denied the plaintiff the 25% chance that avascular necrosis would not have developed; that the reason for this was that the delay allowed the pressure caused by haemarthrosis to compress and thus block the intact but distorted remaining vessels; and that had avascular necrosis not developed the plaintiff would have made a nearly full recovery. The judge awarded the plaintiff £11 500—25% of the £46 000 the injury would have been worth on a full liability basis—plus £150 for pain and suffering.

The authority's argument was simple: damages can be recovered only if a plaintiff establishes that his loss flowed from the defendant's negligence. The standard of proof is the balance of probabilities—in other words, more than 50%. In this case the plaintiff only proved that it was 25% likely that the delay in treating his injury had permitted the avascular necrosis to occur. Therefore he could not establish that any loss flowed from the delay.

Judgment in the Court of Appeal

Giving judgment in the Court of Appeal, the Master of the Rolls said that the health authority's argument was undoubtedly based on well settled principles of law. But what was the loss on which the plaintiff relied? It had been described as "the chance of avoiding avascular necrosis and its consequences." It was the use of that description with its references to chances that had confused the issue. In his view, he said, the essence of the plaintiff's claim was that he had lost any *benefit* that he would have derived if, on his first visit to the hospital, he had received the treatment he received on his second visit. Counsel for the health authority had submitted that the loss of the benefit of early treatment could not give rise to damages when all that could be proved was a chance that it might be successful, because damages in tort are confined to compensating proved financial or physical losses and the loss of a chance was neither. But, as with the categories of negligence, which are said never to be closed, his lordship said he could see no reason why the categories of loss should be closed. As a matter of common sense it was unjust that there should be no liability for failure to treat a patient simply because the chances of a successful cure by that treatment were less than 50%.

Concurring, Lord Justice Dillon said that the fundamental question was: What was the damage that the plaintiff suffered? Was it the onset of avascular necrosis or the loss of the chance of avoiding that condition? In his opinion it was the latter. If counsel for the health authority were right, and a patient's chance of being cured of his ailment or avoiding a further deterioration in his condition were lost through a negligent failure of the doctor to examine him properly or diagnose correctly, with the result that the treatment that alone might have saved the patient was not undertaken, the patient would have no remedy unless he could show that the chance that the treatment would prove successful was more than 50%.

Lord Justice Croom-Johnson, also concurring in dismissing the appeal, said that the defendants were alarmed at the thought that if the loss of a chance of getting better should be capable of being "damage" sufficient to found a cause of action based on medical

negligence it would open the floodgates to many actions where in the end no harm had followed. He did not think that alarm was justified. In the first place, a mere statistical chance would not be enough. The chance must be something lost to the individual patient. Secondly, the chance that something might go wrong was normally subsumed in the eventual result. If no harm was caused in the end the plaintiff would have suffered no damage, even if at one stage in his treatment there was a risk that things might go wrong.

The health authority has until 12 December to decide whether to

petition the House of Lords for leave to appeal. Hempsons, the solicitors for the Medical Defence Union, who conducted the authority's case, believe the Court of Appeal's ruling could have far reaching effects. "Whether or not the case goes to appeal, the view is that there are likely to be many more cases brought against doctors where it can be alleged that a chance has been lost," said a spokesman. Examples might include cases in which a doctor has negligently failed to diagnose an early cancer, when a patient could argue that he was denied the chance of a possible cure.

Medicine and the Media

BBC 2 has started a monthly series, *Antenna* (1 December), that aims at tackling thought provoking stories generated by science and technology. One of the three items in the first edition, produced by David Dugan, investigated the problem of dismantling old nuclear reactors; the two others were medical. The first tackled (yet again) education on the acquired immune deficiency syndrome (AIDS)—what and how to tell the public.

Excerpts from three European commercials were shown. These were fascinating visually but would have been more useful with subtitles. Better still would have been films from English speaking countries and some critical discussion on how other countries have run AIDS campaigns.

Antenna had commissioned a short film from an advertising agency, Young and Rubicam. A young man is seen in bed with two women in quick succession. When asked "Whom are you sleeping with? Whom did you sleep with last night? Who slept with her last night? How do you get AIDS?", he answers repeatedly "I dunno." He ends up in hospital; a doctor is asked how to save him: "I dunno." David Miller, the agency's managing director, and Professor Caxon, director of the social research unit, Cardiff, and a member of the Department of Health and Social Security AIDS committee, then discussed with Dr Susan Blackmore, *Antenna*'s presenter, how to approach the public. David Miller was certain that advertisements should concentrate only on practical possibilities. He had targeted his film at the heterosexual community to reduce promiscuity and to tell them to wear condoms if they have more than one partner.

This programme, like most on AIDS, could not avoid the ponderous but was redeemed by the pith of the advertising film, which may have reached 10 million people because it was included minutes later on the nine o'clock news.

The second medical item, "Life at Any Price," discussed when to continue or withhold treatment in a special care baby unit. There were gruesome yet sensitive scenes of discussions between Dr Andrew Whitelaw and his team at Hammersmith Hospital while they cared for a brain damaged twin and talked to her parents.

Dr Whitelaw's views are criticised by pro-life lobbies. Dr Koop, the United States Surgeon General who urged President Reagan to ban withdrawals of medical treatment, had visited Britain and claimed that whatever the handicap a child still becomes an asset to a family; Dr Whitelaw thought this rare. We were shown several brain damaged children whose mothers agreed that if they had been asked whether the ventilator should have been turned off they would have said yes. One mother claimed that she would not have been in a fit emotional state then to make such a decision and that months later she and her husband were glad to have their own baby, despite the brain damage. These issues are complex and unanswerable, but it might have been helpful to have an ethicist or better still a lawyer explain the differences between murder and manslaughter, and more precisely to distinguish legally between not feeding a baby and not using, or stopping, extraordinary means of survival.

More please, *Antenna*—J H BARON, consultant physician, London.

CULTURE AND sensitivity are not confined to the bacteriology laboratory—as was shown by a recent *Open Space* programme (BBC2, 4 December) on racism in the National Health Service. The film was introduced and narrated by two doctors—Dr Malila Noone and Dr S P Sashidharan—who last year became the first doctors to win cases against health authorities at industrial tribunals on grounds of racial discrimination in consultant appointments. The programme looked at more than these individual cases, but at least one painful disclosure came from Dr Sashidharan's case: in opposing his appointment, one consultant member of the appointment committee is reported to have said that the candidate was "very Asian" and that "there was no significant Asian population for him to serve in Cambridge."

Considering that the NHS has relied for decades on workers from the New Commonwealth, among whom there has been an undercurrent of discontentment over advancing job prospects, it is surprising how long it has taken for television to take up the issue. Perhaps the attraction was that the profession is not often seen to be on "self destruct" on such primal topics as racial prejudice. As Dr Sashidharan pointed out, doctors tend to handle their affairs with discretion and don't often wash their dirty linen in public. It is disconcerting therefore that doctors are driven to seek legal redress.

Nevertheless, doctors are no more immune than other groups to court rulings—and the days of assessments of candidates by subtle criteria implying no direct racial delineation may be over. Cultural suitability to an appointment is not measurable nor probably even defensible—and certainly the observations during the programme by one previous member of appointments committees that some candidates' applications were sometimes discarded simply because their names were foreign was nauseating. He pointed out that appointees often tend to be in the appointer's "own image and likeness" and need to "fit in." Is it possible that hospitals able to appoint more European staff are considered more prestigious, against a backdrop of half of all juniors coming from overseas?

One of the disadvantages of the programme was that it did not examine the difficulties faced by appointment panels in picking the right candidate, and it did not attempt to redress the balance by asking health authority personnel about apparent discrepancies in their career structures. Other explanations as to why there are fewer black nurses higher up the career structure would have been welcome.

The irony of the programme was that, although both presenters proved their point, they were still without consultant jobs. Dr Noone even showed letters from well meaning medical friends who had advised against legal action in case her career prospects became jeopardised. Perhaps we do run a closed shop after all.—PALI HUNGIN, general practitioner, Eaglescliffe, Cleveland.