Loss of chance: what loss?

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A recent New South Wales judgment, *Rufo v Hosking*, explored the concept of 'loss of a chance' in medical negligence claims.[1] 'Loss of a chance' claims involve an allegation that the patient lost the chance of a better outcome as a result of the negligence of the medical practitioner. This article outlines the case and discusses the implications of the judgment for medical practitioners.

Case history

Michelle Rufo, 14 years of age, was diagnosed with systemic lupus erythematosus (SLE) in January 1992. She was seen by a paediatrician who prescribed prednisolone 50 mg per day. On 3 February 1992, Michelle's care was taken over by Dr Hosking, a paediatric immunologist. Dr Hosking continued to treat Michelle with corticosteroids at varying doses depending on the activity of the SLE and, in June 1992, Dr Hosking substituted dexamethasone for the prednisolone. On 24 August 1992, Michelle experienced extremely severe back pain and was admitted to hospital. X-rays revealed vertebral body crush fractures and kyphosis. It was apparent that Michelle had developed osteoporosis secondary to the corticosteroids.

The patient (now a plaintiff) commenced legal proceedings against Dr Hosking alleging, in part, that he was negligent in failing to adopt appropriate measures to reduce the high doses of corticosteroids during the period of treatment before the plaintiff's admission to hospital in August 1992. The plaintiff and the defendant each served expert evidence from an immunologist and a rheumatologist.

The trial was heard in the New South Wales Supreme Court and judgment was handed down on 6 November 2002. The judge found that there was a failure to exercise reasonable care on the part of the defendant in early June 1992 in the following respects:

- in the failure to introduce azathioprine, and
- in the prescription of dexamethasone.

The judge then had to consider the question of causation: had the damage been proved to be the result of this negligence? The damage the plaintiff claimed to have suffered was the progression of the osteoporosis to the point of spinal fractures on 24 August 1992. The judge had to determine if those fractures would have been avoided by the introduction of azathioprine and/or if the plaintiff had not commenced dexamethasone in June 1992. Based on the expert evidence, the judge found that the plaintiff did not, on the balance of probabilities, lose the chance of a better outcome because of the failure to introduce azathioprine in June 1992. The judge also found that it was not probable that the change to dexamethasone resulted in the loss of a chance of a better outcome than had the equivalent prescription of prednisolone been continued until 24 August 1992. That is, it was likely that Michelle would have developed the crush fractures even in the absence of the negligence. Accordingly, the judge found that the plaintiff's claim must fail and judgment was entered in favour of the defendant.

An appeal against the judgment was heard in the New South Wales Court of Appeal. On 1 November 2004, the Court of Appeal set aside the judgment and entered a verdict in favour of the plaintiff. The Court of Appeal found that the plaintiff was entitled to compensation for the loss of a chance that, but for the negligence, the spinal fractures either would not have occurred, or would not have occurred at the time or with the severity of their actual occurrence. That is, the plaintiff was entitled to compensation for a loss of a chance, even though it was less than a 50% chance, of avoiding the spinal fractures. The evidence of the medical experts suggested that there was not a precise correlation between the dose of the corticosteroids and the development of the fractures.

One of the judges, Campbell AJA, concluded that although the proposition of a correlation between these two factors '... lacks the support of studies, as a matter of probabilities, I consider that it lends substantial support to a common sense view that the excess of prednisolone equivalent resulting from the breach of duty did cause a loss of chance'.

Ultimately, the Court of Appeal concluded that it was an error for the primary judge to hold the view that the increased risk was 'too speculative' to justify an award of damages. As noted by one of the judges, Hodgson JA, 'so long as such an increase is material, I think the Court is required to do its best to assess it'.

Discussion

'Loss of a chance' claims involve an allegation that the plaintiff (patient) lost the chance of a better outcome as a result of the defendant's (medical practitioner's) breach of duty of care and negligence. The patient's loss is evaluated by comparing the chances of suffering harm against that which would have existed had the breach of duty of care not occurred. Before *Rufo v Hosking*, a patient whose injury, more likely than not, would have occurred in the absence of any negligence was not entitled to an award of damages. So where negligence was found proved but the lost chance was, say, only a 45% chance of a better outcome, no damages flowed. The judgment in *Rufo v Hosking* concluded that it makes no good sense why a patient with a 50% lost chance is entitled to damages but a patient with a smaller but genuine lost chance is not so entitled. However, the patient is required to prove, on the balance of probabilities, that there did exist a chance of a better outcome had the negligence in treatment not occurred and this was a chance which would have been taken.

Risk management strategies

What are the implications of *Rufo v Hosking* for general practitioners? Up to 50% of claims against GPs involve an allegation of 'failure to diagnose'. In these cases, the patient alleges that if a diagnosis had been made at an earlier time, the patient would have had a better outcome and therefore they should be entitled to an award of damages to compensate for the lost chance of benefiting from a cure or a better outcome.

Consider the following scenario: A 40 year old man attended his GP for review of a pigmented lesion on his back. The GP advised the patient that the lesion was a benign seborrhoeic keratosis. Five months later the patient re-attended complaining that the lesion had grown and was now ulcerated. Excision biopsy revealed a Clark level 4 melanoma. The patient died from metastatic melanoma 12 months later. The patient's wife commenced legal proceedings against the GP alleging failure to diagnose melanoma at the earlier consultation. As a result of the alleged misdiagnosis, the patient's wife claimed that he had lost the chance of a cure of his melanoma. One of the questions to be determined in this case is causation: whether the patient would have survived if his melanoma had been diagnosed 5 months earlier. A medical practitioner's answer to this question would probably be: 'I don't know'. However, for the purposes of the legal proceedings, an answer to this question has to be determined.

Causation remains one of the most problematic areas of the law of negligence. Legal causation depends on probabilities and notions of 'common sense'. However, medical causation relies on scientific proof and great care must be taken by medical experts to provide opinions based on appropriate medical knowledge. Statistics are often quoted but these are usually based on data comprising the outcomes of large numbers of patients, and do not generally provide an accurate assessment of the position of an individual patient. The judgment in *Rufo v Hosking* suggests that Courts will attempt to estimate the percentage loss and award the patient damages. The assessment of the 'loss of a chance' in such cases will be difficult, presenting a significant challenge to those medical experts who are asked to put a percentage figure on the 'loss of a chance'.

Conflict of interest: none.

Reference

1. *Rufo v Hosking* [2002] NSWSC 1041; *Rufo v Hosking* [2004] NSWCA 391.

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