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Causation in clinical negligence

Claim for loss of chance fails

Gregg v Scott is a case on causation and more particularly a claim for loss of chance of a better outcome. The outcome was a success for the defendant in the House of Lords. It has been established that the claimant must prove on the balance of probabilities that the breach caused the injury complained of. This was a welcome decision for doctors and the NHS following the case of Chester-v-Afshar with a return to the principles in Hotson that is, the claimant must prove on the balance of probabilities that he would have survived but for the delay in correct diagnosis.

The facts

Briefly the facts are that Mr Gregg went to his GP, Dr Scott, in November 1994 complaining of a lump in his armpit. Scott examined and palpated the lump but thought it a typical lipoma or benign fatty tumour. Some months later, Gregg went to a new GP with the same complaint and was referred to a surgeon. The lump was diagnosed as a malignant tumour, a form of non-Hodgkin's lymphoma. Due to misdiagnosis treatment was commenced nine months later than it should have been.

It was held that Dr Scott was negligent for two reasons; firstly the positioning of the lump which was centrally in the axilla and which was more consistent with a node than a lipoma and secondly as the lump was found to be a node it could not have been as Scott had described it.

Court decisions

At first instance, and in the Court of Appeal the defendant doctor was successful. In terms of causation it was found that the tumour was in the majority of cases untreatable. Even if Dr. Scott had made a correct diagnosis, there would only have been a 42% chance of remission and avoiding

relapse. This chance had dropped to 25% by the time of referral to a specialist but it was held that damages were not available in English law for a claim based upon loss of chance of a better outcome.

In the House of Lords the claim for loss of chance failed by a majority of 3:2 and the appeal was dismissed with costs. The reasoning put forward was that allowing the appeal would have a huge impact on the fabric of common law with unpredictable consequences. There were also possible financial implications to the NHS. There would be an impact on all clinical negligence cases and a departure from the traditional and sanctioned "but for" test. Finally, areas of forensic dispute would increase where presently there is a consensus (e.g. the need to assess precisely how probable a given outcome was).

Implications of Gregg v Scott

The position remains that where causation is determined in favour of the defendant (even by just 51%) the claimant can recover in full. Where the claimant is unable to make out his case on a balance of probabilities, the claim will fail altogether.

However it must be stressed that claimants may still claim for damages for injuries which have resulted on the balance of probabilities from the delay – such as for the pain and suffering caused by more extensive treatment than was otherwise required, or for an acceleration in the claimant's condition including a reduction in life expectancy. However, in order to claim for damages flowing from a loss of life expectancy, claimants will have to prove that their chances of survival have been reduced to below 50% as a result of the negligence to succeed.

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Fitness to Practise

Regime change at the General Medical Council

Many important changes to the way in which the General Medical Council (GMC) handles complaints about doctors came into force last November. The new procedures are known as the Fitness to Practise Procedures (FTP). Issues of conduct, health and performance now all come under the new fitness to practise umbrella.

Amalgamation

The Professional Conduct Committee, the Committee on Professional Performance, and the Health Committee have been replaced by a single Fitness to Practise Panel which will adjudicate on whether a doctor's fitness to practise is impaired and will have power to impose a range of sanctions.

The new fitness to practise system will amalgamate aspects of the old procedures whilst providing a less structured and compartmentalised approach to cases. Indeed, it is anticipated that most hearings will involve investigation of more than one type of allegation (conduct, performance, or health). The new approach allows much more flexibility and will not require the GMC to pigeon-hole cases at an early stage. One improvement from the point of view of defendants is that they should no longer be faced with the prospect of different allegations being pursued in separate proceedings.

New test

The old test of 'serious professional misconduct' has been replaced by a new test: impaired fitness to practise. Under Section 35(2) of the Medical Act 1983, impairment can be by reason of any or all of the following:

- misconduct
- deficient performance
- a criminal conviction or caution in the British Isles (or elsewhere of an offence which would be a criminal offence if committed in England or Wales)
- physical or mental ill-health
- a determination by a regulatory body either in the British Isles or overseas.

Investigation

It is intended that greater investigation is carried out at the early stages of a complaint; indeed, we are already seeing this in practice. The current screening and Preliminary Proceedings Committee stages have been abolished and there is now one single investigation stage.

On receipt of initial information about a doctor by the GMC which raises concerns about a practitioner's FTP, consideration will be given by the Investigation Officer as to whether the information constitutes an allegation that FTP is impaired. Complaints are subject to a five year limitation period although there is discretion to put the case forward where there is a clear public interest in doing so.

The GMC has powers to make enquiries in order to investigate whether a doctor's fitness to practise is impaired. All complaints which overcome the initial hurdle and are passed on to the Investigation Officer will now be disclosed to a doctor's employers and feedback sought from those employers. This is designed to ensure that the GMC have all relevant information about that particular doctor. The GMC is especially concerned that it should know about any pattern of behaviour (viz Shipman). It is also envisaged that information from the GMC about the doctor will feed into the employer's clinical governance processes.

Once information has been received from employers (and potentially others), the Investigation Officer will determine whether the complaint constitutes an "allegation" (as defined above). If it meets this test, the complaint will be passed on to the case examiners. Otherwise the case will be closed. The Investigation Officer also has a significant power to direct that an assessment of the practitioner's performance or health is carried out.

Doctors will have a chance to comment on the complaint once a decision has been taken to send the case to the case examiners and there is provision for earlier submissions to be made.

Consideration is by a medical and a lay case examiner who must reach a decision jointly. This is a new requirement. If a joint decision is not possible, the case will be referred to the Investigation Committee for consideration on the papers. At the case examiner stage, the medical and lay case examiner may decide to:

- conclude the case
- issue a warning or to refer the matter to the Investigation Committee to consider whether or not to issue a warning; or
- refer the case for adjudication before a Fitness to Practise Panel.

The test which the case examiners must consider is “the GMC’s duty to act in the public interest, which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic prospect of establishing that a Doctor’s fitness to practise is impaired to a degree justifying action on registration.”

All convictions resulting in the imposition of a custodial sentence, whether immediate or suspended, are referred directly to a FTP panel.

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Negligent Associates: lessons for practice owners

RadcliffesLeBrasseur acted for a practice owner who was the Defendant in a claim for damages brought by a former patient who alleged that dental treatment she had received from one of the Defendant’s Associates was negligent. The Defendant had professional indemnity cover, but indemnity in respect of this claim was refused on the grounds that the relevant insurance policy did not include the acts of another dentist. The Defendant was therefore faced with funding his defence out of his own funds and also, if unsuccessful, costs and damages of the Claimant.

Background to the case

The Defendant was the owner of a dental practice, but was at the time unable to practise clinical dentistry due to ill health. In January 2000 the Defendant engaged the services of an Associate to work at his practice.

The Associate treated the Claimant in January 2000 and subsequently ceased working at the Defendant’s practice and moved abroad.

The Claimant claimed damages for alleged negligent dental treatment performed by the Associate and in her claim contended that the Associate was employed by the Defendant who was hence vicariously liable for the acts and omissions of the Associate.

The Defendant denied that the Associate was an employee but rather a self employed Associate, responsible for his own acts and omissions, required to have his own professional indemnity cover.

The Associate had originally been a Defendant in the proceedings, but proved to be untraceable. It also transpired that the Associate did not have professional indemnity cover whilst treating the Claimant as he had previously informed the Defendant he had.

At the trial of the preliminary issue as to whether the Defendant was vicariously liable for the act and omissions of the Associate, evidence was given by the Claimant, Defendant and the Defendant’s practice manageress.

The Defendant’s evidence was that he had verbally agreed the terms of engagement with the Associate when he had met him prior to his commencing work. The Associate was to work at the Defendant’s practice on a self employed part time basis with the hours worked and holiday taken at his own discretion. He would be paid directly for all NHS and Private patients and would be responsible for paying the Defendant a percentage of all fees earned. The Defendant’s evidence was also that he had no control over the clinical treatment provided by the Associate.

The Claimant argued that the true position was that the Defendant did set the hours worked by the Associate and did decide what holidays he took. Further evidence that the Associate was employed was that the Defendant provided all the equipment used by the Associate, together with the premises and ancillary staff. The patients, and hence the goodwill of the patients treated by the Associate were the practice’s; not the Associates. The Claimant also contended that the Defendant’s early financial offer of compensation to try and resolve the complaint was evidence that he was an employer as was the fact that the Associate was temporarily suspended from working by the Defendant when he became aware that contrary to his previous assertions he did not have professional indemnity.

The Defendant supported his arguments by reference to a legal test that focuses on whether the person is engaged to provide his own work and to be subject to control; it was agreed that the Defendant had not imposed such “control”. Reference was also made to a case in which the court had held that there was no clearer example of an independent contractor than a general medical practitioner.

The Claimant placed reliance on a case in which it was found that an Associate who had a standard written Associate Agreement was an employee. The Agreement contained specific terms regarding the hours worked, holiday entitlement and post termination restrictive covenants.

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Findings

The Judge found that the Defendant's Associate was not engaged by the Defendant as an employee but rather as a self-employed Associate. He considered that but for the fact the Defendant owned the practice in question none of the facts as he found them pointed to an employer/employee relationship. He found that the Associate set his own hours of work and decided what holidays he took. The Associate had his own patients and was not supervised in any way by the Defendant. He was also paid directly by the patients or by the National Health Service.

Accordingly, the Judge held that the Defendant was not vicariously liable for the acts or omissions of the Associate and the Defendant was awarded his legal costs.

But what if ?

It would be dangerous to regard this case as a precedent for the status of an Associate as it clearly turned on its own facts. Would perhaps the outcome have been different if:

- the Associate had a written agreement containing written terms of engagement?
- the Defendant had been at the practice and closely supervised the Associate?
- the Associate did not receive his fees directly?

Implications

Whilst in the usual course of events a claim in dental negligence is brought against a treating dentist, there is the rare occasion such as this, where an Associate may be untraceable or unindemnified. In this situation a Claimant may bring a claim against a practice owner. The question that remains is whether practice owners should ensure that they have appropriate indemnity to cover this albeit unlikely eventuality.

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