Causation for nursing

Abstract

This article considers the application of the tests of factual and legal causation to cases of medical negligence. It is argued that in light of the recent development of a number of exceptional approaches to factual causation, each relating to a particular causal problem, the causal process must be identified in any given case so that the correct test for factual causation can be applied. This is illustrated by reference to MRSA claims. It is further argued that where the negligence consists of misdiagnosis or mistreatment of existing illness the causal problem is unique to medical negligence and demands a unique approach to causation.

The 'scope of duty' test for legal causation is illustrated in a medical context and it is argued where the negligence consists of a failure to warn the patient of the risks involved in treatment, although the harm is clearly within the scope of the doctor's duty, it is wrong to establish liability in the absence of factual causation.

Introduction

The Court of Appeal recently affirmed the position that the courts 'cannot draw a distinction between medical negligence cases and others',[1] so the law in relation to causation is the same in medical negligence cases as any other type of case. The causal problems that arise, however, are often more complex in medical negligence cases, so it may be necessary to divert from the standard approach more often.

The causal enquiry is the third stage in a negligence claim after establishing that the defendant owed a duty of care to the claimant and that he breached this duty, and consists of two aspects. The first is factual causation which addresses the question of whether the defendant's negligence had a 'historical involvement' in the occurrence of the harm. Legal causation then addresses whether it is appropriate to consider this factual cause to be responsible for the harm. Each of these aspects of causation raises interesting issues in the medical context, some of which will be considered in this article.

Factual causation: the standard approach

The standard approach to establishing factual causation is to ask whether 'but for' the defendant's negligence the harm would have occurred. If the harm would have occurred even in the absence of the negligence, then the defendant will not be liable. The classic illustration of the so-called 'but for' test is the case of *Barnett v Chelsea and Kensington*

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[1] *Bailey v Ministry of Defence* [2008] EWCA Civ 883

Hospital Management Committee.[2] The claimant in this case was sent away from hospital and told to see his GP in the morning, but died a few hours later from arsenic poisoning. The hospital had been negligent in sending him away, but evidence established that even if he had been seen by the hospital, any treatment would still have been too late to save him. Therefore the negligence did not cause the harm, so the defendant was not liable.
It will often be impossible to say with certainty whether the defendant's negligence was a cause of the harm and the law uses the balance of probabilities standard of proof to cope with this uncertainty. So the question becomes whether it was *more likely than not* that the harm would have occurred 'but for' the defendant's negligence.

Factual causation: different approaches for different causal problems

A number of different approaches have been developed to deal with more complex causal problems. In a recent case a hospital caused weakness to a patient through negligently failing to resuscitate her properly after an operation, and through nobody's fault the patient also suffered pancreatitis which led to weakness. The court was able to say that both sources of weakness made a 'material contribution' to her overall weakened state, which in turn led her to aspirate her vomit and suffer brain damage.[3] So the hospital's negligence was a cause of the brain damage even though it was not possible to measure the precise contribution it made to the weakness. This is because weakness is something that will gradually worsen the more strain is placed on the body, so both sources of weakness were necessary for her to be weak to this extent.

In contrast to this, in *Wilsher v Essex Area Health Authority*,[4] the hospital's negligence led to a premature baby receiving an excess of oxygen which was known to carry a risk of a condition called retrolental fibroplasia (RLF) which leads to blindness. The baby also suffered from four other conditions which can occur naturally in premature babies which also carry a risk of RLF. The crucial difference between RLF in this case, and the weakness in the previous case, is that unlike weakness RLF is not caused by a cumulative effect but can have just one cause. This meant that the court could not say that the negligence made a 'material contribution' to the harm.
However, cases do arise where the 'one cause' can be known but there are various sources of this harmful substance, for instance cases where a victim suffers from

[2] [1969] 1 QB 428
[3] *Bailey v Ministry of Defence* [2008] EWCA Civ 883
[4] [1988] 1 AC 1074

mesothelioma, which is definitely caused by asbestos, but the victim has been exposed to asbestos by the negligence of several previous employers. The courts can then find liability on the basis that a defendant who exposed the claimant to asbestos made a 'material contribution to the *risk* of harm' even though other defendants also exposed him to asbestos and it is impossible to say which asbestos fibre was the 'guilty' one.[5] But with the RLF where there was one cause, it was not known whether it was oxygen or one of the other conditions that was the cause that led to the RLF, so the court was not willing to exceptionally accept that the negligence had made a 'material contribution to the risk of harm'.

The importance of understanding the causal process

The law on causation is currently facing a significant challenge due to the number of approaches to establishing factual causation that have been developed in response to evidential difficulties. Each of the tests outlined above corresponds to a specific type of causal problem and it is essential to identify which type of scenario is involved so that the correct test can be applied.[6] This may be particularly relevant in the future, for example, in the realm of MRSA claims. If the negligence involves a failure to diagnose or treat the infection then, like in *Barnett*, the normal 'but for' test can be applied to establish whether the negligence has made a difference to the outcome. The situation is less clear, however, where the negligence may actually have caused the patient to become infected in the first instance. There is clearly a background risk of MRSA for any patient, but if the negligence of a hospital has led to higher levels of bacteria and therefore a greater risk of infection, then a patient who contracts MRSA may seek to establish that their infection was caused by the hospital's negligence. Given the method by which bacteria reproduce, it seems that the infection can be caused by one single bacterium, and it seems unlikely that science enables the identification of the 'guilty' bacterium and its source. The causal process therefore has strong similarities with the asbestos case considered above and the patient would therefore have to persuade the court that the 'material contribution to risk of harm' test for causation is appropriate to use in such circumstances. It has been suggested though that courts could distinguish MRSA claims on the basis that it is still not possible to say for certain that the patient came into contact with the negligently

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[5] *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 2

[6] Jones, 'Proving Causation – beyond the "but for" test' (2006) 22 PN 251

created bacteria, whereas it was possible to say that the mesothelioma victim had definitely come into contact with asbestos (the unknown element in the case of asbestos being the actual physiological process that then occurred inside the lungs).[7]

This seems to suggest a need for science to clearly explain causal processes in a way that corresponds to the legal tests. There is one area, however, where arguably the law still needs to adapt to reflect the scientific understanding of the causal process. Where a patient is already ill and the medical negligence lies in a failure to diagnose or treat the existing illness and the patient subsequently fails to recover, the courts apply the normal 'but for' test. This means that if the patient's recovery rate was less than fifty percent the court must conclude that, on the balance of probabilities, he was doomed before the negligence, so the negligence has made no impact and there is no liability. It has been argued alternatively that the patient should be able to recover a proportion of the compensation to represent the 'chance' that he has lost, but the courts have rejected this argument so far.[8] This 'all or nothing' approach to compensation has been criticised though as not reflecting the medical reality that in such cases the doctor can never be the sole cause of the outcome because the initial illness was also necessary.
It has been argued that 'medical negligence cases involving therapeutic treatment present difficulties of multiple causation as a matter of routine. Two candidate conditions are automatically present: the patient's condition, which represents a deviation from the standard physical condition of human beings, and the doctor's breach of duty'.[9] Even with medical negligence the harm cannot occur without the illness also existing.
This is therefore an area where a novel approach to causation may be required to address this problem that seems to arise uniquely in a medical context.

Legal causation: defining the scope of the duty.

Finally, once factual causation has been established, it is necessary to consider issues of 'legal causation' to determine whether the defendant's negligence *ought* to be considered a cause of the harm. The current approach to legal causation involves determination of the 'scope of the duty'. In a case outside medical negligence, Lord Hoffmann drew on a

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[7] Plowden and Volpé, 'Fairchild and Barker in MRSA cases: do Fairchild and Barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?' [2006] J.P.I.Law 259, 264
[8] *Hotson* v. *East Berkshire HA* [1987] A.C. 750; *Gregg* v. *Scott* [2005] U.K.H.L. 2.
[9] M. Stauch, 'Causation, Risk and Loss of Chance in Medical Negligence' (1997) OJLS 205, 213-4.

medical example to illustrate the concept of 'scope of duty'.[10] He considered a situation where a mountaineer about to undertake a difficult climb is examined by his doctor and negligently advised that his knee is fit for the climb when in fact it is not, and later suffers an injury that is an entirely foreseeable consequence of mountaineering but in no way related to the state of his knee. Although he would not have gone on the expedition if he had been given the correct information about his knee, so would not have suffered the other injury 'but for' the doctor's negligence, the doctor would not be liable because such an injury is outside the scope of the duty that he has to his patient because it is unrelated to the state of the knee. More recently, the Court of Appeal applied this approach to an instance of medical negligence. A baby developed a spot which developed into an abscess shortly before he was due to have a series of immunisations against various diseases including polio. His parents were concerned about whether he should still receive the immunisations and were negligently advised by the doctor that there was no reason to cancel them. Following the immunisations, the baby had to have the abscess lanced under general anaesthetic and subsequently caught polio as a result of having had the polio vaccine. Although the doctor had been negligent to warn the parents that the baby may have to undergo surgery for the abscess, it was held that this was because a reasonable doctor would foresee the possibility that an adverse reaction to the immunisations could cause the baby discomfort at a time when he would be in discomfort from surgery, or that the surgery could weaken the effect of the vaccinations. It could not reasonably be foreseen that the baby would catch polio. This harm was therefore outside the scope of the doctor's duty. So although as a matter of factual causation the negligence was a 'cause' of the baby catching polio, the doctor was not liable because the harm caused was outside the scope of his duty. This therefore highlights the importance of understanding not only whether a defendant's conduct is that of a reasonable doctor or nurse, but also *why* the reasonable doctor or nurse would act a particular way.[11] In other words, what are the foreseeable risks that the reasonable nurse would guard against in any given situation?

One further case merits attention for the unorthodox approach taken to factual causation on the basis of arguments as to the scope of the duty. In *Chester v Afshar*[12] the defendant neurosurgeon carried out an operation on his patient without negligence, but had

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[10] *South Australia Asset Management Corporation v York Montague Ltd* [1997] 3 All E.R. 365

[11] Post, 'Legal Causation: the neglected sibling', [2007] J.P.I.Law 15

[12] [2005] 1 AC 134

negligently failed to warn her of a 1-2 percent risk of paralysis which was inherent in the particular procedure and which materialised on this occasion. If the patient had been able to say that she would have refused the operation if she had been warned of this risk, then clearly 'but for' the doctor's negligent failure to warn her of the risk, she would not have undergone the operation and would not have suffered the harm. Unfortunately the most the patient was able to say is that she would not have undergone the operation on that particular day, but after seeking further advice may still have decided to take the risk and undergo the operation on a different occasion. An orthodox application of the 'but for' test would therefore have found that a causal link was not established, but the House of Lords exceptionally applied the but for test narrowly and found that causation was established on the basis that 'but for' the negligence, the harm would not have occurred *on that day*. The court effectively took arguments relating to the scope of the doctor's duty as a starting point to justify a finding of liability in the absence of a causal link. It was said that the doctor's duty to warn 'ensures that due respect is given to the autonomy and dignity of each patient'.[13] Lord Hope further stated that the 'function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content'. Yet this statement omits to recognise that causation of harm is central to the tort of negligence whose function is more generally accepted as being a system of individual responsibility. As Lord Bingham argued, the 'patient's right to be appropriately warned is an important right, which few doctors in the current legal and social climate would consciously or deliberately violate. I do not for my part think that the law should seek to reinforce that right by providing for the payment of potentially very large damages by a defendant whose violation of that right is not shown to have worsened the physical condition of the claimant'.[14] So although the outcome is questionable in its approach to causation, it serves to emphasise the perceived need to protect the rights of patients and to ensure that the duty to warn is acted upon.

These are only some of the challenges currently facing causation and it is to be hoped that the law can respond appropriately to the medical realities.

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[13] Per Lord Steyn at para 18

[14] At para 9