BRIEFING

MEDICAL LAW

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INTRODUCTION

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The up and down life of (semi) lockdown rumbles on. If you want a break from slack chats, remote court hearings and virtual quiz nights for a few moments, we have another 1CL Medical Law briefing for you.

Ella Davis looks at the approach taken by courts where the Defendant's breach creates a lacuna in the evidence. The court will take a more benevolent approach to the Claimant's case / evidence in such a scenario, but It is not all plain sailing for Claimants – they have hurdles to pass, and Ella explores this.

Susanna Bennett reviews the recent decision in *Bradfield-Kay v Cope* [2020] EWHC 1351 (QB) and the application of *Bolam / Bolitho*. This test is so fundamental to clinical negligence cases it is always worthy of comment when there is a judgment dealing with it. Let's face it, at one time or another we have all sat across the table from an expert (whether for the Claimant or Defendant) where they have been unshakeable in their opinion that there has/has not been a breach of duty, but getting to the bottom of their reasoning (or even scratching the surface of their reasoning) causes problems. *Bradfield-Kay v Cope* is a timely reminder to exercise caution in such cases.

EVIDENCE AND BENEVOLENCE

ELLA DAVIS

An issue that arises often in clinical negligence claims is how the court resolves issues in the face of a lack of evidence when that lack of evidence is the result of the defendant's breach of duty.

In such circumstances claimants often cite the Court of Appeal's decision in *Keefe v Isle of Man Steam Packet Co Ltd [2010] EWCA Civ 683*. The claimant worked in the galleys of ships, including some owned by the defendant. He suffered hearing loss which he attributed to excessive noise on the ships. The judge dismissed his claim on the basis that the claimant had not proved he had been exposed for periods over 8 hours to noise levels in excess of 85 decibels. The judge also found that the defendant was in breach of duty in failing to take any measurements of noise levels in its ships. The Court of Appeal, in overturning the judge's finding of fact, held that he did not appear to have given any weight to the important factor that the claimant's difficulty of proof was caused by the defendant's breach of duty. In such circumstances the court should judge the claimant's evidence benevolently and the defendant's evidence critically. Further, a defendant who has, in breach of duty, made it difficult or impossible for a claimant to adduce relevant evidence must run the risk of adverse factual findings.

These principles were recently considered in the clinical negligence context in two 2019 cases. The first was *ZZZ v Yeovil District Hospital NHS Foundation Trust [2019] EWHC 1642 (QB)*. X had been involved in a car accident with Z. Z settled X's personal injury claim and then sued the hospital trust arguing that its breaches of duty had contributed to X's spinal injury. T he judge (Garnham J) found the defendant had breached its duty in failing to treat X on the assumption that she might have suffered a spinal injury and failing to take the full range of spinal precautions to ensure as far as possible that she did not move her spine. The judge found that X's spine was not moved to any significant degree and that therefore Z could not establish causation by direct evidence. Further the judge found on the basis of the medical evidence that the damage to the spinal cord was complete at the time of the accident and that the paralysis which X later suffered was inevitable from the moment of the collision. At that point the spine was locked in a contorted and extended position which caused pressure and continuing damage. Her condition worsened not because of additional trauma but because of structural and chemical changes occurring in the spine. There could not have been an event in the hospital which caused or contributed to the injury.

Z argued that it could still prove causation by analogy to *Keefe*. It was argued that because, breach of duty, no proper neurological examination was carried out, the court should be willing to accept at face value a nursing assessment which said that X had normal lower limb power on admission. The judge rejected that argument. There was hard scientific evidence that lower limb function would not have been normal. Further, in "sharp contra-distinction" from *Keefe*, there was, as above, evidence which explained the deterioration in limb condition.

The second case is *Younas v Okeahialam [2019] EWHC 2502 (QB)*. The claimant suddenly lost consciousness as a result of undiagnosed intermittent atrioventricular (AV) block. He fell to the ground and suffered a serious spinal-cord injury. The claimant alleged that that injury was caused by the defendant GP's admitted failure to refer him for further investigation in response to an abnormal ECG result obtained approximately three months earlier. The issue was whether, if he had been referred, the intermittent AV block would have been diagnosed and treated before the fall.

The claimant relied on *Keefe* in relation to the reconstruction of the diagnostic process. The judge (Rowena Collins Rice), noted that treating the claimant's evidence with benevolence does not amount to a reversal of the burden of proof. In *Keefe*, the defendant's negligence wrongly deprived the claimant of the best evidence to support causation and the Court of Appeal therefore took a benevolent approach to such positive, if second-best, evidence as there was. On that basis they found the claimant's burden of proof

discharged.

In conducting the exercise of reconstructing the diagnostic process the judge reminded herself frequently that the burden of proof remained on the claimant to propose an account of the diagnostic and treatment process that made sense and was founded and sustainable on the best evidence available. She then continued:

"46. I must also bear in mind that it is the fault of the defendant that we are having to undertake this exercise at all, and it would be unfair for the defence to seek to capitalise on the absence of the very evidential audit trail of which the claimant has been wrongly deprived. The claimant starts at a disadvantage inflicted by the defendant; it is right both that that disadvantage should not be unfairly exacerbated, and also that a degree of minimisation of the disadvantage should be looked for, to level things up as fairly as possible. That is what 'claimant benevolence' tries to achieve.

47. I cannot, however, simply assume that the diagnostic process, or any part of it, would have happened as quickly as the claimant needs it to in order to win his case. Nor can I disregard relevant evidence that is not in his favour, even in this hypothetical space. I have to build up the picture as best I can on the materials before me. Where I am satisfied that the evidence points to a decision within a range, but cannot otherwise discriminate within that range, then I should incline to the point in the range favouring the claimant. But it is the claimant's obligation to satisfy me as to that range. I must give him the benefit of the doubt, but he must persuade me to doubt in the first place. These are fine distinctions, but real ones, in conducting a difficult exercise fairly."

Applying those principles the judge accepted that, if a second ECG would have led to the diagnosis of the intermittent AV block, a pacemaker would have been fitted before the fall. She then had to consider whether the ECG would have led to diagnosis. She rejected the claimant's submission that Keefe could be relied upon without more to conclude that if the electrical signals in the claimant's heart could have been interrupted during a 72 hour ECG that they would have. However, the experts had agreed that the likelihood of there being interruptions was higher around the time of a symptomatic episode such as the one which caused the fall. The judge did therefore apply claimant benevolence to find that the ECG would have happened as close in time to the fall as was consistent with the timetable she had already found. On that finding she accepted that the ECG would have led to a diagnosis and causation was established.

It is clear that defendants must be wary of arguments that there is a lack of evidence to support a claimant's case where that lack of evidence is the result of the defendant's own breach of duty. A commonly encountered example is a failure to obtain relevant imaging. Nevertheless, a claimant in such circumstances cannot merely invoke *Keefe* to make their case on causation in the absence of any supportive evidence or, as in *ZZZ v Yeovil*, in the face of compelling evidence to the contrary. For example, it will not be sufficient for a claimant to simply make a bare assertion as to what imaging would have shown. But where there is other evidence from which the court could infer what would have been shown on that imaging, the court will likely take a more benevolent approach to that second-best evidence than it would if the defendant had not, in breach of duty, deprived the claimant of the best evidence.

THE IMPORTANCE OF BEING AN EXPERT": BRADFIELD-KAY V COPE [2020] EWHC 1351 (QB)

SUSANNA BENNETT

The recent High Court decision of *Bradfield-Kay v Cope [2020] EWHC 1351 (QB)* casts a fresh gloss on the Bolam/Bolitho test for negligence. It is a reminder to practitioners that a Court will be prepared to interrogate an expert's reasoning and come to its own conclusion.

What was the case about?

Mr Bradfield-Kay, the Claimant, underwent a left total metal-on-metal hip replacement on 18 December 2009, which was performed by Consultant Orthopaedic

Surgeon Mr Cope, the Defendant. The Claimant had previously undergone a right total hip replacement which had been successful. After the operation on 18 December 2009 Mr Bradfield-Kay did not make a swift recovery: he experienced serious pain in the left thigh and groin and ultimately developed iliopsoas tendonitis in the affected joint. He required two left hip revisions, the first of which was performed by Mr Hemmady on 15 March 2012.

Mr Bradfield-Kay brought a claim against Mr Cope on the grounds that (a) in carrying out the left total hip replacement on 18 December 2009 he had permitted the acetabular component of the prosthetic hip to be prominent, causing him to develop iliopsoas tendonitis (b) in the aforementioned operation he had used the incorrect femoral component and (c) at an appointment on 9 August 2010 he had failed to record or investigate his groin pain.

How did the Judge approach the expert evidence?

HHJ Sephton QC rejected the third limb of Mr Bradfield-Kay's claim based on the factual evidence. In relation to the first limb he heard expert evidence from Mr Chatterji, a Consultant Orthopaedic Surgeon instructed by the Claimant and Mr Manktelow, a Consultant Orthopaedic Surgeon instructed by the Defendant. Mr Chatterji had a practice focused primarily on knee replacement surgery, although he had experience of performing metal-on-metal hip replacements. Mr Manktelow's practice was focused on primary and revision hip replacements; in the latter procedures he would encounter the work of surgeons who had undertaken the initial hip replacement.

The experts agreed that if the acetabular component (the "cup" of the prosthesis) was placed too far forward, so as to protrude beyond the acetabular rim of the native bone, it could catch on the iliopsoas tendon and cause iliopsoas tendonitis, as had occurred in this case. The protrusion of the acetabular component is influenced by its orientation: ideally it should be anteverted by between 15° and 25°.

Mr Manktelow gave evidence that a number of surgeons made the error of placing the acetabular component too prominently, such that it interfered with the iliopsoas tendon. Mr Cope himself said that he had never been trained to ensure that the acetabular component did not protrude. The experts agreed that there were circumstances in which it was impossible for surgeons to prevent the acetabular component from being prominent, but that none of these applied to Mr Bradfield-Kay's case. Notwithstanding his criticism of the positioning and orientation of the acetabular component following the hip replacement procedure in this case, Mr Manktelow contended that it did not constitute a breach of duty by Mr Cope.

HHJ Sephton QC placed greater weight on the opinions of Mr Manktelow because of his expertise in the field of hip replacements (paragraph 11). He rejected Mr Manktelow's conclusion that there was no breach of duty in the light of his evidence. He states at [37]:

"Mr Manktelow, though critical of the orientation of the acetabular component, would not describe that in its own right as constituting a breach of duty on the part of the treating surgeon. I felt that Mr Manktelow did not explain satisfactorily why what Mr Cope did was not in breach of duty. He, Mr Manktelow, plainly thought that a surgeon ought to avoid prominence of the acetabular component. Although he gave evidence that there were surgeons who did not ensure that the acetabular component was not prominent, he clearly disapproved of their views, as I have pointed out earlier in this judgment. Mr Manktelow did not offer a justification or rationale for neglecting to ensure that the acetabular component was not prominent. I was left with the impression that Mr Manktelow's justification for asserting that there was no breach of duty was because he said so."

On the basis of Mr Manktelow's evidence he found that Mr Cope did not have a Bolam/Bolitho defence, because there was "no logical basis for neglecting to ensure that the acetabular component was not placed in a position that could interfere with the iliopsoas tendon" (paragraph 44). At [43] he describes the Bolam/Bolitho test:

"*...In my view, both Bolam and Bolitho require the court to examine the different schools of thought and to ask itself whether the school of thought relied upon by the*

defendant can demonstrate that its exponents' opinion has a logical basis."

Accordingly HHJ Sephton QC found for the Claimant on the first limb. He also allowed the claim on the second limb based on the factual evidence (paragraphs 47-61).

What can we learn from this?

A Court will examine the basis of an expert's opinion and, if necessary, will reject an expert's conclusions if these are not supported. A Court will also not be shy to find that an accepted practice among a body of practitioners lacks a logical basis, as in this case.

HHJ Sephton QC's comments on the Bolam/Bolitho test reveal his view that both judgments require a Court to consider whether the particular school of thought has a logical basis. They are to be regarded as one single test which a Defendant must meet.

The judgment is a timely reminder to clinical negligence practitioners that an expert's conclusions regarding breach of duty must be supported by their reasoning. It is the reasoning which a Court will interrogate and which will (if relied upon) form the basis for its decision. The fact that Mr Manktelow maintained the surgeon was not in breach of duty was not enough for the Defendant. The lack of reasoning to support his opinion was fatal to the defence. An awareness of this must inform clinical negligence practice.

Finally, the judgment is a reminder of the untold value of instructing an expert whose expertise is the procedure which is the subject of the claim. Mr Manktelow's evidence in this matter was favoured by the judge because his primary expertise (unlike Mr Chatterji's) was in hip replacements. Luckily for the Claimant his reasoning contradicted his conclusion and allowed the Claim to succeed.

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