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European Causation in Tort Law: a Comparative Study with emphasis on Medical Law in the United Kingdom, Germany and France and Luxembourg

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Abstract

This purpose of this paper is to explore how the different jurisdictions under consideration here treat the legal notion of causation. These jurisdictions are the United Kingdom, Germany and France and Luxembourg. The problem of causation has been described as insoluble and I shall not be trying to solve it. Rather I shall consider how each of the jurisdictions here treats causation in the law, the better to ascertain whether there can be any common European idea of causation in this field. The reason for this is not only as two of the European projects aiming at codification in tort law seek to attempt if not strictly a definition of causation then recommendations in ways in which it could be refined. The European Court of Justice itself has been mandated to extract general principles common to European Union member states with regard to non-contractual obligations which can be applied when faced with a problem in tort law.

I must necessarily explain the notion of causation more generally before considering causation in the law so causation itself is understood. Within the sphere of causation in the law, there are a number of theories that I examine, which can be found, to a greater or lesser extent (or sometimes not at all), in one form or another, in the jurisdictions under consideration.

My conclusion is that there can be no common idea in causation from which principles in furtherance of any European codification projects may be stated. In most cases in court, a discussion of causation is not even entered into, as it is not controversial. There can be no "common sense" solutions in cases where causation is in doubt. I offer no principles. I make only one suggestion at the end with regard to experts' reports.

The originality I hope to bring to this area of law is that this will be the first work that considers French (and Luxembourg), German and British law under one cover. I conclude by what seems to be the opposite view from many jurists in that, who hold that, however courts may arrive there "the results are [or will be] just the same" in causation.

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Table of Important Terms for Translation

I have kept many of the the primary sources I have obtained in their original language and a modest amount of French and German will be required to read this paper from beginning to end. Where others have translated the sources into English, I have indicated this. To that end, I insert here a table of frequently used (or important or both) terms that will be used in this paper for ease of reference. Of course, the translations will not be exact, especially given the subject matter, but I have made my best efforts to select the *mot juste*.

English	French	German
allocation	**allocation**	**Zuweisung**
appearance	**apparence**	**Auftreten**
aptitude	**aptitude**	**Eignung**
argument	**argument**	**Herbeiführung**
to ask too much	**trop demander**	**überfordern**
blow of fate	**coup de sort**	**Schicksalsschläge**
causation	**causalité**	**Kausalität**
certainty	**certitude**	**Gewißheit**
chances of success	**perspectives**	**Erfolgsaussichten**
consent	**consentement**	**Einwilligung**
to consider	**considérer**	**Erachten**
consideration	**considération**	**Betracht**
defendant	**défendeur**	**Beklager (Bekl)**
disclosure liability	**obligation d'information**	**Aufklärungspflicht**
emergency	**urgence**	**Dringlichkeit**
expert's report	**une expertise**	**Gutachten**
failure	**manquement, défaut**	**Misserfolg**
intent	**intention**	**vorsätzlich**
intervention	**intervention**	**Eingriff**

leading	**important**	**leitend**
liability	**responsabilité**	**Häftung**
mistake	**erreur**	**Fehverhalten**
necessity	**nécessité**	**Notwendigkeit**
negligence	**negligence, imprudence**	**Farhlässigkeit**
nosocomial infection	**infection nosocomiale**	**nosokomiale Infektion**
omission	**omission**	**Unterlassung**
over-sensitive	**hypersensible**	**zimperlich**
plaintiff	**demendeur**	**Kläger (Kl)**
possible	**possible**	**etwaigen**
prospects (prognosis)	**perspective (prognostic)**	**Aussichten**
reasonable	**raisonnable**	**einsichtig**
strange	**étrange, bizarre**	**eigenartig**
strict liability	**responsabilité sans faute**	**Gefährdungshaftung**
tort law	**responsabilité civile**	**unerlaubte Handlung**
unalterable	**immuable**	**unumstößlich**

Chapter 1: Introduction

This paper examines the rules applicable to the study of causation, in particular in medicine, in delictual[1] liability in four European jurisdictions: the United Kingdom, Germany, France and Luxembourg.[2] I hope to show at the end of this paper that there are no common rules in causation that can be found following a study of these jurisdictions and that projects that purport to advance some kind of commonality or suggestions in this area must necessarily be modified. I ultimately focus in my conclusions, not unsurprisingly then, on the Principles of European Tort Law (PETL) and the Draft Common Frame of Reference (DCFR). These are two projects that aim to provide some kind of model harmonisation of tort law in due course. Even they appear to disagree on causation, but more of that later. The European Court of Justice (ECJ) also plays a role. It has been specifically mandated to decide on matters of non-contractual obligations by the Treaty on the Functioning of the European Union as amended (TFEU). It has been instructed to find "general principles common to the laws of the Member States" when ruling on non-contractual liability where it has jurisdiction.[3] It is my contention, as I hope to show, that there are no such common principles. Notwithstanding this finding, it must be accepted that this article of the TFEU and the ECJ itself are both here to stay, at least for the foreseeable future and I do suggest one way in which the ECJ could ultimately change its approach. It is important to recognise from the outset that I am making absolutely no recommendations with regard to the codification of causal principles. I suggest nothing to those who have drafted either the PETL or the DCFR. I do this not from a destructive will or desire but simply because I do not find that causation lends itself to any kind of codification. This was not my hypothesis, and, in the scientific tradition, I happily admit it. I did hope to be able to analyze causation in the jurisdictions in consideration and thereafter be able to contribute to some generalizing principles in the area. This was my aim. After my research, however, I find this impossible. I hope my reasoning becomes clear in my findings. This then is the crux of the paper. Before, however, considering this further, I think it is

[1] the word "delictual" shall be used interchangeably here with the word "tortious".

[2] although the United Kingdom is not one civil law jurisdiction, the rules of causation in delict are sufficiently similar to be considered here together.

[3] Art 340 TFEU

necessary to understand what causation is and why it is important. I do this in this introduction.

It is causation that links the delictual act to the tortfeasor. Causation, therefore, is a question of prime importance to a lawyer and goes to the root of any true understanding of culpability: how the law treats "cause", what the law means by "the plaintiff[4] *caused* the injury" can often, however, be quite at odds with what the average reasonable person may understand by causation. This paper will not attempt to deal with all problems in causation[5] but shall focus rather on one area of delictual liability in particular: liability in the field of medical negligence. This is an area of causation that has proven fecund for the development of causal problems. There are so many uncertainties and variables connected with the human body that often the law has had to prove inventive to arrive at a particular result in the name of justice.

I shall argue here that such is the state of the case law at the moment in all four jurisdictions that a search for any kind of common principle or principles in this area is fruitless and ought to be abandoned. I submit that the search for a common understanding of causation should be jettisoned and principles cannot be suggested selecting the "best" from each jurisdiction.[6] My work is not, however, based on this idealistic universalism.[7] My approach is multilateral (between more than two legal systems), synchronic (contemporary systems) and both substantial and procedural, and, although I do not attempt to discover an optimal uniform law, I do not eschew a borrowing of ideas and solutions from other jurisdictions. I am, however, more interested in a critical, or perhaps more observational functional analysis (roughly,

[4] the word "plaintiff" will be used here as opposed to any other variation thereon: save where there is a Scots case where I shall refer to the "pursuer".

[5] such a treatment would be extremely difficult, if not impossible.

[6] R MICHAELS, "The Functional Method of Comparative Law", *Duke Law School Legal Studies, Research Paper Series*, No 87, http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2033&context=faculty_scholarship

[7] G MOUSAOURAKIS, "Comparability, Functionalism and the Scope of Comparative Law", (2008) 41 *Hosei Riron* 1

how different legal systems respond to similar scenarios) that allows for a "tolerance and critique" of the different laws.[8]

[8] R MICHAELS, "The Functional Method of Comparative Law", *Duke Law School Legal Studies, Research Paper Series*, No 87, http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2033&context=faculty_scholarship, at p42, I am paraphrasing

1.2 Schema

This paper was in part inspired by many an interesting discussion that I had with students past and present confirming indeed the contention that there is no such thing as universal "common sense".[9] Causal arguments often refer to "common sense".[10] Our ideas of common sense vary considerably and this was brought out in various arguments in class.[11] I submit that only where causation is not in dispute is there a common sense idea of what it is! In the vast majority of cases in tort, causation is never in dispute. I might even go so far as to say that where it is in dispute then there can be no "common sense" idea of what it is.

This introduction will consider preliminary matters about which a word or two I think need be said: certain comparative notions and ideas, what the problems in medical causation actually are, proving causation in the law and how this is different from proving causation in science, burdens of proof and the jurisdictions concerned. Chapter 2 will then examine certain causal theories that form the basis, or lay claim to form the bases, of the jurisdictions under consideration. I believe it is essential to have an understanding of these and related theories before embarking on a consideration of the jurisdictions themselves. It is important to describe these issues here, as they will be treated to a greater or lesser extent in later chapters.

Chapter 3 shall focus on the United Kingdom and Chapters 4 and 5 on France and Luxembourg, and Germany respectively. These shall consider medical causation and the peculiarities involved in the particular jurisdictions, the better to contrast causal approaches in the final chapter.[12]

I shall try to avoid making a critical analysis of the solutions found by each jurisdiction. It is not the purpose of this paper. I shall also reflect on the use of other

[9] S LLOYD-BOSTOCK, "The Ordinary Man, and the Psychology of Attributing Causes and Responsibility" (1979) 42 *Modern Law Review* 143

[10] HLA HART HLA and T HONORE T, *Causation in the Law* (Oxford, Oxford University Press, 1985), Chapter 2

[11] the classic "poisoned canteen" problem and the case of *Dillon v Twin State & Gas Electric Company* (1932) 85 NH 449 proved insightful examples for students.

[12] for asbestos and hepatitis C infections, for example

kinds of evidence such as statistics, expert evidence and anecdotal evidence. I submit that there is no pan-European agreement with regard to which causal theory to follow and that the theories are so malleable in any case that a judge can claim to be following one theory while in reality just applying policy. Even "common sense" can be regarded as a theory.

Chapter 6 shall be the essence of the paper. Here I shall make the classical comparative lawyer's analysis of all countries considered in this paper to assess whether there is any commonality in the field of causation. Although such an approach may be commonplace, I do not find it simplistic, ineffective or inefficient as I think it can highlight important and crucial differences to substantiate my core argument.[13] This notwithstanding, I do try to make immediate comparisons where I find this relevant and allow these to build into my overall conclusion.[14] My ultimate finding is that there is no commonality. Given this, I shall then move on to criticise such projects that attempt to find or assert principles in the area of causation in the law that should be followed by courts or tribunals. The two in question are the PETL and the DCFR. It is also in this chapter that I shall consider the role of the ECJ. It is, after all, mandated to make certain findings in the area of non-contractual obligations and therefore necessarily make findings in the area of causation. I shall comment on the TFEU in this regard. The ECJ has already had questions of causation come before it and I shall consider the relevant case law together with other determinants of causation at this level.

I hope the main contribution to originality is the bringing together of three important European legal families, together with the ECJ where it has been so mandated, and considering causation's treatment by those systems to inspire those who ultimately foresee some kind of common tort law in Europe to reflect on whether such principles could be adapted. Just by considering one essential element common to all the jurisdictions – namely causation - in tort law and by showing that sometimes even what might be considered the "easiest" cases would not be treated similarly. On this

[13] J REITZ, "How to do Comparative Law" (Autumn 1998) 46 *American Journal of Comparative Law* 617 at 634

[14] ibid

basis, I suggest that it is unwise to extract principles from case law. Therefore I suggest that either the projects must remove any expansion on the understanding of the word "cause" (as causation cannot be codified) or if they do not, any application thereof will be so vague and nebulous as to mean nothing at all.

1.3 Jurisdictions and Approach

As mentioned, this paper shall consider four jurisdictions: the United Kingdom, Germany and France and Luxembourg. The first is chosen as Scotland is my home jurisdiction and the United Kingdom is a common law jurisdiction.[15] Germany is chosen because its tradition tended to rely more on philosophical approaches to causation – at least historically - than the other three jurisdictions. Finally France and Luxembourg are chosen, as they are both Civil law jurisdictions with which to compare the common law jurisdiction of the United Kingdom. I also currently reside in Luxembourg. I hope these four jurisdictions will provide enough breadth in their history, traditions and scope to allow for a comprehensive and full analysis of causation in so far as it is deals with medical liability on which to base an evaluation of causation in the European projects. The three largest jurisdictions will have been the most fertile for case law and academic writing so unless otherwise stated, I shall consider France and Luxembourg together. Any reference to France should be taken to include a reference to Luxembourg also and I hope no umbrage is taken by Luxembourg readers. Where appropriate, reference will also be made to some theories that could be of further interest from the United States of America or Australia but which, strictly speaking, are outwith the scope of this paper but which are worth consideration in the context.

[15] Scotland is a "mixed" jurisdiction often compared to that of Quebec, Louisiana and South Africa.

1.4. Comparative Notions

It is the essence of any legal system based on fault that the defendant's acts or omissions be shown to have caused the damage. This is recognised in all the jurisdictions under consideration. Indeed, according to Aristotle, it is the essence of even moral responsibility that we are liable for our voluntary or mixed actions.[16] Aristotle's classification of (1) the agent; (2) the act; (3) the object or medium of the act, and sometimes also (4) the instrument (5) the aim and (6) the manner, are principles[17] that are reflected when considering the art of a medical practitioner and whether or not he has acted lawfully in the execution of his task. Causation is used to determine lawfulness and responsibility. Causation is also important for psychological reasons. The jurisdictions here may have attempted to extract or posit certain causal principles theoretically. Although causation has classically been based on theories, I shall argue that in medical liability at least, such theories have become so intermingled, confused and uncertain that often the case law is confusing, puzzling and counter-intuitive and not at all what a reasonable person (or several of them together) may jointly predict. If causation were simply a question of common sense or what the man in the street thought, then similar problems in the different jurisdictions would not result in such diverse results.[18] I shall implicitly argue against the neo-Aristotelian[19] methodology's approach in comparative law in that there cannot be found a *ius commune* or *ius gentium* with regard to causation.[20] While many of the problems in the four jurisdictions are similar, the solutions are not necessarily comparable. In the end, case law shows it comes down to a question of public policy, judicial predilection, common sense, whatever that may mean, or a mixture of some

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[16] ARISTOTLE, *The Nichomachean Ethics*, (London, Penguin Books, 2004) p50

[17] ibid, p43

[18] for example, loss of chance, as we shall see.

[19] essentially, and according to Aristotle, that everything strives towards its perfection philosophically: its *telos*. Similarly, it could be argued, law strives also towards a *telos* or *causa finalis* which must be its perfection. For a nice summary, see MICHAELS R, "The Functional Method of Comparative Law", 2005 *Duke Law School Legal Studies Research Paper Series*, No 87, http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2033&context=faculty_scholarship at pp7-9

[20] J ESSER, *Grundsatz und Norm in der richterlichen Rechtsfortbildung*, 1956 or J GORDLEY, "The Universalist Heritage" in *Comparative Legal Studies: Traditions and Transitions* (2003), eds, P LEGRAND, R MUNDAY, (Cambridge, Cambridge University Press, 2003), pp31-45

or all of these. Causation is used as an effective controlling device in the law and for public policy makers.[21] It is the perfect tool.[22] It can be used for whichever policies tort law aims to pursue if these can indeed be determined.[23] There is already a certain amount of awareness of other jurisdiction's approaches to causation or indeed, cross-fertilisation on the subject. I submit it is a mature legal system that approaches its enquiry in such a way. For example, Lord Bingham in *Kay's Tutor v Ayrshire and Arran Health Board*[24] at para 32 stated

> If....a decision is given in this country which offends one's basic sense of justice, and if consideration of international sources suggests that a different and more acceptable decision would be given in most other jurisdictions, whatever their legal tradition, this must prompt anxious review of the decision in question.

I would agree with this. While it is not strictly part of this paper, I would indeed advocate contemplating other jurisdictions' solutions where appropriate. This, however, is something quite different from stating how the law "ought" to be in a European sense.[25]

The question of who caused the medical injury or, in essence, causation, is then of the utmost importance in understanding this paper. There are so many variables in each case to consider that make the study of it at once exciting and arduous. Before I set out on a study of causation in the realm of medical liability, I would like to state simply that science simply does not understand perfectly how the body works nor

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[21] including judges

[22] M HOGG "The Role of Causation in Delict" 2005 *Juridical Review* 89

[23] G CALABRESI, "Concerning Cause and the Law of Torts: An Essay for Harry Kalven, Jr", *The University of Chicago Law Review* 69; where Calabresi notes two goals with tort as a functional concept, viz Compensation Goals and Deterrence Goals

[24] 1987 UKHL 17

[25] R MICHAELS in his article contributes a brief discussion of Neo-Kantian law in this vain ; see MICHAELS R, "The Functional Method of Comparative Law", 2005 *Duke Law School Legal Studies Research Paper Series*, No 87, http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2033&context=faculty_scholarship at pp17-19

how all the factors that impact on the body affect it.[26] The examples abound. Science may be able to predict statistically on the one hand, that if person A smokes twenty cigarettes per day, then he is more likely to develop lung cancer than person B, someone who does not. This, of course, is assuming that all other things are equal. This is the essence of such problems. All other things are never equal. This is why courts in Europe are reluctant to allow recovery in such cases. Statistics are only of limited use. They can never tell the whole story. They are only generalisations. What if person A also worked in a particularity sooty environment for twenty-five years? How do courts take into account variables to which nearly everyone is exposed every day? These include fumes from vehicles, radiation, asbestos and other chemical products. Also, perhaps person A had a particular genetic predisposition to lung cancer. How should courts consider that, if indeed they should at all? These are all questions with which courts could be confronted and scientific uncertainty is an element with which courts have to deal. Each of us lives with these risks daily and yet courts have to decide whether a particular defendant is responsible or not. In tort, it is often causation that is of the essence.

[26] this is not to say that science will never know.

1.5 Problems in Medical Causation

It is perhaps due to this uncertainty described above that it may be thought that a defendant has an automatic advantage. After all, it is for the plaintiff to prove his case. While in general all jurisdictions under consideration follow, courts have often found ways to help a plaintiff who is hindered by scientific uncertainties. This is more evident in some countries than in others. Courts have been particularly creative in their jurisprudence and procedure when determining whether a case has been proven or not. If a case has not fallen within a decided ratio already, courts are often willing, indeed eager, to develop the law.[27] For example, the concept of "loss of a chance", as yet unknown in British in medical liability cases (although not categorically excluded for the future) or German law, allows plaintiffs in France to obtain damages for a loss of the chance of recovery or loss of chance of survival. This avoids some of the procedural difficulties that may exist where the standard of proof in France may at first sight appear higher than in the United Kingdom.[28] So while there may be a procedurally lower standard of proof in the United Kingdom,[29] France allows loss of a chance. This is only one example of a difference yet an important one.

So what of the actual problems themselves? What kinds of problems arise where the issue at stake is that of causation in medical liability? There are two kinds of medical negligence which it is important to distinguish. There is what has been called treatment malpractice and there is also disclosure malpractice.[30] The former concerns an iatrogenic act or omission during the actual medical intervention itself. It includes the whole gamut of treatments from beginning to end: from diagnosis, prognosis to post-operative care. It is where the care-provider has been at fault in some way and this, if causation between the fault in treatment and the plaintiff's damage is proven, will allow the plaintiff to recover in delict. A typical example might be where a surgeon has left surgical equipment inside a patient and this leads to further physical damage to tissue that would not have occurred but for the

[27] *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22

[28] In France or Luxembourg, a plaintiff generally has to convince a judge so that the judge has an *intime conviction* of the veracity of the plaintiff's claim. This shall be considered more fully *infra*.

[29] on the balance of probabilities

[30] M STAUCH, *The Law of Medical Negligence*, (Oregon, Hart Publishing, 2008), p1

negligence of the surgeon.[31] However, what about the case where a plaintiff was negligently discharged from hospital following heart surgery even though he had a chest infection?[32] The resulting thrombosis (from the chest infection) led to the loss of one leg. The doctor could not have detected the chest infection and the patient was asymptomatic. Should the hospital be rendered liable for the eventuation of such a risk or should the causal chain be broken somewhere? Should there be some kind of "security obligation" (to translate from the French) the moment a patient enters a hospital? These are questions that shall be considered here.

Disclosure malpractice, on the other hand, is concerned with the care-provider's failure to advise a patient of certain risks associated with a medical procedure such that this in some way vitiates the patient's consent. In general, a patient should consent before receiving medical treatment. A patient should on the whole be told about the risks inherent in a procedure although there are certain dissimilarities among the jurisdictions. The important causal aspect to investigate here is where a patient has not been made aware of a disclosable risk inherent in a procedure, what would that patient have done had that patient known of the risks? Courts are on their guard for claims of self-serving plaintiffs who suggest that they would not have undertaken the operation at all. Courts are also sensitive to history, which often shapes current policy. Germany will not go too far in supplanting what it thinks as a reasonable decision for that of the plaintiff's given its history in World War Two with forced medical experiments. What we can see, however, in general during the twentieth century, is a move away from very much a paternalistic attitude of "doctor knows best" to a position at the beginning of the twenty-first century where patients' rights groups are becoming ever more vocal.[33]

The essential problem in proving medical causation lies in its uncertainty. As mentioned above, science is often not at that stage where it is able to say definitely that variable *x*, or variables *x* and *y*, jointly caused the patient's injury, *z*, with one

[31] the phrase "but for" is of the essence when considering causation and it is one that shall be considered again and again.

[32] *Brown v Lewisham and North Southwark Health Authority* (1999) PIQR P324 (CA)

[33] for example, The Patients' Association in the UK

hundred per cent certainty. The danger here is that courts may on occasion reward a plaintiff with damages where the defendant's act or omission did not actually cause the damage and value judgements are made that are peppered with metaphors like "breaking the chain of causation". This is a policy choice. For example, where an employee who had polio was injured at her work and a doctor negligently advised amputation of the employee's leg, the bank where the employee worked was nonetheless found liable on the basis that the negligent advice did not "break the chain of causation".[34] Responsibility was shared. Here the courts are dealing with an omission. He had omitted to discuss the implications of such an operation and he did not advise on possible alternatives. The plaintiff could not prove it was only the doctor's omission caused the damage. It will be shown that it is difficult to bring such cases within any traditional theories of causation.[35] Yet a court is holding that both the bank and the employer "caused" the damage. I suggest such decisions are more linked to procedural evidential rules and simple policy decisions of the court. This is not to criticise but simply to recognise.

[34] *Webb v Barclays Bank* (2001) Lloyds Medical Reports 500

[35] these theories themselves shall be considered herein

1.6 Proving Causation in Science and Proving Causation in Law

Even though a care-provider's acts or omissions may be said **in law** to have caused a particular outcome, this does not mean that they have done so **in fact**. Courts are there to judge a result **in law**. A judge is not an expert in science or in medicine. He may, however, have recourse to an expert or experts. A judge's decision in theory is independent of that of the expert yet in reality often closely follows it. In English law a judge can choose not to follow an expert's opinion but the situations where it would be appropriate not to do so have not been made clear.[36] In Luxembourg, judges can appoint one or more experts but they usually appoint one.[37] It has been held that they may even disregard the expert opinion.[38] I have sympathy for judges to know what to do where experts disagree. I suggest that it is not for judges to pronounce on such medical controversies but a judge is rarely (is not) called on to do so. As Penneau said, what would be the point of a judge's requesting an expert opinion and then not to follow it but replacing it by

> ...sa pseudo-connaissance livresque, les véritables problèmes juridiques qui sont pourtant seuls de sa vértiable compétence.[39]

A judge may consider an expert's qualifications, experience, his credibility in the witness stand where this is part of normal procedure, the evidence of other witnesses and, of course, the general standard of proof. The whole of the evidence must be considered. In the United Kingdom, I think there is close scrutiny of scientific witnesses given the possibility for cross-examination. Courts should necessarily be criticised for making a judgement that does not stand up to closer scientific analysis. It is for courts to consider other evidence such as other witnesses, aetiology, epidemiology, and probability. Courts should also consider the functional aim of tort law in their jurisdiction. Courts are always pursuing some overall policy.[40] Where

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[36] *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771

[37] Art 264 Luxembourg Code of Civil Procedure: experts' differences must be expressed in a report.

[38] CC 1 13 Feb 1985, JCP 1985 II 20388

[39] J PENNEAU, *Faute et erreur en matière de responsabilité médicale* (Paris, LGDJ, 1973), 99

[40] see generally F GIGLIO, *The Foundations of Restitutions for Wrongs*, (Oxford and Portland, Hart, 2007) and T KEREN-PAZ *Torts, Egalitarianism and Distributive Justice* (Aldershot, Ashgate, 2007)

should the risk ultimately fall? With this in mind, changes in ideas of causation have often been brought about by particular catastrophes that have caught the public's attention resulting in special systems. I find such systems important for an appreciation of causation, as, in my opinion, such special schemes necessarily show how a jurisdiction recognises where there could be causal problems for a plaintiff and comes to her support. In France, for example, the scandal of contaminated HIV blood brought about legislation to provide for compensation.[41] Similarly, the Damages (Asbestos-related Conditions) (Scotland) 2009 Act and the Compensation Act 2006 have shown how parliaments are quick to respond to perceived injustices in causation.[42] It can therefore be seen that proving a causal link in law is something other than proving a causal link in science. More general societal, moral or political factors may be taken into account before providing justice in an individual case.

[41] loi du 4 mars 2002

[42] *Barker v Corus* [2006] UKHL 20

1.7 Burdens of Proof and Other Procedural Matters

Causation cannot be separated from the idea of burden of proof. The jurisdictions have adopted varying approaches. Each has its proponents and its detractors.[43] I am not going to enter into a discussion of the advantages and disadvantages of each.[44] It is not enough to say that but for the behaviour of the care-provider the plaintiff would not have suffered the injury. The burden of proof is usually on the plaintiff and he must convince the court to a certain standard that his injury was caused by the defendant. In France, a judge must have an *intime conviction* that the plaintiff's version of events is true. What will appear a prima facie higher standard of proof than in the United Kingdom is actually diluted to a considerable extent by recourse to certain causal presumptions[45] and use of doctrines such as the loss of chance (*perte d'une chance*). The idea of overall burden of proof and how this may shift during the course of a civil trial shall be considered. The law has invented the concept of the burden of proof and what the law treats as only probable can often result in the certainty of even full recovery for a plaintiff. What has probably caused a loss becomes what has certainly legally caused a loss. Science differs from law. The truth is not necessarily sought in a courtroom but rather that the plaintiff prove his case. Such notions are not necessarily familiar to non-lawyers. Consideration of such issues then, I submit, accentuates my argument that causation is not a common sense concept. It is necessarily linked to procedure and procedure varies.

[43] however, for an interesting discussion on the topic, see M FAURE and V BRUGGEMENT, "Causal Uncertainty and Proportional Liability" in L TICHY (ed) *Causation in Law* (Prague, E Rozkotova, 2007) p105

[44] ibid

[45] for example arts 1384 et seqq French Civil Code, famously "On est responsible non seulement du dommage que l'on cause par son propre fait, mais encore de celui qui est causé par le fait des personnes dont on doit répondre, ou des choses que l'on a sous sa garde."

Chapter 2: Understanding Causation

2.1 Introduction

I propose to set out here the various causal theories common to the traditions of each of the jurisdictions under consideration. These theories are those that have formed the backbone of much causal reasoning in the law. I shall also consider some of the more modern theories and approaches that have influenced causal thinking especially from the last century. I could trace thought and deliberation on causation from Aristotle (or before) and work forward from there. However, this would bring nothing new and simply be a summary of old arguments (if not simply a history). In this chapter, I shall consider how causation relates to other disciplines and how causation in the law cannot be totally divorced from causation in other fields; second, I shall show why and how causation is important in the law. Common sense and conditions shall then be examined before an estimation of the use of logic is made in the world of causation in the law. I think it is important to consider logic as the lawyer and scholar must be precise and accurate when they make causal statements.[46] "Jane caused John's head injury" tells us nothing about responsibility or space-time relations in the scenario. It is important that all these themes are introduced as I find them important when criticizing ultimately those who purport to find common principles in tort law and apply them European-wide.

This part of the paper should be considered as a general introduction to the different kinds of theories and approaches used in causation. I shall refer to these notions liberally in this paper. Problems and approaches in this section will not necessarily focus only on medical negligence and they are presented rather as an introduction to the kinds of challenges with which lawyers are faced when causation is an issue. I present the problems in medical negligence this way as a more rounded understanding of causation can be gleaned from the problems that are faced in causation in general.

[46] and particularly when drafting their writs

2.2 Causation in Law and Causation in Life

First, causation is not some dry, academic, esoteric or abstruse concept for use only by the initiated but rather, it is an idea that can be intuitively understood by all, is used by all in daily life and is appreciated by all in our everyday actions and omissions. Indeed causation in law can be seen as a subset of causation in life. Law is, of course, part of life but like other concepts in common parlance when applied to the law, causation in the law has an autonomous meaning. This is not to say that it has an agreed meaning even in law but when causation is spoken of in law, it is generally used as a device to allocate responsibility. The **general** answer to the question "what is causation?" will most probably depend of whom it is asked and in which field that person works. There can be no one thing as causation in itself valid for all disciplines.[47] Whether or not "cause" actually exists is a more philosophical argument and is outwith the scope of this work.[48] However, this is not to say that philosophical theories will not be considered. Modern philosophical writings have been influential in the law. They form the foundation of causation in Germany (and from there to France). Germany's case law and academic writing is often today still based on it.[49] The seminal treatise of *Causation in the Law* by Hart and Honoré was published only in 1952 and it was a considerable contribution to our understanding of different causal approaches to legal problems. To exclude philosophical writings then from this paper would be folly. Indeed much French doctrine refers explicitly to the reception of equivalence and adequacy theory[50] by virtue of the German modern philosophers who themselves referred to Roman, Greek and Enlightenment philosophers. So to divorce completely philosophy from an understanding of causation - and therefore causation in medical liability - is wrong; to invoke such philosophical luminaries in every legal causal problem is equally wrong and would

[47] J STAPLETON, "Cause-in-Fact and the Scope of Liability for Consequences" (2003) 119 *Law Quarterly Review* 388

[48] see D HUME, *A Treatise of Human Nature* (Dover Philosophical Classics, 2003); and in general the debate between the Enlightenment philosophers of rationalism and empiricism.

[49] see HLA HART and T HONORE, *Causation in the Law Causation in the Law* (Oxford, Oxford University Press, 1985) p432 where they state that "Unlike the Anglo-American writers who have made piecemeal contributions to the study of causation, Continental jurists have not hesitated to apply to the law philosophical doctrines of considerable complexity."

[50] for which, see *infra*

not help in leading to reparation of a wrong but rather to an interminable academic debate on epistemology and metaphysics. This is not the purpose of the law.

Causation in law is a particularly mercurial and evasive concept to define.[51] One (reasoned) response is just as valid as another. Although an approach to the causal problem may be understood in different ways by the sciences and arts, causation in law retains significance, an idea, or at least an understanding, the purpose of which can be said to be distinctly *sui generis*. There may be dispute about its function, interpretation or purpose subject to the multifarious interpretations of jurists, lawyers and scholars within each jurisdiction. Causal hypotheses may come from legal families which purport to emphasise "common sense";[52] other postulates may stem from jurisdictions which underline a more philosophical, statistical or mathematical approach to the subject, at least in their theories;[53] and some countries' conceptions may appear prima facie in disarray or inconsistent.[54] Indeed, in all of the jurisdictions under consideration, special regimes have been created where the need to show causation in a traditional sense has been greatly mitigated and there exist some systems of near strict liability. Whether or not these are exceptions from a general rule is not clear as it suggests the existence of a general rule. Some may even be of the opinion that causation (or at least paying heed to causation) in the law is unnecessary and consequently may advocate its abolition.[55] None of these interpretations is relatively more valid than the other overall. Jurisdictions have their own margins of appreciation and the case law abounds. Those who call for causation's abolition, would surely recognise, or at the very least not deny, the crucial role that causation today plays in tort law today. Very crudely, one is liable for the legally recognised damage one has caused and it is this that can serve as the *tertium comparationis* for this study.

[51] see in general HLA HART and T HONORE, *Causation in the Law*

[52] the United Kingdom, the Commonwealth and the United States of America

[53] Germany

[54] France

[55] I imagine this would have to be in conjunction with the abolition of tort law altogether as is the case in certain jurisdictions such as New Zealand

2.3 Causation and Other Disciplines

What has been said above, however, is meant not to isolate causation in the law from causation as may be understood in other disciplines. Causation in the law derives and borrows meanings from causation in science and philosophy. Causation is not readily definable in these other disciplines. To take an example from science, Newton's law *a=f/m* allows us to say that forces causes acceleration, not that *f/a* **causes** the mass. As Pearl noted

> Such distinctions are not supported by the equations of physics, and this leads us to ask whether the whole causal vocabulary is purely metaphysical, "surviving, like the monarchy…"[56]

So it is important to react when we hear or see the word "causation", reflect and pay special heed that we are using the word in a focused and concentrated way, the better to enhance other people's understand of what we mean. Causation in the law does not seek objective knowledge. It may well be true to say in the natural sciences that "Smoking causes cancer" or "Climate warming is a causal effect of industrialisation" but it would be wrong to translate these into a legal case.[57] If causation is not sometimes readily definable in other subjects, then why should it be so in the law? I think the short answer is it is like the proverbial elephant: unable to be described but we know it when we see it. More than this, the law must have, if not a definition of causation, then at least an appreciation or a conception of what it is. This is not to say that everyone agrees on such an appreciation or conception. This is why lawyers should be aware of all causal arguments. Law is there inter alia to assist people to assert their rights or find remedies when they have been wronged.

Use of metaphysical language in law ought to be discouraged. It is not the place of the courts to pronounce on whether causation can be part of the world itself or whether it is only part of our perception. Is it possible, in fact, to know *à priori* a law of changes to determine all phenomena[58] independent of experience or are we

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[56] J PEARL, *Causality: Models, Reasoning and Inference* (Cambridge, Cambridge University Press, 2006) at p338, quoting Bertrand Russell

[57] K NUOTIO, "Some Remarks on the General Philosophy of Causality and its Relation to Causation in the Law", in L TICHY (ed) *Causation in Law* (Prague, E Rozkotova, 2007) 27 at 28

[58] I KANT, *Critique of Pure Reason* (New York, Dover Publications, 2003), p138

doomed never to know that the sun will rise tomorrow, leave everything to chance, but still go about our lives using a constant conjunction?[59] It is interesting – but perhaps not so in a writ. I do not wish, however, to ignore many of the causal paradigms that are to be found within works of philosophy.[60] An interesting interpretation is put on Man's fall from Grace in the Garden of Eden hours after Adam's eating from the tree of knowledge. Adam is "already an expert in causal arguments."[61] God never asks for the cause but just for the facts:

> Have you eaten from the tree from which I commanded you not to eat?
>
> The man said, "The woman you put led me. She gave me some fruit from the tree and I ate it."[62]

Eve then refers to the serpent in similar tones.[63] Causation is seen here to pass or allocate responsibility. This has been its function even from the earliest days and this is still its function today. What can be said with certainty with regard to causation is that a full understanding of causation – even in the law - is necessarily a multi-disciplined approach. However, this paper is concerned with just one approach: causation in the law and more particularly causation in medical liability. Whether one's profession is that of lawyer, philosopher, psychiatrist, scientist, economist, or indeed theologian, problems of causation will most likely be encountered at some point. If legal writing on the subject is comparable to that in the aforementioned disciplines, I am sure there will be no shortage of reference material. Crucially, the law is ready and able to borrow ideas of causation from other disciplines and apply

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[59] the argument from HUME that continually seeing the same cause and effect leads to a constant conjunction, leading to probability allowing us to lead our lives. He makes clear, however, that we cannot "…penetrate into the reason of the conjunction": see, D HUME, *A Treatise of Human Nature* (New York, Dover Publications 2003), p67

[60] For a gentle introduction into the subject, I used the following: ARISTOTLE, *The Metaphysics* (London, Penguin Books, 2004); D HUME, *A Treatise of Human Nature* (New York, Dover Publications 2003); I KANT *Critique of Pure Reason* (New York, Dover Publications, 2003)

[61] J PEARL, *Causality: Models*, p332

[62] *The Bible*, Genesis, Chapter 3, v 11-12, taken from *The New International Version*, (Sevenoaks, Hodder and Stoughton Limited, 1990)

[63] ibid, v 13, "The woman said, 'The serpent deceived me and I ate it'"

them appropriately. New theories, or their variations, and policies in causation are arising frequently and it is important for lawyers and scholars to recognise them.

2.4 Responsibility and Causation

The role that causation plays in tort law is a pivotal one.[64] Along with injury and fault, it is one of the hurdles that must be surmounted by a plaintiff who claims reparation from a defendant. All jurisdictions under consideration here accept that A is liable to B to make reparation to B if A causes a legally recognised harm to B through A's fault. A could also be said to be responsible morally for harm he has caused to B whether or not A has a legal remedy against B. For example, if A had arranged to meet B for a dinner and A decided at the last minute that he would rather stay at home and B had expended money (for example, on a new suit) in the knowledge of the up-coming dinner, then it could be said that A is responsible for (as he caused, though everyone would not necessarily agree on this) B's expenditure even though A would have no legal remedy against B.[65] The law simply does not recognise social contracts in this way.[66] Blameworthiness, responsibility, culpability, fault and even guilt: if these can be imputed to the tortfeasor and only if, can be said that he caused the legally recognised damage will he be able to recover in tort. It is the essence of the maxim: *damnum iniuria datum*.[67] However, "cause" is the problem verb. In none of the legal jurisdictions under consideration is it defined or even refined. It would be extremely difficult to do so. The PETL and the DCFR attempt, however, legally to define it or at least expand its application. In the jurisdictions under consideration, causation's application is left to the courts or academic writers or both.

Further, causation's role can be seen as an intuitive response to liability or a "get out controlling device".[68] It is not the only one. A first-year law student in the United

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[64] G RAVARANI, *La responsabilité civile des personnes priveés et publiques*, (Luxembourg, Pasicrisie luxembourgeoise, 2006), 5, "C'est en effet au 17ème siècle que la faute accéda de son rôle du cause, parmi d'autres, de la responsabilité civile, à une condition nécessaire de toute responsabilité."

[65] although for an interesting European comparison, see J GORDLEY (ed), *The Enforceability of Promises in European Contract Law* (Cambridge, Cambridge University Press, 2001), "Case 4 – a promise to come to dinner", p105

[66] J THOMSON and HL MACQUEEN, *Contract Law in Scotland* (Edinburgh, Butterworths, 2000), 2.64

[67] J THOMSON, *Delictual Liability*, (Edinburgh, Butterworths, 1999), p1

[68] M HOGG, "The Role of Causation in Delict", (2005) *Juridical Review* 89 at 93

Kingdom would generally learn the common-law basis of establishing liability in negligence[69] for *damnum iniuria datum* is

(i) showing a duty of care existed;[70]

(ii) showing the duty of care was breached;

(iii) showing a causal relationship between the plaintiff's injury and the defendant's action or omission.

Showing a causal relationship between fault and damage is a reminder of what was said previously. The ideas of causal relationship, cause, effect or result can appear nebulous and inherently emotional and subject-dependent. In any (legal) situation, can we really say "If *a*, *b*"? Such logical deductions are far too formulaic for the law and unhelpful, especially when dealing with the area of medical science. This does not, however, mean they should be eschewed in toto. It can often be difficult when the law and science meet (medical negligence cases) to affirm what was the cause-in-fact of a particular injury. If legally we ought not[71] to take into account all antecedent causes, where do we stop? This is the eternal problem. The answer depends on the field of study. This is a paper on law and solutions in law are considered principally.

To return to the criteria noted above with regard to foundations of delictual liability, perhaps the first "escape route" for not finding a defendant liable could be found in the first of these tests. That a plaintiff must show a duty of care exists involves an appraisal of what is "fair, just and reasonable."[72] Often, however, it is clear that a duty of care exists and this cannot be used as a controlling device. Resort could then be had to causation. If causation is a matter of dispute in the case, I submit it cannot be resolved intuitively by common sense. If it were simply a question of common sense, the matter would not have to come to court in the first place.

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[69] *Donoghue v Stevenson* [1932] AC 562

[70] following the tripartite test in *Caparo v Dickman* [1990] 2 AC 605

[71] and none of the jurisdictions does notwithstanding reference to the theories sine qua non and equivalence

[72] *Caparo v Dickman* as [1990] 2 AC 605 per Lord Bridge at 616-618

So notions of causation and responsibility are very closely related. The answer to the question "Did person A cause loss *x*?" is very often the same as the answer "Is person A responsible[73] for loss *x*?" – but not always. So although the two concepts of responsibility and causation are linked, they are not synonyms.

[73] with all the suggestions and conceptions of responsibility that this may entail

2.5 Common Sense, Causation and Conditions

In causation, appeal is unfortunately often made to "common sense" solutions.[74] Indeed much of Hart and Honoré's seminal work on causation focuses to a great extent on "common sense".[75] I suggest any notion of "common sense" is a glib one to which judges can refer when they are incapable of explaining a certain solution. It is for this reason among others that I believe that it will be impossible to come to some common understanding about causation. Notwithstanding where Hart and Honoré note

> Common sense is not a matter of inexplicable or arbitrary emotion, and the causal notions which it employs, though flexible and complex and subtly influenced by context, can be shown to rest, at least in part, on stateable principles; though the ordinary man who uses them may not, without assistance, be able to make them explicit.[76]

I would not agree with this statement. If the principles were common sense, then the person who used them ought to be able to state them. Indeed a judge perhaps more than anyone should have a duty to state them. Why would such principles not be stateable? In any case, common sense is not an agreed concept among human beings and I would suggest that there are no stateable principles.[77] It is not just the ordinary person who may have difficulty explaining the principles. Judges struggle too. Perhaps when a judgement is reached empirically, and, typically without much explanation or reasoning, as I found was often the case for French judgements, then there are hidden "common sense" principles behind the decisions. It may be the case, but surely an appropriate elucidation would not be improper in the context to avoid confusion or indeed fallacious or inaccurate principles being presumed from such judgements. Linked to this, Hart and Honoré also suggest, and their comment may well be legitimate, that because there appears to be an obsession with words such as "cause and effect", that this may lead us to believe that there is only one

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[74] HLA HART and T HONORE, *Causation in the Law*, Chapter 2 entitled "Causation and Common Sense"

[75] ibid

[76] ibid, p27

[77] S LLOYD-BOSTOCK, "The Ordinary Man, and the Psychology of Attributing Causes and Responsibility" (1979) 42 *Modern Law Review* 143

notion of causation.[78] Linguistically, do we know the difference between the words "effect", "consequence" or "result"? To adapt their examples to medicine, the patient's recovery was a **result** of the operation; its **effect** may lead to the greater happiness of the patient with longer life as a **consequence**.[79] Are these words really interchangeable in this sentence? It is suggested then that "common sense" can be at once useful and dangerous. It is useful in that it allows for public policy flexibility but dangerous in that it makes the vindication of rights more difficult and elusive as resort to the reasoning behind such arguments need not be expansive.

Common sense would dictate, for example, that it was not oxygen that caused the fire but rather (say) a short circuit. However, it is not necessarily clear prima facie how a court should treat the following cases from a "common sense" point of view:

(i) **Example 1**

An accused supplied drugs to a victim. The accused supplied the victim with not only the drugs but also with a syringe for the immediate self-injection. The accused injected him and died.[80] Should the accused be charged with murder rather than just manslaughter? Did the accused **cause** the death?

(ii) **Example 2**

An accused left a wine bottle containing arsenic on a window-sill. She knew that her husband was an alcoholic. She left the house. He drank the solution and died.[81] Should the wife be held responsible? Did the accused **cause** her husband's death?

(iii)**Example 3**

A boy, playing on a bridge, falls. Before he hits the ground, he hits electricity wires that have been negligently left there by a defendant electricity company. The boy is electrocuted. If he had not been electrocuted, he would have been killed when he hit

[78] HLA HART and T HONORE, *Causation in the Law*, p27

[79] Their examples are that of a prisoner's acquittal being a result of a trial, its effect on the public being astonishment leading to a change in the law as a consequence

[80] *R v Kennedy* (no 2) [2008] 1 AC 269

[81] RGSt 1 (1880) 373, 374

the rocks, or at least he would have been seriously injured.[82] Did the electricity company **cause** the boy's death? If so, how should the boy's life be valued for the purposes of ascertaining damages?

(iv) **Example 4**

Fire *a* burns house *x* before fire *b*, where *b* was a certain event to burn house *x* anyway. Perhaps many juries would regard fire *a* as the cause. But what if two fires, *a* and *b*, started independently then later joined together to form one greater fire, fire *c*, and then destroyed house *x*? If Mr Z was responsible for fire *a*, should he be held liable for the loss to the owner of house *x*?[83] Did Mr Z **cause** the damage to house *x*?

All the above problems have had suggested solutions in law. Does this mean that these are also common sense solutions? I suggest not. How do we begin to answer these questions where, there is no intuitive answer where all can agree? In this regard, I must agree with Stapleton where she criticises Hart and Honoré in that

> [they] acknowledge that such notions [of common sense] are not hard-edged and may not provide clear answers in borderline cases. Yet despite this they assert that there is a "central core of commonly agreed meaning" which they go on to enunciate and analyse at length…the authors pay little, if any, attention to empirical work concerned with these phenomena. They simply state that "the ordinary person" uses words in such and such a way, according to a particular causal connection in such and such circumstances, as if these were established facts.

I agree. There is empirical research on how people view causation and they did not quote it.[84] With regard to the above examples I cited, people will disagree; there will not be one uniform solution. This is neither a good thing nor a bad thing. It just is.

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[82] *Dillon v Twin State & Gas Electric Company* (1932) 85 NH 449

[83] HLA HART and T HONORE, *Causation in the Law*, p89 where they note that in New York since 1886 it has been the law that if a fire negligently started spreads to buildings, damages may be recovered only in respect of the first of the buildings affected

[84] S LLOYD-BOSTOCK, "The Ordinary Man and the Psychology of Attributing Causes and Responsibility", (1979) 42 *Modern Law Review* 143; Hart and Honoré's second edition was published in 1985 so after this article was published.

Generalizing theories only answer part of the problem. For example, it would now appear to be a generally accepted fact in common parlance that smoking can cause lung cancer and consequent death but in no case in Europe has any action been successful against a tobacco company.[85] Why is this? This may seem initially surprising to some but the reasons for this lie at the heart of causation **in** the law. To cite the above example, to state that leaving poison on a shelf causes death is as meaningless as the statement "car accidents cause death".[86] The context must always be considered. All evidence must be considered to update any probalistic function.[87] Not to individualise evidence is irrational. This is why, for example, cases against tobacco companies are rarely successful. Some cases in France, and indeed legislation in Scotland, have gone to the other extreme essentially based on a precautionary principle where no damage as such has been shown.[88] Yet some may consider this a question of *iniuria* rather than causation. I shall consider this further below.

2.5.1 Causes and Conditions

Causes should be distinguished from mere conditions.[89] The real test is often, for the purposes of law, was there a human voluntary (or negligent) interference or omission from the **normal course of events** which made a difference in the way things developed?[90] Conditions can be seen as the "background" and cause something

[85] *McTear v Imperial Tobacco* 2005 CSOH 69; in France, see the Affaire Gourlain JCP 1998 II n° 1 0088 and now in the Netherlands, see A KEIRSE, in H KOZIOL and BC STEININGER (eds), *Tort and Insurance Law Yearbook, European Tort Law 2008* (Springer, Vienna, 2009) pp481-483

[86] JL MACKIE, *The Cement of the Universe*, (Oxford, Oxford University Press, 1980), see Chapter 3 on Causal Regularities

[87] J PEARL, *Causality: Models*, p310

[88] *Bouygues Telecom* case at JCP E 2009.1336 and Damages (Asbestos-related Conditions) (Scotland) Act 2009 allowing for the recovery of pleural plaques. These pleural plaques may induce fear of future asbestos-related disease in their hosts but are not harmful in themselves. They may increase the risk of some future disease but I would agree with Wright where he notes that "Risks are merely abstract *ex ante* statistics that report the frequency of occurrence of some harm given a specified set of conditions….risks per se do not constitute an actual setback to another's equal external freedom through an invasion of the other's rights in his person or property, as is required for an interactive justice wrong": R WRIGHT, "Liability for Possible Wrongs: Causation, Statistical Probability, and the Burden of Proof", (Summer 2008) 41 *Loyola of Los Angeles Law Review* 1295 at 1296

[89] for which, see HLA HART and T HONORE, *Causation in the Law*, p28

[90] ibid; a modification of HLA HART's and T HONORE's test at p29; this idea of "the normal course of events" is similar to adequacy theory, for which, see infra

which interferes with or "manipulates" this.[91] Yet in medical liability, it can be difficult to differentiate. Medical science is not a perfect science. It can often be difficult to say what the normal course of events is or would have been. While it may be thought of as normal for a patient undergoing an operation not to die under anaesthetic,[92] the statistics are more difficult when determining (say) why a person has developed cancer. In short, in as much as it is possible to say that anything normal, that would have been there anyway, that is in accordance with natural laws, can be said to be a mere condition. Oxygen can be said to be a condition of a fire (at least on Earth!).[93] There is generally oxygen in a room in the normal course of events.

Arguments as to what is a cause and what is a condition are at the heart of causation in medical liability. To what extent are diseases, predispositions and hastened death caused by conditions that is to say, the environment itself?; this is something that happens, or rather, something that is, in the natural course of things. Being born is, after all, a cause of dying but this statement is useful only for philosophers and it would seem absurd if introduced into a writ. The jurist has to be aware of spatial and temporal limits to the parameters surrounding effect, *e*, death (or injury), and it is doubtful that being born would be a relevant cause – it is more likely to be a condition – indeed a causally irrelevant one – in the law in any case.

Having now distinguished causes from conditions, I propose to consider theories in causation. I begin with the equivalence of conditions theory.

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[91] K NUOTIO, "Some Remarks on the General Philosophy of Causality and its Relation to Causation in the Law", in L TICHY (ed), *Causation in Law*, (Prague, E Rozkotova, 2007) 27 at 28

[92] Chances of this alone are 0.01% to 0.016% as noted in "Survey of Anaesthesia-related Mortality in France", A LIENHART, 2006, *Anaesthesiology*, 2006, 105: 1087-97

[93] HLA HART and T HONORE, *Causation in the Law*, p35

2.6 Theories in Causation

2.6.1 Equivalence of Conditions

The equivalence of conditions theory can be said to be the starting point of the classical theories in causation that must be understood before a true comparative analysis of causation in medical liability proper can begin. Glaser's formulation of the equivalence theory in Austria was later adopted in Germany.[94] It states that the sum total of each of the phenomenon that caused a particular outcome can be regarded as the cause: in other words, all causes are "equivalent".[95] This has since developed to cause in fact or the sine qua non theory. Hart and Honoré sum it up nicely when they state that if we look to the past of any event then there is an infinite number of events, each of which is a necessary condition of the given event and so, as much as any other event, must be called a cause.[96] They note that this is called the "cone" of causation in that the series of causes "fans" out as we go back in time.[97] Glaser states

> if one attempts wholly to eliminate in thought the alleged author [of the act] from the sum of the events in question and it then appears that nevertheless the sequence of intermediate causes remains the same, it is clear that the act, and its consequence cannot be referred to him…[98]

Traeger in his writing also considered the most often cited theory of conditio sine qua non. He writes simply and logically. His *Kausalbegriff* is still the most often cited work

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[94] J GLASER, *Abhandlung aus dem österrichen Strafrecht* (Vienna, Tendler, 1858, Bd 1) 298 (some of the following spellings may seem odd to modern readers of German but I quote directly); "Es gibt für die Prüfung des Causalzusammenhanges einen sicheren Unhaltspunct; versucht es, den angeblichen Urheber ganz aus der Summe der Ereignisse hinwegzudenken, und zeigt sichs dann, daß nichtsdestoweniger der Erfolg eintritt, daß nichtsdestoweniger die Reihenfolge der Zwischenursachen dieselbe bleibt, so ist klar, daß die That und deren Erfolg nicht auf die Wirksamkeit dieses dieses Menschen zurückgeführt warden können."

[95] von BURI takes this further by saying that where four-fifths of one mill pond provides the water to turn a mill wheel and another mill pond provides one-fifth of the water, then each must be regarded as the cause: M VON BURI, *Die Kausalität und ihre strafrechtlichen Beziehungen*, (Stuttgart, Verlag von Ferdinand Ente, 1885), p2: "Wenn das Umschwingen eines Mühlrads ein bestimmtes Quantum Wasser verlange, und aus zwei oberhalb der Mühle gelegnen Sammelteichen A 4/5, B1/5 desselben abgelaffen, so könne nicht behauptet warden, daß A zu 4/5 und B nur zu 1/5 den Umschwung des Rades verursacht habe."

[96] HLA HART and T HONORE, *Causation in the Law*, p69

[97] ibid, they cite G WILLIAMS, *Joint Torts and Contributory Negligence*, (London, 1951), p239

[98] HLA HART and T HONORE, *Causation in the Law*, p443

on causation in Germany's courts today.[99] He notes initially that every legal theory on causation has emanated from the conditio sine qua non.[100] He then goes on to say that the next question is which of the many conditions of an event as a result of their attributes (*Eigenschaft*) can be considered as efficient, predominant and adequate (*wirksamster, überwiegender, adäquater usw.*) so that they may be called a cause.[101] Traeger then distinguishes the legal category into which an injury or event falls. If it is possible to remove the antecedent condition and the legal categorisation changes thereby, then it is no longer possible to say that the particular antecedent condition was actually a legal condition. For example, if for the legal categorisation of bodily injury K (let us call this *Wirkungskategorie-K*), factor *x* was required then the removal of this factor *x* would result in the consequence *Wirkungskategorie non-K*.[102] So removing *x* would change the legal categorisation of damage. He summaries this idea of conditions by stating that a condition in the sense of conditio sine qua non is one where

> ...jeder Umstand, der nicht weggedacht werden kann, ohne dass der dann vorhandene Zustand überhaput nicht mehr in die betreffende juristische Erfolgskategorie W fällt.[103]

It is this elimination in thought, or *wegdenken* and *hinwegdenken,* where Traeger allows us to imagine another possible world.[104] However, it is not the conditio sine qua non theory as we know it today so we could conclude, "Adam and Eve are the cause of all torts". This is not what the law proposes. This is more akin to philosophical theorising than legal practicality. Interestingly, Hart and Honoré conclude their section on the rise of the theory of conditions with

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[99] L TRAEGER, *Der Kausalbegrif im Straf- und Zivilrecht* (Marburg, NG Elwert'sche, 1904): HLA HART and T HONORE, *Causation in the Law*, p471, ft 29; or at least they affirm it was the most often cited work in German courts in 1985 when the second edition of *Causation in the Law* was published.

[100] *Der Kausalbegriff im Straf- und Zivilrecht*, s38, "...dass jede juristische Kausalitätstheorie von der condicio sine qua non auszugehen hat."

[101] ibid

[102] ibid, p42

[103] ibid

[104] HLA HART and T HONORE, *Causation in the Law*, p443, where they cite GLASER's *Abhandlungen aus dem österreichen Strafrechte* I, 298; for more, see supra

> In the civil law the theory of conditions has had very little success, courts preferring on the whole to make use of adequacy theory or of the metaphors associated with the individualizing theories.[105]

I shall consider adequacy theory itself shortly.

2.6.2 Counterfactuals and Logic

Counterfactuals and logic are central to causal problems. Lawyers may not recognise the latter as much as the former and even then, lawyers may not refer to them as "counterfactuals". It is right that they should be considered with equivalence theory. Counterfactuals, as far as lawyers are concerned, are possible philosophical worlds in which they can imagine that which has actually happened as "contrary-to-fact".[106] To modify the example quoted by Collins, Hall and Paul

> If the glass had not been struck then it would not have shattered and thus caused the plaintiff injury.[107]

What this implies is the factual scenario that glass has indeed been struck, and, as a result of this striking, has caused the plaintiff loss. The shattering is counterfactually dependent on the striking or as we can now say, the striking of the glass (say a window) is a conditio sine qua non of the plaintiff's injury. Assuming that the court in question allows recovery for such injuries (legal causation) then the plaintiff will most likely recover the cost of the shattered glass together with resultant legally recognised damage from the defendant. This can be represented in the following way where *x* is the striking of the window and *y* is the shattering of the window: if *x* ---> *y*. If, however, the defendant can show that where he had not struck the window, the window would have shattered in any case and caused the plaintiff damage, it may be the case that the defendant would not be held liable. Philosophically and logically, what the lawyer is doing is demonstrating to the court that there exists another **possible world** where the window would have shattered at (say) approximately the same time and the plaintiff would have suffered the same damage in any case and

[105] HLA HART and T HONORE, *Causation in the Law*, p445

[106] J COLLINS, N HALL and LA PAUL "Counterfactuals and Causation: History, Problems and Prospects" in J COLLINS, N HALL and LA PAUL (eds) *Causation and Counterfactuals* (Cambridge, Massachusetts, MIT Press, 2004), p1

[107] ibid, p2

therefore the defendant should not be held liable. Arguing in such a way can be seen as weak counterfactual.[108] This means that the striking was not necessary for the shattering of the window. A strong counterfactual argument by contrast would be that if the window had not shattered then it would not have been struck. This means the only possible way that the window could have been shattered is by its being struck (by the defendant). Philosophy and logic are then useful. Of course, it is not the lawyer's task to prove to the court that the window would shatter in any event as a result of (say) a nuclear war at some undetermined point in the future; rather a court will limit such counterfactual worlds in space and in time. [109] In medical negligence, strong counterfactuals are extremely rare.

Mill noted that a cause is "…the sum total of the conditions positive and negative taken together…which being realised, the consequent invariably follows." [110] Davidson, in his article, cites one of Mill's examples of Smith's death from falling from a ladder.[111] He notes that Mill would say that a slip from a ladder is not necessarily followed by death. Mill writes

> If we do not, when aiming at accuracy, enumerate all the conditions, it is only because some of them will in most cases be understood without being expressed, or because for the purpose in view they may without detriment be overlooked. For example, when we say, the cause of a man's death was that his foot slipped in climbing a ladder, we omit as a thing unnecessary to be stated the circumstance of his weight, though quite as indispensable a condition of the effect which took place.[112]

So we miss vital information. What were the surrounding circumstances? How much did Smith weigh? How solid was the ladder in the earth? Was the ladder made of

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[108] J MACKIE, "Causes and Conditions", in *Causation*, SOSA E and TOOLEY M (eds), (Oxford, Oxford University Press, 2007) p33 at p39 "sufficient…in the circumstances"

[109] see generally, J MACKIE, "Causes and Conditions", in *Causation*, SOSA E and TOOLEY M (eds), (Oxford, Oxford University Press, 2007)

[110] JS MILL, *A System of Logic Ratiocinative and Inductive* (8th ed, London, 1886), Book I, chap V, s3; taken from the Project Gutenberg Ebook online project, p409

[111] D DAVIDSON, "Causal Relations" in SOSA E and TOOLEY M (eds), *Causation*, (Oxford, Oxford University Press, 2007), p76

[112] JS MILL, *A System of Logic Ratiocinative and Inductive* (8th ed, London, 1886), Book I, chap V, s3; taken from the Project Gutenberg Ebook online project, p403

durable material? The set of circumstances is almost endless and certainly unique. It is possible to gage probabilities of similar deaths in similar (identical?!) situations but we can never predict such situations as, of course, we only know the circumstances post-facto. This is how a court treats medical cases of causation in particular. It strives to know all the facts by individualisation. The facts in each case are particular to that patient and once the court has as many of the facts as it can ascertain, it should then gage probability. Thereafter the court will ask itself whether the plaintiff has discharged his burden of proof.

It is suggested that as far as the law is concerned the injection of temporal necessity is essential. Davidson posits six sentences.[113] It is interesting to see how five of these sentences can be adapted to conform to case law:[114]

(i) *it is a fact that* Jack fell down;

(ii) Jack fell down *and* Jack broke his crown;

(iii) Jack fell down *before* Jack broke his crown;

(iv)Jack fell down *which caused it to be the case* that Jack broke his crown;

(v)*That* Jack fell down *explains the fact that* Jack broke his crown.

Now (i) and (ii) essentially are descriptive only. If they are to be adapted to the law, number (ii) does not mean that Jack's falling down is the cause of his breaking his crown. Indeed the time between Jack's falling down and breaking his crown is unknown. In (iii) "before" is simply an adverb of time. Jack could indeed have fallen down in 1982 but have broken his crown in 2000. Number (iv) is more helpful. Here there is a causal connection that can be used but again the time between the two is unknown. There may be a question of causal potency to be ascribed to Jack's falling down causing it to be the case that he broke his crown. Once we introduce the ontology of time Davidson explains

> there exists events e and e' such that e is a falling down of Jack, e', is a breaking of his crown by Jack, and e caused e'. [115]

[113] D DAVIDSON, "Causal Relations" in *Causation*, p79

[114] original italics

[115] ibid, p80

Sentences like "The short-circuit caused the fire" then look quite vacuous for their singularity as they omit a space-time analysis.[116] Once we introduce time, matters look more precise either in

> There exist times t and t' such that Jack fell down at t, Jack broke his crown at t', and t preceded t' [117]or
>
> The one and only falling down of Jack caused the one and only breaking of his crown by Jack.[118]

Logical formulations such as these are important in understanding causation. As we shall see later on, there are many events where time is important. There is much case law dealing with asbestos-related diseases. These bear witness to a long gap between the breathing in of asbestos fibres and the developing of a disease. The above sentences can also be adapted to fit cases like "Mr Smith smoked 30 cigarettes a day for 40 years and he developed lung cancer". This counterfactual is not that he would not have developed lung cancer.

It could be questioned whether such logical analyses are either necessary or helpful in questions relating to medical liability. I propose that they are. In medical science, uncertainty pervades. It is often crucial to know what would have happened in the event that the care-provider had not been negligent. What judges and lawyers are often doing is postulating possible worlds where (normally) delictual behaviour is supplanted for correct behaviour. Yet such "perfect possible worlds" are sometimes, from the facts of the case, not the ones to be postulated. For example, it is not enough to say that had the ship been fitted with a life ring that the crew would have been saved. The behaviour to postulate is whether the crew would have grabbed the life rings, had they known how to swim with one and so on. Yet the problem with using the conditio sine qua non formula with omissions is that, as Magnus has noted, an omission as such is almost meaningless as there are many possible acts which have

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[116] D DAVIDSON, "Causal Relations", in *Causation*, p80

[117] ibid, p79

[118] ibid

been omitted.[119] It is crucial to ascertain precisely which act has been omitted. It is important to disregard conditions and concentrate on cause: in theory, at least. Further, as noted above, temporal considerations can be fundamental, especially in the area of medical negligence. It is no use for a lawyer to say, "Dr Smith performed his operation negligently and Mr Smith suffered injury"; first, we need a factual (*conditio sine qua non* or counterfactual correlation) connection between Dr Smith's performing the operation and the injury (à la Jack's crown examples given above). The two events must be proximate enough in time to allow the court to recognise causation. The correct counterfactual question must be posed in proceedings; and what is the philosophical counterfactual world to which the court must have regard? In the recent *Montgomery v Lanarkshire Health Board* it was held that a lower court had erred in this regard and that the proper question which should have been asked was not what the pursuer would have done in the event she had been advised of the minimal risk of a grave consequence but rather what the plaintiff would have done if she had been advised moreover of the risk of shoulder dystocia.[120] So counterfactual questions change with time; therefore causation changes with time. It is not a fixed concept.

There is also a difference between causation and explanation as was shown by sentence (v) of the "Jack's crown" sentences above. A care-provider's fault in performing an operation may well **explain** an injury yet the law may not allow recovery for it for some reason. For example, in the United Kingdom, only fault that meets the standard of "negligence" will be recoverable. In France, recovery is allowed for even a *faute légère*. Yet, as shall be seen, for all these logical arguments that are made, courts will often decide in a way simply having regard to public policy.[121]

[119] U MAGNUS, "Causation by Omission", in L TICHY (ed) *Causation in Law*, (Prague, E Rozkotova, 2007) p95

[120] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 at per Lord Kerr and Lord Reed at 103

[121] and they will openly say this: *Chester v Afshar* [2004] UKHL 41

2.7 Adequacy Theory

Adequacy theory is a refinement of the equivalence theory. With the equivalence theory, every antecedent can be regarded as a cause. With adequacy theory, what is considered is to what extent an event becomes more probable statistically[122]or what normally follows in the "natural course of events".[123] It was used so that attributions of liability were to be based on foreseeability rather than only pure factual causation.[124] The theory was born in Germany but also now has an extensive use in France.[125] The history of the theory shall be considered here and France's refinement of it shall be considered in the French chapter.

It was von Kries who was interested in probability and statistics. His writings reflect this. For him, a given contingency was an adequate cause of harm if it satisfied two conditions:

i. it must be a sine qua non of the harm; and

ii. it must have increased the objective probability of the harm by a significant amount.[126]

Von Kries held further that the actor's subjective knowledge must be taken into account. If the actor was mistaken in any way, then this should be considered.[127] Rümelin put forward an idea of objective hindsight taking into account the

[122] See J VON KRIES, *Die Prinzipien der Wahrscheinlichkeitsrechnung* (Freiburg, Mohr, 1886) and HLA HART and T HONORE, *Causation in the Law*, pp 467 et seqq; F BYDLINSKI has referred to the exclusion of liability where an individual has caused a damage "mechanically", though I am really not sure what this means: see F BYDLINSKI, "Causation as a Legal Phenomenon", in L TICHY (ed) *Causation in Law* (Prague, E Rozkotova, 2007) 5 at 17

[123] RGZ 81 (1913), 362

[124] K NUOTIO, "Some Remarks on the General Philosophy of Causality and its Relation to Causation in the Law", in L TICHY (ed), *Causation in Law* (Prague, E Rozkotova, 2007) 27 at 31

[125] G VINEY and P JOURDAIN, *Traité de droit civil: Les conditions de la responsabilité* (3rd ed, Paris, LGDJ, 2006), 340-1: "Mais c'est incontestablement la théorie dite la 'causalité adéquate' qui a exercé la plus grande influence tant en France qu'à l'étranger. Ne retenant parmi les conditions du dommage que celles qui contenaient la 'possibilité objective du résultat', les partisans de cette these font appel à l'idée de 'prévisibilité' en précisant généralement que cette notion doit s'apprecier objectivement et non d'après la psychologie de l'auteur.": evidently 'l'étranger' does not include the United Kingdom.

[126] J VON KRIES, "Über die Begriffe der Wahrscheinlichkeit und Möglichkeit und ihre Bedeutung im Strafrecht" (1889) 9 *Zeitschrift für die gesamte Strafrechtswissenschaft* 528

[127] HLA HART and T HONORE, *Causation in the Law*, pp482-484

knowledge of all mankind and such events as were discernible to the optimal observer.[128] Traeger thought this was too limiting and added the knowledge that the "originator" of the condition should have had in mind.[129]

Traeger then appraises von Kries and Rümelin's objective and subjective adequate theories respectively.[130] This is the crescendo to the climax of his theory later on where he writes that

> Eine sich also conditio sqn eines bestimmten Erfolgs erweisende Handlung oder sonstige Begebenheit ist dann adäquate Bedingung des Erfolgs, wenn sie generell begünstigender Umstand eines Erfolgs von der Art des eingetretenen ist, dh wenn sie objectiven Möglichkeiten eines Erfolgs von der Art des eingetretenen generell in nicht unerheblicher Weise erhöht.[131]

This "increased possibility judgement" is made taking into account general human experience at the time of the event and all circumstances an optimal observer could know at the time of its occurrence (*die einsichstigsten Menschen*[132]) and furthermore those that were known to the tortfeasor himself (*ferner die dem Täter selbst ausserdem noch bekannten waren*).[133] This is much attributive knowledge.

Some commentators have translated the "possibility judgement" as "objective probability".[134] Perhaps this is not the most appropriate translation at this stage of Traeger's exegesis. This idea of probability is brought in later on in Traeger's

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[128] M RÜMELIN, *Die Verwendung der Kausalbegriffe im Straf- und Zivilrecht* (Tübingen, Mohr, 1900), p19 where he writes "Es wird also allerdings vorausgesetzt, was dem Täter bekannt war oder bekannt sein mußte, außerdem aber auch, was sonst bekannt war oder bekannt geworden ist, zB die durch nachträglichen Verlauf aufgebeten, aber zur Zeit der Tat schon vorligenden Umstände, sowie das gesammte Erfahrungswissen der Menschlichkeit."

[129] L TRAEGER, *Der Kausalbegriff im Straf-und Zivilrecht* (1904), (Marburg, NG Elwert'sche, 1904) p136 et seqq for Traeger's critique on Rümelin

[130] ibid, pp130-144

[131] ibid, at p159

[132] the actual quote is in the dative

[133] ibid, at p159

[134] for example, W van GERVEN, *Tort Law,* (Oxford, Hart Publishing, 2000), p400

writing.[135] Traeger affirms that the adequate cause is simply not something that is a typical normal cause and an adequate condition is not simply a condition that brings about a normal, general result.[136] He notes that simply because a man dies of traumatic fever is not a normal progression from the condition of an injury but he states that it could possibly be considered as an adequate condition of the death.[137] Traeger also considers simply that probability must be considered from "the rules of life" (*nach der Regel des Lebens*) and rejects any abstract formulae in this regard.[138] Simply then he sums up that a result whose objective possibility as the result of a particular tortious act given *ex ante* general knowledge was not increased, is simply an accident.[139] As Hart and Honoré conclude, the Traeger principle of description as to whether a given act should be considered as causally relevant for increasing the probability should now be stated in the negative, viz

> that circumstances not known or knowable either to the actor or a most prudent man are excluded from the description. [140]

The notion of "description" then is important when it comes to explaining the act. The example given[141] is that of shoving a man from a cliff to his death. Von Kries said that the act should be described as "giving a shove on the edge of a cliff" only if

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[135] L TRAEGER, *Kausalbegriff*, pp162 et seqq; interestingly he compares subjective and objective probability and indicates how this might be calibrated: "Auch wenn nun unter vorauszusetzenden Bedingungen diejenigen mit inbegriffen warden, die – zwar selbst für den einsichtigsten Menschen nicht erkennbar – zur Zeit der Handlung dem Täter bekannt waren, so wird dadurch das Wahrscheinlichkeits- oder Möglichkeitsurteil nicht zu einem subjectiven Wahrscheinlichkeitsurteile, es bleibt vielmehr ein objectives. Den nest ist nach wie voz zu fragen, ob unter Voraussetzung der genannten Bedingungen die objective Möglichkeit eines Erfolgs von der Art des eingetretenen generell erhöht wird. 3. Das Möglichkeitsurteil wird auf Grund des gesamten Erfahrungswissens gebildet. Stren genommen ist das Wahrscheinlichkeits- oder Möglichkeitsurteil zwar nur dann objeectiv, alllgemeingültig, wenn es auf Grund vollkommenen nomologischen Wissens abgegeben wird, aber da wir nie oder doch fast niemals festellen können, ob wir solch vollkommenes Wissen besitzen, so ware das Möglichkeitsurteil überhaupt ausgeschlossen."

[136] ibid, p161

[137] ibid, p162

[138] ibid, p165

[139] ibid, p166, "...ein Erfolg, dessen objective Möglichkeit durch eine bestimmte Handlung oder ein sonstiges Ereignis in vorher erkennbarer Weise generell nicht erhöht wird, schlechthin als zufälliger gilt."

[140] HLA HART and T HONORE, *Causation in the Law*, p483

[141] ibid

the actor knew he was standing on the edge of a cliff. Traeger said that the act must be so described if the most prudent of men would have realised this (ie the optimal observer at the time the event occurred) and this is the view that has now been adopted by the *Bundesgerichtshof* ("**BGH**"), the German Federal Supreme Court.[142]

What we have now is a theory which holds that there is no causation if the event would only have happened "in general and [not] under abnormal, completely improbable circumstances" or if the circumstances were "unique" and "quite improbable to which no attention would be paid if events had followed a normal course."[143] Of course there are elements of probability here and the extent to which the probability of an act's occurring increases depends on the adaptation of the adequacy theory in a particular jurisdiction. It is France and Germany that have paid judicial heed mostly to adequacy theory while the United Kingdom tends to shun such theories favouring the condictio sine qua non theory and legal causation.

Stauch notes that compared to the common law approach of "reasonable foreseeability", the use of adequacy theory in Germany is arguably stricter.[144] Only that which constitutes a co-incidence could in theory be excluded from adequacy given the objective and subjective knowledge with which a defendant can be attributed. To obviate such potentially boundless liability, courts in Germany have developed yet another test and it is one which has been received to a certain extent in the United Kingdom but less so in France.

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[142] ibid

[143] W GRUNSKY, "Die Ursache muß danach im allgemein und nict nur unter besonders eigenartigen, unwahrscheinlichen und nach dem gewöhnlichen Verlauf der Dinge außer Betracht zu lassenden Umständen geeignet seinm einen Erfolg dieser Art herbeizuführen. Ob eine Ursache adäquat kausal ist, beurteilt sich nicht ex post danach, wie die Dinge effecktiv verlaufen sind…maßgeblich ist vielmehr der ex-ante-Standpunk der Schädigers…." Weise erhöht" *Münchener Kommentar Bügerliches Gesetzbuch* (3rd ed, Beck, München, 1994), Band 2, §249, at 40c

[144] M STAUCH, *The Law of Medical Negligence in England and Germany* (Oregon, Hart Publishing, 2008), p55

2.8 The Purpose of the Rule Violated

Another causal theory is that of the protective purpose rule. In Germany, this is called the *Schutzzwecklehre*.[145] Here causation is only established if the damage is one that the rule was designed to guard against and this is usually set out in legislation. Sometimes it can be difficult to ascertain the policy or rule in question.[146] France does not recognise the purpose of the rule violated to show causation.[147] This also encroaches on areas of legal policy such as should the defendant be left without a remedy, the need for deterrence, and the respective social status between the parties.[148]There is then a division between those who believe that courts should not attempt to find policy and those who think that it is at least appropriate.[149] Courts should then reduce problems to solutions that are acceptable to society for the time and place. Others believe that in a search for "cause" we should at least try to discern some rules from which solutions to future cases could be hypothesised.[150] Courts may attempt the latter but ultimately, and as this paper seeks to show, the former prevails.

I propose to show in this paper that as legal policy differs so much from jurisdiction to jurisdiction there can be no harmonisation of the rules of causation as may be proposed by the drafters of PETL or the DCFR. Although France does not recognise the purpose of the rule violated in causation, its case law on causation reflects the mores of that country. Crudely, it is more victim-friendly than (say) the United Kingdom. Germany is more sensitive to what risks must be disclosed to patients than (say) the United Kingdom. This is partly a result of its history. Causation is used as a controlling device. Policy also differs from country to country with the special liability systems inaugurated in each jurisdiction. Therefore I suggest

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[145] U MAGNUS, "Causation in German Tort Law", in J SPEIR (ed), *Unification of Tort Law: Causation*, (The Hague, Kluwer, 2000), p65

[146] ibid

[147] S GALAND-CARVAL, "Causation under French Law", *Unification of Tort law: Causation*, J SPIER (ed) (The Hague, Kluwer, 2000) p53 at p57

[148] L KHOURY, *Uncertain Causation in Medical Liability*, (Oxford, Hart, 2006), p71

[149] HLA HART and T HONORE, *Causation in the Law*, p103

[150] ibid, p105

that as policy plays a central role in causation, there can be no harmonisation of causation across Europe.

2.9 Other Factors

So while the equivalence theory, adequacy theory and purpose of the rule violated are three central theories that are referred to time and time again in case law and in academic writing with regard to causation, there are a number of other important principles to take into account.

As shall be seen in this paper, the following questions arise independently of the above theories whether or not they are being considered part of them or not:

- What is the legal policy?
- What was the causal "force" or "efficiency"? (proximate cause)
- Can we hold this purported tortfeasor liable or, was indeed the "chain of causation" in some way broken?
- Is the result just?

Ultimately, of course, causation has one design: to determine who is responsible. Research will often lead to the unearthing of "causal generalisations". These can be seen as particular conditions that usually result in a particular event. For example, the firing of loaded gun at the skull of a man usually results in his death. This can be seen as a casual generalisation. Such generalisations are not, however, always so easy to state. In *Re Polemis*,[151] it was held that where a plank in the hold of a ship was negligently dropped causing a spark which caused vapour to ignite then the defendants were liable for a resulting fire even though that fire was not reasonably foreseeable.[152] The court's reasoning here was that as **some** damage was reasonably foreseeable then **all** damage as a direct consequence of that the fire was recoverable. This case has often been criticised and it is obvious why. The ratio would appear to hold that there was ultimately no limitation on damages. This is a ratio to be expected from a tortfeasor who had *deliberately* caused the fire but perhaps not where it is a negligent act. In *The Wagon Mound*[153] certain employees had acted negligently allowing oil to leak from a ship which covered the

[151] [1921] 3 KB 560

[152] ibid

[153] [1961] 1 All ER 404

water and the shore. Welders nearby produced hot metal which caused the oil on the water to ignite. This in turn caused substantial damage to the wharf and the ships that were moored there. It was held here that although some damage to the wharf was foreseeable, damage by fire was unforeseeable by the spillage. The ratio of *The Wagon Mound* is that a man is only responsible for the probable consequences of his act[154] and in turn reasonable foreseeability became the effective test for remoteness of damages.[155] This can be seen here as either a kind of common-sense "ordinary man in the street" test[156]or an adequacy test. I have not found any overt reference to adequacy theory in the United Kingdom in any of the cases I have researched.

In this case, Viscount Simmons, delivering the judgement for their Lordships, was highly critical of the test applied in *Re Polemis*. He excused it party by opining the law of negligence *qua* independent tort was recent and the full implications had never been examined. Following *The Wagon Mound*, however, *Re Polemis* was no longer of sound law in the United Kingdom.[157]

It can be seen therefore that the above two examples provide some of the clues to the principles and concepts in a search for causal principles. As was stated in *Re Polemis*[158]

> In whatever form we state the rule of 'natural and probable consequences', we must remember that it is not a logical definition, but only a guide to the exercise of common sense. The lawyer cannot afford to adventure himself with philosophers in the logical and metaphysical controversies that beset the idea of cause.[159]

This paragraph is somewhat unfortunate. First, I am not clear as to what a "logical" definition is and, on the contrary, merely by considering counterfactuals, a lawyer **is**

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[154] ibid, 422

[155] ibid, 426

[156] ibid, the words actually used at 424

[157] it never had been the law of Scotland

[158] *The Wagon Mound* [1961] 1 All ER 404 at 570

[159] citing Sir F Pollock, *The Law of Torts*, (1887), pp35, 36

involved in philosophy and logic. The lawyer imagines possible worlds but does not necessarily do so in such a way that he is perplexed or confused or in a way that need baffle the court. A medical negligence lawyer will certainly at some point in his career be confronted with causation in "Jack's crown" scenario. When a court is saying that the defendant caused the plaintiff's damage, it is simply saying that the defendant legally caused the plaintiff's damage. It is a pity that courts are often so willing to pooh-pooh logic or philosophy in this way as if it had nothing to do with real situations when in reality, philosophy and logic are arguably at the very heart of causation.

However simple such a ratio may be to quote, it still leaves the lawyer with the problem of ascertaining what common sense is. Sir F Pollock above merely muddied the already turbid waters of causation by referring to common sense. The judgement in *The Wagon Mound* was simply that the negligent welding operation of the employees did not cause the damage to the wharf. This may appear perhaps prima facie perplexing. The acts of the employees factually caused the damage to the wharf. The court limited recovery to "natural and probable" consequences of their action so the causal chain **to** the fire was not completed or the debris that caught fire and lit the molten metal "**broke**" the chain of causation. Their acts did not legally cause the damage to the wharf but they did factually. This is all the court is holding: nothing more and nothing less.

It can be seen then that causation is inseparably linked up with foreseeability. Damages will only be limited (often) to what is foreseeable. Some express the test in contract (and medical relationships in France and Germany are generally in contract) as what was in the "reasonable contemplation of the parties".[160] But it is suggested that courts do not really require to use "foreseeability" and they mix causal language with the language of damages. I would suggest that it is possible simply to do away with ideas of limiting damages to what is foreseeable and include everything in a causal argumentation. Courts simply need to hold that the defendant did or did not cause the plaintiff's damage (or caused it to the extent they determine). Such

[160] HL MacQUEEN and JM THOMSON, *Contract Law in Scotland* (Edinburgh, Butterworths, 2000), p238

arguments, however, are strictly outwith the scope of this paper. In any case, what I aim to show here is how policy can be used by courts at the same time as they co-opt causal terminology. I cited case law of what may be "reasonable foreseeability", "common sense" or that given event *a*, the "natural and probable consequences" are cause, *b*. Yet this is all terminology perhaps reminiscent of adequacy theory. It may be and as I shall show, these terms often dissolve into one.

2.10 Conclusion

Causation matters then because it appeals to our intuitive notions of justice and causation is reflected in all of the jurisdictions under consideration. One is only liable for legally recognised harm caused. Causation is also a controlling device in as much as it can provide the link between harm done and responsibility. It matters because, especially in hard cases, it can be difficult to know which theory, if any, to apply. There are a number of problems in all the jurisdictions relative to causation in general. I wish to concentrate primarily on the subject of medicine and disease. Recurring themes can be seen in each jurisdiction and I have outlined in this chapter a number of those theories.

Each jurisdiction approaches causation in a different way. This usually reflects the society. How causation is understood is a result of, among other things, openness to philosophical reception, history, the legal system itself (*inter alia* is precedent important?), policy and any special regimes in place. To try to deduce common principles or guidance from the abundance of case law and academic writing on the subject, I think is not only impossible, but also pointless. I hope to show simply that there are no such common principles and even if those that certain European projects advance are applied, the causal language of them leaves enough room for manoeuvre for courts to do what they want. Such rules are unconvincing.

I wish to underline again that when a court says that A caused B's death, it should be understood to mean that A is **legally** responsible for B's death and nothing more. It should not be understood by the public to mean that given A solely caused (in a wide sense) B's death. There are always individualising factors and any judgement or interpretation of a scenario that does not account for these should be treated with scepticism. For example, if B stabs A, but A is a haemophiliac, we should say B caused A's death. Now we do not mean that B scientifically or medically caused A's death; rather B precipitated A's death from that uncertain moment in the future when it was going to happen anyway. It is the blood leaking from the stab wound, resulting in a lack of a flow of oxygen to the brain which would ultimately and scientifically cause A's death. His haemophilia must be taken into account as a contributing cause scientifically, perhaps not legally. For the jurist, however, it is

only B's stabbing of A that is relevant: nothing else.[161] The leaking of the blood from the stab wound and ultimately brain death are almost conditions for the jurist: they occur naturally from the stabbing in the normal course of things.

Humans are moral actors and must be held liable generally for their voluntary acts.[162] Each of the jurisdictions under consideration acknowledges this link in some form or another.[163] There would appear no reason to abandon it for its own sake. Here there is commonality. As mentioned above, humans are not always in agreement as to when it is most fitting to use causation to attribute responsibility. In this way, causation serves as a controlling device and it would be disingenuous to say that it is clear for a lawyer at the outset what a court will decide in difficult cases as these are often simply resolved by public policy. That is why, I suspect, none of the jurisdictions in their codes have attempted a definition of causation and that is why I am sceptical of codes or principles that attempt to prescribe such rules.

In this chapter, I have sought to introduce causation in the law from first principles. This has necessitated a brief history of causation in the law together with an explanation of some concepts that I will refer to in this paper such as the equivalence theory and adequacy theory. This more instructive and explanatory chapter aims to form a precursor to the main thrust of this paper which is to deny the validity of such sections of European projects in tort law in so far as they attempt to define or expand on causation. They attempt to see how problems might be solved in the given jurisdictions and from this deduce certain principles which they have then published. I do not believe that this is possible and I hope to show this in particular with regard to causation in medical liability.

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[161] of course, the defendant's counsel may well argue that his haemophilia should be taken into account but many jurisdictions have rejected such notions in favour of the "thin skull" rule.

[162] at least, this is the society in which we live at the moment; see ARISTOTLE, *The Nichomachean Ethics*, Chapter 3; also *MacAngus v HM Advocate* 2009 SLT 37 and Sheriff Stoddart's commentary on the same in the *Journal of the Law Society of Scotland*, April 2009

[163] Art 1382 French and Luxembourg Civil Codes and § 823 German BGB

In order to substantiate my argument then, evidence is necessary. It is to this which I now turn by a consideration of how causation is treated in each of the jurisdictions under consideration here: the United Kingdom, France and Luxembourg, and Germany. The final chapter of this paper shall then summarise this evidence demonstrating that harmonisation projects in so far as they relate to causation must be futile.

However, it would be wrong of me not to consider causation in tort law as it has been considered by the ECJ. It must consider tort law in general in accordance with principles common to the member states. My contention is, at least in the area of causation, that there are none. I suggest only that the TFEU must be amended the better to reflect the reality of ECJ decisions with regard to non-contractual obligations. I offer nothing further in this regard. I think by now it should be clear, that I believe there are no stateable principles on which causation can be based which can be applied with any consistency.

Chapter 3: Causation in the United Kingdom

3.1 Introduction

Proving causation is essential to establishing delictual liability. The search for the causal link in the United Kingdom is similar to that in the other jurisdictions under consideration here. It is an attributive inquiry.[164] That is, how does a court attribute what has happened to the defendant and allow the plaintiff to recover? The method in the United Kingdom is what shall now be considered.

Fault liability remains the basic principle of liability in the United Kingdom. The plaintiff must show that the defendant owed the plaintiff a duty of care, that that duty was breached and that the plaintiff suffered damage caused by the defendant. These are the basic principles of *Donoghue v Stevenson*,[165]the most fundamental case in British tort law.[166]

The burden of proof remains squarely with the claimant. He must prove his case on the balance of probabilities. This means that the claimant must persuade the judge that his version of events was "more likely than not". In theory this is a standard of 51% but "A judge deciding disputed questions of fact will not ordinarily do it by use of a calculator."[167]

Traditionally the search for causal attribution in the United Kingdom is based on a judicial dichotomy of an analysis of causation-in-fact and causation-in-law. It is a two-stage test and any textbook in tort will refer to this.[168] It is perhaps a nice division but it is not often clear what it means in practice. Although Thomson writes that the first essential is that the defender's acts or omissions are a cause of the pursuer's damage and this is a question of fact, he does not further expand on this

[164] HLA HART and T HONORE, *Causation in the Law*, p24

[165] [1932] AC 562

[166] it was actually a Scottish case

[167] *Hotson v East Berkshire Area Health Authority* [1987] 2 All ER 909, as per Lord Mackay at 916

[168] B MARKESINIS and S DEAKIN, *Tort Law*, (Oxford, Oxford University Press, 2003) p185; and JM THOMSON, *Delictual Liability*, Chapter 6

other than quote case law.[169] I think Markesinis and Deakin are more candid and forthright. They state that the use of the two stages of enquiry "factual" and "legal" is by no means free of controversy. What was apparent from reading the case law was that even the former factual analysis requires a value judgement in itself and is by no means obvious or clear. I shall treat this in more detail in the final chapter. Traditionally, at the first stage, the question is asked: but for the plaintiff's act or omission, would the defendant still have suffered the loss? If the answer is yes, then the defendant would be absolved at this point. There would be no need for further enquiry and the litigated circumstances may be termed "mere conditions".[170] If the answer is no, then the court would move on to a legal cause analysis. It is at this second stage when notions and vocabulary such as "direct", "proximate", "efficient" and "reasonably foreseeable" can be introduced. As I shall show through the case law, this is principally a test of policy.

Many of the cases illustrating causation stem from medical negligence. I shall consider here areas of British law that have been controversial. In the United Kingdom, there would appear to be now more emphasis on legal causation (in the policy sense), epidemiology, and, loss of chance. I shall now examine factual and legal causation as they are treated in the United Kingdom.

[169]JM THOMSON, *Delictual Liability*, p135; this is a Scottish textbook so I keep the terms "pursuer" and "defender".

[170]B MARKESINIS and S DEAKIN, *Tort Law*, p185

3.2 Causation in Fact or the conditio sine qua non

In the United Kingdom, there are a number of cases in medical liability which illustrate the concept of causation-in-fact. Case law is at the heart of British law and I shall set out the facts of some important cases first leaving my commentary on them to the end.

Barnett v Chelsea and Kensington Hospital Management Committee[171]is the epitome of the "but for" test. Here the plaintiff's husband drank poisoned tea and died. Although he presented himself at hospital, the attendant doctor told him just to go home. This was negligent and a breach of the doctor's duty of care. It was found, however, that Mr Barnett would have died anyway as he would not have had the chance to take the antidote before he died.

In *Kay's Tutor v Ayrshire and Arran Health Board*,[172] Andrew Kay was admitted to hospital with suspected meningitis on 28 November 1975. He was about two and a half years old. He was given about three hundred times the required amount of penicillin. The health board did not deny negligence. They did deny negligence for some of the sequalae, namely, deafness and associated behavioural dysfunction. Deafness was a relatively common occurrence in any case with children who had suffered from meningitis. There were no reported cases, however, of overdoses of penicillin in se causing deafness. The pursuers relied somewhat on *McGhee v National Coal Board*[173] but Lord Keith of Kinel concluded that there was no evidence on which to apply the ratio of there being a material increase in risk.[174] Indeed there was no evidence at all in this case that giving an overdose of penicillin to a child could in fact have caused his deafness. Neither was it accepted simply that just because there was

[171] [1968] 1 All ER 1068

[172] [1987] UKHL 17

[173] see infra at 1973 SC (HL) 37, 1973 SLT 14 following on from *Wardlaw v Bonnington Castings* (1956) SC (HL) 26 which held that where there were two potential sources of danger operating concurrently then if one of them materially contributed to the plaintiff's injury then the conditio sine qua non test would have been overcome. In *McGhee*, it was held that where there was a material increase in risk following on from two sources of danger operating consecutively then if it could be established that there was a material contribution to the risk then the conditio sine qua non test would also be overcome.

[174] Bailli, p14/19

a material increase in risk in neurological damage globally[175] that this included deafness. Lord Mackay of Clashfern noted

> The next step is to consider whether there is evidence that the overdose materially increased the risk of deafness. In my opinion, it is not right to ask whether it materially increased the risk of neurological damage when the evidence available distinguishes between different kinds of neurological damage...In none of those [cases] who survived an overdose [of penicillin], and the number of cases is very small, was the particular type of neurological damage which results in deafness found to have occurred. I cannot accept that it is correct to say that because the evidence shows that an overdose of penicillin increases the risk of particular types of neurological damage found in these cases that an overdose of penicillin materially increases the risk of a different type of neurological damage, namely that which causes deafness when no such deafness has been shown to have resulted from such overdose.[176]

So what His Lordship was opining here was that although penicillin may cause damage which was general neurological damage, it was not deafness. There were twelve study results from intrathecal overdoses of penicillin: in eight the result was death, in two the result was complete recovery and in the last two, the result was permanent neurological damage although it was not deafness.[177] What is required then, and this might remind us again somewhat of Traeger's principle above, is that a specific kind of damage, K, is required to have been caused. Neurological damage in this case, ie non-K, was, therefore, too vague, although K may have been its subset.

In *Bolitho v City and Hackney Health Authority*,[178] the issue of causation was somewhat clouded and obscured with that of professional negligence. Here, a child, Patrick

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[175] Lord Mackay of Clashfern p 18/19

[176] Bailli, p17/19

[177] ibid

[178] [1997] 4 All ER 771; this case is perhaps most famous (or notorious) for the dictum of Lord Browne-Wilkinson who observed at p9/7 (Bailli) that with regard to the medical standard of care and expert evidence "...if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible. I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable." This would be an interesting subject for further comment in itself but is unfortunately outwith the scope of this paper.

Nigel Bolitho, was admitted to St Bartholomew's hospital under the care of a senior paediatric registrar, Dr Horn. Although a nurse asked Dr Horn to attend, she failed to attend on two occasions. Patrick later collapsed, was unable to breathe, suffered cardiac arrest and later died. It was accepted that Dr Horn was in breach of her duty of care in not attending on Patrick. It was held in evidence that even if Dr Horn had attended, she herself would not have intubated. The plaintiffs led evidence that intubation would have been appropriate in the circumstances. The defendants led evidence that intubation would not have been appropriate in the circumstances.[179] Lord Browne-Wilkinson appears to note two issues in causation. He states[180]

> There were, therefore, two questions for the judge to decide on causation: (1) What would Dr Horn have done, or authorised to be done, if she had attended Patrick? and (2) If she would not have intubated, would that have been negligent?

The answer in fact was that she would not have intubated. The court accepted the expert evidence advocated on behalf of the defendants in that intubation was not necessarily a routine procedure but carried risks with it and therefore that non-intubation was not negligent.[181]

This case raised the question of proof of causation when the negligent act was one of omission. Interestingly, His Lordship noted here that the question "what would have happened?" would not have been determinative in itself of causation. For example, if it had been established that Dr Horn would not have intubated and not intubating would have been contrary to accepted medical practice, then she should not escape liability simply by proving that even if she had attended, the same damage would have occurred anyway because she would have committed some other breach thereafter![182] His Lordship in this case referred to the analysis of Hobhouse LJ in

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[179] The plaintiffs led eight medical experts, the defendants three

[180] [1997] 4 All ER 771, Bailli p5/9

[181] The court firmly stated that medical negligence is a legal question and not one to be determined by doctors. Re-stating the locus classicus test of medical negligence in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583, McNair J affirmed that a defendant would have to show that he acted in accordance with the practice accepted as proper by a "reasonable body of medical men" (at p 587; later adjectives of "responsible and respectable" are added.); this case, of course, must now be read with the caveat of the recent *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 which now holds that "informed consent" is part of British law

[182] This makes me re-think *Barnett v Chelsea and Kensington Hospital* [1968] 1 All ER 1068 which I mentioned above

Joyce v Merton, Sutton and Wandsworth Health Authority[183]where he opined

> Thus a plaintiff can discharge the burden of proof on causation by satisfying the court *either* that the relevant person would in fact have taken the requisite action (although she would not have been at fault if she had not) *or* that the proper discharge of the relevant person's duty towards the plaintiff required that she take that action. The former alternative calls for no explanation since it is simply the factual proof of the causative effect of the original fault. The latter is slightly more sophisticated: it involves the factual situation that the original fault did not itself cause the injury but that this was because there would have been some further fault on the part of the defendants; the plaintiff proves his case by proving that his injuries would have been avoided if proper care had continued to be taken. In the *Bolitho* case the plaintiff had to prove that the continuing exercise of proper care would have resulted in his being intubated.[184]

So what does this mean for a plaintiff? First, if a plaintiff can show that the action to be taken by the defendant would have been constitutive of negligence then the plaintiff overcomes the causal hurdle. For example, in this case, if the plaintiff could have shown that intubation would have been a negligent course of action and that Dr Horn would have intubated had she attended then the causal hurdle would have been overcome. The second condition of this disjunction would require that the plaintiff prove his case by showing that his injuries would have been avoided if the proper care had been taken. In this case then, it required that the plaintiffs show that proper care was Patrick's intubation. This factual enquiry, of course, remains in the realms of hypothesis and it is intriguing to observe how the courts confront causation-in-fact with omissions. It shows how courts can convert investigation of fact into normative counterfactual investigations.

What I have tried to illustrate here with regard to a few cases in factual causation is that it is often not simple to agree on which is the correct causal solution. Even with what would appear simple cases such as *Barnett* cited above, some would say that it

[183](1996) 7 Med LR 1

[184] *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771, p5/9, Bailli

would be unfair to leave the defendant in this case without a remedy.[185] The doctor after all clearly breached his duty of care. Cases like *Kay's Tutor* show how philosophy of causation is still relevant in analysing cases regardless of how judges may belittle a philosophical analysis (for example, Traeger's analysis) in other cases. *Bolitho* again deals with philosophical hypotheticals and counterfactuals in the case of omissions particularly. It suggests how a condictio sine qua non can be determined.

Yet this strict "but for" rule would be harsh if applied absolutely. I turn now to the dilution of the sine qua non test in the United Kingdom in cases where a rigorous application of the test would lead to injustice. It is this I wish to examine more fully to understand factual causation in the United Kingdom.

3.2.1 Factual Causation – Dilution of the "but for" test

The strict application of the "but for" test in British law could have produced harsh results and the courts have recognised this. In certain cases therefore, its strict application has been regulated.

In *Wardlaw v Bonnington Castings*,[186] the plaintiff developed pneumoconiosis from breathing dust in the atmosphere at work. The dust came from two sources: the first source was a hammer and the second, machines in the workplace. It was held that if the plaintiff could demonstrate that one of the two sources had **materially contributed to** his injury then he could recover from his employer. Whatever was material was more than *de minimis*. The plaintiff was able to show this and he recovered. This is perhaps an unremarkable decision in itself.[187]

In *McGhee v National Coal Board*,[188] the plaintiff was employed by the National Coal Board and worked in a hot and dirty kiln. Each day he cycled home. There were no

[185] I took a poll among my second year tort students this year and out of the 42 students I had, 18 disagreed with this decision, 20 agreed with it and 4 were undecided. I do not have precise data from other years but I can recount anecdotally only that it is not only one or two who disagreed with this decision; quid then "common sense" in causation in the so-called "easy cases"?

[186] 1956 SC (HL) 26

[187] J STAPLETON, "Law, Causation and Common Sense", (1988) 8 *Oxford Journal of Legal Studies* 111 at 127

[188] 1972 SC (HL) 37

on-site washing facilities where he could clean himself before going home. The plaintiff contracted dermatitis. The House of Lords held that the employer breached its duty of care to the employee by not providing on-site washing facilities. There were two sources of danger which operated consecutively and the defender was only responsible for the second. The problem for the pursuer was that he could not prove that not having the showers materially contributed to his dermatitis. Yet the House of Lords expanded its approach in *Wardlaw*. There are two famous dicta by Lord Reid and by Lord Salmon and it is worth quoting them here. Lord Reid laid the foundation. He reasoned

> But it has often been said that the legal concept of causation is not based on logic or philosophy. It is based on the practical way in which the ordinary man's mind works in the every-day affairs of life. From a broad and practical viewpoint I can see no substantial difference between saying that what the defender did materially increased the risk of injury to the pursuer and saying that what the defender did made a material contribution to the injury.[189]

Lord Salmon went further in his eschewal of philosophical niceties

> In the circumstances of the present case, the possibility of a distinction existing between (a) having materially increased the risk of contracting the disease and (b) having materially contributed to causing the disease may no doubt be a fruitful source of interesting academic discussion between students of philosophy. Such a distinction is, however, far too unreal to be recognised by the common law.[190]

What was shown, however, was that cycling to work materially increased the **risk** of his contracting dermatitis. This ratio was applied to dilute the "but for" test still further and mitigate the injustice that its application would have caused.

In *Fairchild v Glenhaven Funeral Services*,[191] two different employers, E1 and E2, employed the plaintiff, P, at different periods of his active working life. During his employment P developed mesothelioma as a result of over-exposure to asbestos. It was impossible to say whether the cancer was caused during P's employment with E1

[189]ibid at 53-54

[190] ibid at 62

[191] [2003] 1 AC 32

or E2 or indeed with both employers. It was, however, accepted that the risk had been materially increased by his overall exposure to asbestos. It was difficult to state that one employer "materially contributed to" the contracting of mesothelioma. There was then a problem of sequentiality, concurrence and synergies which raised points of scientific evidence. This case progressed on the basis that mesothelioma may be contracted by the inhalation of a single fibre and clearly the chances of inhaling a single fibre are increased the more one is exposed to asbestos. Asbestosis, on the other hand, is generally affected by the total amount of dust that is inhaled. It was therefore scientifically impossible to isolate the "guilty" fibre either when P was working for E1 or when he was working for E2. The plaintiff recovered based on the materially contributing to the risk ratio.

There is a subtle difference between *McGhee* and *Fairchild* and it is this. In *McGhee*, the illness was sustained as a result of the defender's behaviour even if the illness might not have been actually brought about as a result of the defender's negligence; it was contracted by his conduct. In *Fairchild*, the ratio goes further by holding that the defendant may be liable even when the illness could have been caused by another person completely based on the scientific evidence of the "guilty" fibre. Second, as Thomson notes, there are limitations to *Fairchild*.[192]The ratio applies only when it is scientifically impossible to establish the cause of the plaintiff's injury. Further, although the sources of danger can be different, it must be shown that each source could in fact have caused the pursuer's injury. This is why the pursuers failed in *Kay's Tutor* as there was actually no evidence that penicillin could in fact have caused the child's deafness. Lord Nicholls wanted to make sure that "There must be good reason for departing from the normal threshold 'but for' test".[193]

It is difficult to know what to make of *Fairchild*. There is a difference between an increase in risk in itself and an injury consequent on an increase of risk of causing the disease. As Horton Rogers has stated, the limits of *Fairchild* are unclear and it is intended to apply where conventional proof is impossible not just difficult.[194]

[192]JM THOMSON, *Delictual Liability*, p141

[193] *Fairchild v Glenhaven Funeral Services* [2003] 1 AC 32 at para 43

[194] in B KOCH (ed) *Medical Liability in Europe: a Comparison of Selected Jurisdictions*, (Berlin, de Gruyter, 2011), p179

Another limitation is that the agents must have caused the damage in substantially the same way.

Lord Bingham in *Fairchild* cited the study of van Gerven in that both France and Germany would find a remedy for the plaintiff but based on different legal principles: Germany would use principally risk-creation together with a certain reversal of the burden of proof.[195] France, for its part, would have perhaps adopted an approach similar to the classic hunter cases where it could not be established which of the hunting party fired a shot into a forest and injured the plaintiff. The Cour de cassation has held that the whole group was liable.[196]

Ending his comparative discourse, Lord Bingham noted that "most jurisdictions would, it seems, afford a remedy to the plaintiff." I suggest that His Lordship is correct in his analysis for those jurisdictions forming part of this study.

Lord Hoffman also appealed to the idea notion of a principled approach eschewing notions of "common sense" stating that

> ...there is sometimes a tendency to appeal to common sense in order to avoid having to explain one's reasons. It suggests that causal requirements are a matter of incommunicable judicial instinct. I do not think that this is right. It should be possible to give reasons why one form of causal relationship will do in one situation and not in another.[197]

"Common sense" is often indeed referred to in dicta where causation is an issue. It contributes only to unpredictability.

In *Barker v Corus*,[198] there were similar facts, only here some of the employers had become insolvent. The House of Lords held that the plaintiff could only recover proportionately and the defendants were not jointly and severally liable. Following a

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[195] *Fairchild v Glenhaven Funeral Services* [2003] 1 AC 32 at para 25

[196] *Litzinger v Kintzler* (CC 2, 5 June 1957, D1957.497)

[197] *Fairchild v Glenhaven Funeral Services* [2003] 1 AC 32 at para 53

[198] [2006] UKHL 20

political backlash against this judgement, it was left to Parliament to reverse this aspect of the judgement with the Compensation Act 2006.

In *Wilsher v Essex Area Health Authority*,[199] a boy was born three months premature. His life was in the balance. He survived nonetheless. He succumbed to retrolental fibroplasia (RLF). This is an incurable condition of the retina which caused total blindness in one eye and severely impaired vision in the other. A catheter was negligently inserted into the heart instead of the aorta. This resulted in a false reading of oxygen pressure. He sued the health board in negligence. The Court of Appeal held that the burden of proof lay on the defendant to show that it was not in breach of its duty the plaintiff also had to show that this damage did not result from such breach of duty.[200] Much was made of the case law, especially *Wardlaw* and *McGhee* relative to both the ratio of "material contribution" and the shifting of the burden of proof respectively. Mustill LJ at appeal held that

> If it is an established fact that conduct of a particular kind creates a risk that injury will be caused to another or increases an existing risk that injury will ensue; and if the two parties stand in such a relationship that the one party owes a duty not to conduct himself in that way; and if the other party does suffer injury of the kind to which the risk related; then the first party is taken to have caused the injury by his breach of duty, even though the existence and extent of the contribution made by the breach cannot be ascertained.[201]

So Mustill LJ took *McGhee* and applied it to this case holding that even though we cannot be sure of the presence or degree of the contribution, it is the creation of the risk of injury that is important.

The dissenting judgement by Sir Nicolas-Browne Wilkinson VC in the Court of Appeal was later lauded by Lord Bridge in the House of Lords. There were five other noxious agents at play here for which the defendant was not responsible and these could have been responsible for the child's injuries. It was never proven the

[199] [1987] UKHL 11

[200] ibid, Bailli, p4/20, relying on *McGhee v National Coal Board* [1973] 1 WLR 1 and *Clark v MacLennan* [1983] 1 All ER 416

[201] *Wilsher v Essex Area Health Authority*, p6/20 (Bailli)

excess oxygen caused or contributed to the RLF suffered by the plaintiff. There was no evidence as to which of the six possible causes could have caused the injury. If precedent is accepted, this is a hard case but a right one. Lord Bridge expressed sympathy for the plaintiff and remarked that

> Many may feel that such a result serves only to highlight the shortcomings of a system in which the victim of some grievous misfortune will recover substantial compensation or none at all according to the unpredictable hazards of the forensic process.[202]

He goes on to note that it is not for the courts to change issues such as proof of fault. This is for Parliament and society would not benefit if the law were made more unpredictable.[203] Further in evidence, Lord Bridge quoted Sir Nicolas Browne-Wilkinson VC where he said

> "In the *McGhee* case there was no doubt that the pursuer's dermatitis was physically caused by brick dust; the only question was whether the continued presence of such brick dust on the pursuer's skin after the time when he should have been provided with a shower caused or materially contributed to the dermatitis which he contracted. There was only one possible agent which could have caused the dermatitis, viz brick dust...In the present case the question is different. There are a number of different agents which could have caused the RLF. Excess oxygen was one of them. The defendants failed to take reasonable precautions to prevent one of the possible causative agents (eg excess oxygen) from causing RLF. But no-one can tell in this case whether oxygen did or did not cause or contribute to the RLF suffered by the plaintiff. The plaintiff's RLF may have been caused by some completely different agent or agents, eg hypercarbia, intraventricular haemorrhage, apnoea or patent ductus arteriosus. In addition to oxygen, each of those conditions has been implicated as a possible cause of RLF."[204]

So it is important then, for the purposes of causation, to distinguish between those cases where there is only one noxious agent and where recovery will be allowed for increase in risk or materially contributing to the risk and cases like *Wilsher* where there is more than one agent and it cannot be established which one agent caused the

[202] ibid, p14/20 (Bailli)

[203] ibid, p19/20 (Bailli)

[204] ibid, p12/20 (Bailli)

injury or if the relevant agent contributed to or materially increased the risk of the damage, as was the case here.

So while the "but for" rule remains the norm in theory, it has been relaxed in certain situations where an injustice would result in practice. I submit that "but for" is not really a principle rule but that these theories exist in parallel. The case of *McGhee* in particular has been criticised by a number of leading academics.[205] Hogg, for example, suggested that it would be wrong to equate risk creation to causation. He suggested that risk of harm is not the same as causing actual harm.[206] His example is that of driving a car creates a risk of causing a pedestrian harm. I would partly agree with Hogg in theory when he notes that

> ...*McGhee* fundamentally undermined the rule that a connection, demonstrated by counterfactual analysis, was needed between harm and loss before causation could be established. It opened up the possibility that a defender might be held liable for damage which in actuality he had not caused.[207]

The problem with *McGhee*, of course, is that it is entirely retrospective. It looks back at the risk that was created and considers this as causal – even if indeed the defendant may never have caused it. I think Hogg is being somewhat overdramatic in his statement that *McGhee* opens the possibility that a defendant may be held liable for a damage he did not cause. I do not think it matters that the "rule" of condictio sine qua non was undermined. Justice had to be done and this was the way to do it as the courts saw fit.[208] This was always the case given the standard of proof we have in the United Kingdom. It is only necessary to prove one's case to 51% in any case.

While the *McGhee* ratio was concerned with material increase of risk, there were limits on its ambit as stated above; for example, there must have been one noxious agent

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[205] See for example, M HOGG, "Re-establishing Orthodoxy in the Realm of Causation", (2007) *Edinburgh Law Review* 8 and JM THOMSON, (2003) 7 *Edinburgh Law Review* 80

[206] ibid, M HOGG at p13

[207] ibid

[208] I do readily understand, however, a Scots lawyer's preference to principle over equity, not that I advocate particularly one over the other. For a severe example of how Scots law has stuck rigidly to its rules in property law, see *Sharp v Thomson* 1997 SC (HL) 66 a case ultimately over-ruled by the House of Lords.

only and there must have been a breach of duty. So while I agree that the counterfactual "but for" test was not just diluted but replaced in this case, I am not ill at ease with the *McGhee* ratio together with its limitations. For me then *Wilsher* is not a refusal to follow *McGhee* but simply a problem about proof and is easily distinguishable.

The hypothetical of the "but for" plays a significant role in any causal enquiry and I now wish to examine this aspect of causation in the United Kingdom more closely.

3.2.2 Hypothetical Causation

The essence of the "but for" test is the counterfactual. What would have happened if the defendant had not acted as he did? What would the plaintiff done had she been aware of the risks that were kept from her before consenting to a medical intervention? This simple question can create numerous problems but essentially the test in the United Kingdom (but not with regard to the disclosing of risks) is that set down in *Bolitho v City and Hackney Health Authority*[209] that where a doctor can show that there exists a body of responsible medical opinion which believes that the treatment was not negligent then the doctor will usually not be held to have acted negligently. However, such opinion must have a logical basis and the court ultimately decides the issue, not experts – at least in theory.[210] This shows that causation is a value judgement.

One case I should like to consider in the United Kingdom with regard to the advising of risks is that of *Chester v Afshar*.[211] I would like to consider this case in some detail as it shows perhaps the situation when the plaintiff genuinely does not know what she would have done.[212] This case is also important from a number of other aspects. It deals with a doctor's failure to warn, policy reasons to allow causation and certainly shows, in my submission, that there can be no "man in the street" understanding of causation.

In this case, Miss Chester was recommended to undergo surgery by a neurologist, Mr Afshar. Mr Afshar failed to warn Miss Chester of a one to two per cent risk that she could suffer cauda equine syndrome after the surgery.[213] This risk did eventuate, however, but there was no suggestion whatever that Mr Afshar performed the

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[209] [1997] 4 All ER 771

[210] ibid, as per Lord Browne-Wilkinson at 779

[211] [2004] UKHL 41

[212] I have written about this case elsewhere and I shall incorporate my findings in this paper as this case is fundamental to an understanding of causation in medical negligence in the United Kingdom: E HYSLOP, "Causal Theories in *Chester v Afshar* [2004] UKHL 41", (2008) 4 *European Review of Private Law* 629

[213] a neurological condition of the back where the nerve roots of the spinal canal below the conus lose their function

operation negligently. It could not be established evidentially that even if Miss Chester had known about the risk she would have gone ahead with the operation (the counterfactual). All that could be established was that she would not have gone ahead with the operation on that particular day. She would have obtained further advice and considered other options. There was no doubt that Mr Afshar was negligent in not informing his patient of the small risk but the problem in this case was causation: no counterfactual hypothesis could be established in the long term about whether she would have gone ahead with the operation or not. The House of Lords held, by a majority of only 3:2,[214] that causation could be established and this mainly on grounds of public policy. I would like now to consider what causal ratio (if any) can be extrapolated from this case.

As mentioned, the problem here was that Miss Chester could not show that had she known about the risk that she would not have gone ahead with the operation. She said that she did not know what she would have done. She testified she would not have gone ahead with the operation that day but would have taken advice. So the "but for" test was not passed. She should therefore have failed in her claim but, as Lord Hoffman noted

> the claimant has failed to prove that the defendant's breach of duty caused her loss. On ordinary principles of tort law, the defendant is not liable. The remaining question is whether a special rule should be created by which doctors who fail to warn patients of risks should be made insurers against those risks.[215]

The majority in this case held that causation (both factual and legal) was established essentially on grounds of policy. Reference was made to the Australian case of *Chappel v Hart*[216]where a patient underwent an operation without having first been warned of a small risk inherent in the procedure. It was established in this case that had she known of the risk, she would not have proceeded at that time but rather at a later time under the supervision of a more experienced surgeon. Recovery was allowed on the basis of a loss of chance to have the operation performed by a more

[214] the same majority as *Gregg v Scott* [2005] UKHL 2

[215] *Chester v Afshar* [2004] UKHL 41 para 32

[216][1998] HCA 55

experienced surgeon.

Chappel was used in *Chester* to allow recovery based specifically on "common sense" or "loss of opportunity to pursue a different course"[217]and even that Mr Afshar had a duty to inform; he did not inform and that therefore the vague and nebulous "legal consequences must follow".[218] It is somewhat strained, I find, to apply such reasoning to the facts as Miss Chester did not make a case as to what chance she had lost. It is important to remember that she did not state that she would not have submitted to the operation and nor was it proven that there would be fewer risks inherent in the operation had she proceeded with it in the future. As Hogg notes, a plaintiff must still show that there was the chance of avoiding injury, and, that but for the defendant's fault, the plaintiff would not have lost the chance.[219]The plaintiff did not show this. What does exist in *Chappel* by contrast is an indication that a more experienced surgeon may have been available and that, had Mrs Hart been warned, she would have deferred the operation to a more experienced surgeon. In my opinion, *Chester* is distinguishable as such circumstances are not present here. Although strictly outside the ambit of this paper, I suggest rather that the approach of the minority in this case was the more consistent with the law. While the "but for" test is not a comprehensive nor exclusive test of causation, there was no other rule-based replacement for it.[220] Perhaps Lord Hope sums up the feeling of the majority most succinctly in *Chester* at paragraph 73 where he opines "Yet the patient to whom the duty was owed is left without a remedy."

Lord Hoffman, for his part, focuses on principle. He opines at paragraph 56

> The concepts of fairness, justice and reason underlie the rules which state the causal requirement for liability for a particular form of conduct (or non-causal limits on that liability) just as much as they underlie the rules which determine that conduct to be tortuous.

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[217]Lord Hope at para 74

[218]ibid at para 76 citing Kirby R in *Rogers v Whittaker* (1992) 175 CLR 479 at 490

[219]M HOGG, "Re-establishing Orthodoxy in the Realm of Causation," (2007) *Edinburgh Law Review* 8 at 15

[220] *Chappel v Hart* [1998] HCA 55 as per Hayne J at para 116

He continues

> The problem in this appeal is to formulate a just and fair rule. Clearly the rule must be based on principle. However deserving the claimants may be, your Lordships are not exercising a discretion to adapt causal requirements to the individual case. That does not mean, however, that it must be a principle so broad that it takes no account of significant differences which affect whether it is fair and just to impose liability.[221]

From this, I think we can see that Lord Hoffman is criticising rules based on policy. Lord Hope quite openly states that his decision is one of policy, and does not hide this nor pretend to rationalise using previously established causal principle. At paragraph 87, he opines

> On **policy** grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn.[222]

It is unclear what can be extrapolated from this. This is a policy decision but His Lordship appears to be stating that where an injury is "intimately involved" with a duty to warn, then there is liability. I do not understand what "intimate involvement" means nor how it magically resolves the causal puzzle.

The majority in *Chester* has overridden the requirement for causation with policy while paying lip-service to causal satisfaction. Only Lord Hoffmann broaches the possibility of creating a special rule in which he sees the potential for a modest solatium award.[223]From this case, it would appear that there is no clear agreement as to when policy should prevail and similarly, prediction is not a simple task. So while I may criticise *Chester* for not being consistent with causal rules that had developed to date,[224] I submit that cases like these go some way towards proving the central theme

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[221]*Chester v Afshar* [2004] UKHL 41 at para 60

[222] my emphasis

[223] *Chester v Afshar* [2004] UKHL 41 at para 34

[224] E HYSLOP, "Causal Theories in *Chester v Afshar* [2004] UKHL 41" (2008) 16 *European Review of Private Law* 629

of this paper: that in the area of medical liability, there is no certainty or clear idea of causation and nor can "common sense" principles be derived therefrom. It can be seen that even with a majority of 3:2, their Lordships were certainly not in agreement as to the correct decision. There was no common sense decision and this was certainly not a correct decision in the sine qua non sense. This leads me then to the second test in British law: legal causation. After the sine qua non test has been fulfilled, the question arises as to whether the courts are going to allow the causal chain to be broken for some reason or whether they are going to allow it to be completed. Legal causation can be used even when factual causation returns an unsatisfactory answer (as I showed with *Chester* above). It is this that I shall now consider.

3.3 Legal Causation (*causa causans*)

As Thomson notes, it is not enough that the defendant's act is the sine qua non of the plaintiff's injury, it must also be the legal cause or the *causa causans*.[225] Thomson's example is that of A, who drops a brick on B's toe. B is taken in an ambulance to hospital. The ambulance is driven negligently such that it crashes and B dies. Should B's executors then have a claim against A, who dropped the brick and certainly was (inter alia) the factual cause of B's death. The question here is should B be held to be the *causa causans*.

Whether or not a defendant is held to be liable is often analysed in terms of reasonable foreseeability or remoteness. The defendant's act must have as its reasonable and probable consequence harm, to the plaintiff. There are many cases which set out how the criterion of foreseeability is to be judged. It is to be judged by the courts as to what the reasonable person foresaw and not as to what the particular plaintiff foresaw.[226]

Similarly, if a doctor negligently amputates a leg from a patient then the doctor would be liable for the patient's loss of earnings and psychiatric stress. This is what is called derivative economic loss. If the plaintiff contends, however, that as a result of this negligence, he was unable to purchase a winning lottery ticket that he was in the habit of buying, then these losses would normally be considered as too remote. In England, it used to be the case that loss, even though it was not reasonably foreseeable, could be recovered provided it was a direct consequence of the harm.[227] As can be imagined, this could lead to liability to a great extent. English courts later developed a test that if damage is unforeseeable then there can be no recovery.[228] So tests of remoteness, foreseeability and causation, in my opinion, all smelt into one. In Scotland, the test has been one that is much more Continental, at least in theory perhaps. It has been held that the test is not where a loss was reasonably foreseeable

[225] JM THOMSON, *Delictual Liability*, p142 et seqq

[226] *Muir v Glasgow Corpn* 1943 SC (HL) 3, 1944 SLT 60

[227] see supra, *Re Polemis and Furness, Withy & Co Ltd* [1921] 3 KB 560, CA

[228] *Overseas Tankship (UK) Ltd v Morts Dock and Engineering Co, The Wagon Mound* [1961] AC 388

but rather where it happened "naturally and directly" from the delict.[229] As ever, a consideration of some case law can give us an idea of legal causation in the United Kingdom.

In *Sabri-Tabrizi v Lothian Health Board*[230] the pursuer had a sterilization which failed. She became pregnant but had a termination. She then knew she was fertile and had sexual intercourse with her husband even though she took precautions. The defenders admitted liability for the first pregnancy but not for the second. Lord Nimmo-Smith agreed. He found

> She avers that she took precautions, but in so far as there remained a residual risk, in a question between her and the defenders I think that it is unreasonable of her to expose herself to that risk. Accordingly I regard her decision to have sexual intercourse in the knowledge that she was not sterile as constituting a novus actus interveniens, breaking the chain of causation, with the result that the defenders cannot be held liable for the second pregnancy and the consequences thereof.[231]

In *Webb v Barclays Bank plc and Portsmouth Hospitals*,[232]the claimant injured her polio affected left leg for which the defendants were responsible. The consultant surgeon advised her to have an above the knee amputation. This advice was negligent. The Court of Appeal held that the negligence of the consultant surgeon did not "eclipse the original wrongdoing" and the employer's liability - Barclays Bank - was assessed at 25% while the health trust's was held at 75%. So what is discernible then in these two cases is a limitation of causation's scope, and a formulation of its application, in terms of a *novus actus interveniens*.

In *Bailey v Ministry of Defence*,[233] the plaintiff returned from holiday in Africa with possible gallstones. Inspection was by way of an Endoscopic Retrograde Cholangiopancreatography (ERCP). Following this ERCP there was a period of lack

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[229] *Campbell v F and F Moffat (Transport) Ltd* 1992 SCLR 551, 1992 SLT 962, OH

[230] 1998 SC 373

[231] ibid at 378

[232] [2001] EWCA Civ 1141

[233] (2007) EWHC 2913 (QB)

of care and in particular a failure to resuscitate. At the same time, the plaintiff developed pancreatitis. There was, however, no allegation that pancreatitis was a result of the hospital's lack of care. The plaintiff later suffered brain damage when her air passages were blocked following her vomiting on lemonade. The question before the court was did the weakened state of the plaintiff materially contribute to the brain damage. Accepting the judge's conclusions, Lord Justice Waller stated that the weakened state of the plaintiff caused her body not to react naturally to vomiting and this did not in any way break the chain of causation.[234]

What I find common in these cases (and indeed in many of the cases in this chapter) is that although a break in the chain of causation is actually referred to, in essence what the courts are doing, is stating policy reasons. These judgements, I suggest, are policy ones and need not use such causal wording. Indeed, I think it impossible, especially in the realm of legal causation, to attempt to state causal principles and what we have time and time again is an application of policy. Although judges might claim to rely on what the man in the street thinks, I suggest that there are no common sense answers to such cases and if there are no common sense answers to such cases then it is impossible to extract principles from them when ultimately such cases are based on policy.

[234] ibid, at para 32

3.4 Loss of Chance

In *Hotson v East Berkshire Health Authority*,[235] the House of Lords held that a Court of Appeal judge erred in law when he allowed for recovery for loss of a chance. Here the plaintiff suffered injury when, as a 13-year old boy, he climbed a tree and fell injuring his left femoral epiphysis. He was taken to hospital but there was a failure to diagnose this injury and he was sent home. A few days later he returned to the hospital and this time he was diagnosed accurately. The question that arose here was whether "but for" this initial mis-diagnosis, would the subsequent avascular necrosis of the epiphysis have eventuated? Evidence from both medical experts was at two extremes. On the one hand, the plaintiff's expert said due to the injury sustained in the fall, the rupture of such a high proportion of blood vessels supplying the epiphysis with blood was such that necrosis was bound to develop.[236] He said that although there was a "small chance"[237] that necrosis would not have developed, the delay had made it inevitable. Lord Bridge identified the reasoning of the lower judge.[238] The Court of Appeal judge in his own words faced the dilemma of classification of the issue: was it a case of causative negligence or was it a case where the real question was quantum? Lord Bridge opined that he knew of no principle of English law which would permit recovery for the plaintiff even at a discount from the full measure of damages to reflect this chance. Loss of chance in tort was not recognised. He did not rule out future recovery for loss of chance.[239] Lord MacKay considered American authority in his judgement. In *Herskovits v Group Health Co-operative of Puget Sound*[240] in the USA, a plaintiff's tumour was not diagnosed on first examination. If it had been, there was a 39 per cent chance that he would have survived for more than 39 years. When he was eventually treated, this had reduced to 25 years. Although the

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[235] [1988] UKHL 1

[236] ibid at 2

[237] ibid

[238] ibid at 3

[239] Reference was made to the cases of *Chaplin v Hicks* (1911) 2KB 786 and *Kitchen v Royal Air Force Association* (1958) 1 WLR 563. Both cases concerned contract. In the former, an actress lost the chance to enter a competition. If she had entered, she may have obtained a more lucrative contract. A money value was put on this and she was allowed to recover for the loss of this chance to enter the competition. In the latter case, there was again a breach of contract where a solicitor through his negligence did not lodge an appeal. This was valued and recovery allowed.

[240] (1983) 664 P 2d 474

Superior Court of King County held for the defendants, the Supreme Court of Washington reversed this. They based their decision inter alia on the American Restatement of Torts and also the principle by Dore J that

> To decide otherwise would be a blanket release from liability for doctors and hospitals any time there was less than 50 per cent chance of survival, regardless of how flagrant the negligence.[241]

Lord Mackay noted that Dore J concluded that this was sufficient for the matter to go to the jury and for them to decide on proximate cause while pointing out to them that such reduction in the opportunity to recover did not necessitate a total recovery against the negligent party.[242] Lord MacKay also referred to the use of statistics alone in such cases[243]underlining the fact that they must be backed up by individualising evidence. So the ratio of *Hotson* was that it is not possible to recover for a loss of chance in cases of medical negligence. In quoting Lord Diplock in *Mallett v McMonagle*,[244] Lord Mackay set out the fundamental principle of proof in English law in that

> "In determining what did happen in the past the court decides on the balance of probabilities. Anything that is more probable than not it treats as certain."[245]

This is something that shall be discussed in the comparative chapter and the differences with France and Germany (and between France and Germany) are readily apparent. Lord Ackner does not favour extending the loss of chance doctrine as

> ...to do so would be to propound a wholly new doctrine which has no support in principle or authority and would give rise to many complications in the search for

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[241] ibid, p477

[242] *Hotson v East Berkshire Area Health Authority* [1988] UKHL 1 at 10

[243] ibid, at 10; by giving an example per Lord Guthrie in *Kenyon v Bell* (1953) SC 125 where he notes that in a town with four taxis, three yellow and one blue, and where one person were knocked down by a taxi then it would be wrong to rely solely on the statistical evidence that there was a 75 per cent chance that it was a yellow taxi and therefore find against the yellow taxi company.

[244] (1970) AC 166

[245] ibid at 176

mathematical to statistical exactitude.[246]

As far as the United Kingdom is concerned, he is not entirely correct in that it is recognised where medical negligence is not in issue. In *Chaplin v Hicks*,[247] a case referring to the loss of a chance of securing valuable employment, His Lordship suggested that there would be "formidable difficulties" in applying these analogies to medical negligence cases.[248] He did not expand on this. Yet he did say that perhaps this case was not a "suitable occasion for reaching a settled conclusion as to whether the analogy can ever be applied".[249] In *Hotson* then as the plaintiff could not prove causation above 50% on the balance of probabilities, his claim necessarily failed.

Lord Ackner further referred to *Bagley v North Herts Health Authority*,[250] where the judge discounted an award for the parents of a stillborn child, as there was a 5% possibility that the child would have been stillborn anyway. Lord Ackner criticised this reduction as the causal hurdle that must be overcome is proof on the balance of probabilities. It was shown that on the balance of probabilities the hospital's negligence caused the still birth, indeed almost to a degree of certainty: that should have been an end of the matter. What comes across in this judgement at any rate is that such chances cannot be given a monetary value and cannot be regarded as an asset the diminution in the value of which by a tortfeasor results in a discrete action of loss of chance.[251]

Another case where there could have seen some development of the loss of chance doctrine was in *Gregg v Scott*.[252] In this case, Dr Scott negligently diagnosed Mr Gregg. The latter attended on the former for a consultation. He presented Dr Scott with a

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[246] *Hotson v East Berkshire Area Health Authority* [1988] UKHL 1 at 16

[247] (1991) 2 KB 786

[248] *Hotson v East Berkshire Area Health Authority* [1988] UKHL 1 at 4

[249] ibid

[250] (1986) 136 NLJ 1014

[251] *Hotson v East Berkshire Area Health Authority* [1988] UKHL 1 as per Lord Mackay of Clashfern's judgement at 5 et seqq

[252] [2005] UKHL 2

lump under his left arm. Dr Scott said it was not harmful and sent him away. Some nine months later, Mr Gregg consulted another doctor who said it could possibly be innocuous but sent him for tests nonetheless. The disease spread. It was stated (not without opposition on behalf of one of the Law Lords) that his chances of disease free survival[253]had been reduced from 42% to 25%. This case was ultimately decided in the House of Lords on a 3:2 majority. The decisions make for fascinating reading. The case was held against Mr Gregg. He could not recover even though Dr Scott had been negligent in not referring him initially to a consultant. His case was presented initially as one of pain and suffering for increase in the size of the tumour but then turned to one of loss of life expectancy or loss of the chance to avoid the damage. This was new. I should like to turn first to those Law Lords who gave dissenting judgements in this case.

First, Lord Nicholls recognised that it would be impossible to say with certainty what would have happened had Mr Gregg been correctly diagnosed. Rightly he appreciated that the prospects of assessing chance of survival are open to such speculation and filled with many variables.[254] So would Mr Gregg's cancer have been at such an advanced state but for Dr Scott's negligence? Lord Nicholls reminded us that the law defines the claimant's actionable damage by reference to opportunity that was lost rather than a loss of a desired outcome that was never within his control.[255] He noted that indeed lost opportunity had been endorsed in other areas. For example, where a solicitor negligently failed to lodge a writ in time, the court assessed the probability of success, which the solicitor's negligence had prevented the claimant from pursuing.[256] He noted, referring to Tony Weir, that of course, losing the chance of saving a leg is not the same as losing a leg itself but that is not a reason for declining to value the chance for whose loss the doctor was directly responsible[257]and that justice required in the latter case as much as the former that

[253] survival meaning living for more than 10 years

[254] *Gregg v Scott* [2005] UKHL 2 at para 23

[255] ibid, at para 17

[256] *Kitchen v Royal Air Force Association* (1958) 1 WLR 563

[257] T WEIR, *Tort Law*, (Oxford, Oxford University Press, 2002), p76

the loss of a chance should constitute actionable damage.[258]

From a policy perspective also, he reproached the floodgates argument as one that is always advanced whenever the law is under development and in any case, the righting of a wrong weighs more.[259] Whether indeed it would cost more on the British National Health Service (NHS) he said was a matter of speculation and stated this a matter for parliament.[260]

Notwithstanding the inherent uncertainty in knowing whether Mr Gregg belonged to the 58% survivor or 42% non-survivor category, the law has often found solutions for evidentiary lacunae. The ratios of "material contribution to" or "material increase in the risk of" were novel at the time.[261]

However, as his Lordship opined, medical negligence cases are different in that the patient's actual condition at the time of the negligence will often be determinative of a sine qua non answer.[262] For example, in contrasting *Gregg* with *Hotson*, there was a factual question that ultimately determined the legal outcome. The factual question was did the child actually have enough blood vessels to keep his left femoral epiphysis alive? The answer to this then determines whether the avascular necrosis would have been avoided and, as His Lordship rightly noted, many cases are not like this. The present case, for example, is one of these. In *Gregg*, the answer in the hypothetical world to initial mistaken diagnosis could not provide an answer as to what the outcome would have been if he had been treated promptly.[263] His Lordship then formalised this dichotomy and stated either there is a *Hotson*-type case where there is really no uncertainty on the usual probability basis or they fall into the present case where there is a lot of uncertainty.

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[258] *Gregg v Scott* [2005] UKHL 2 at para 25

[259] ibid, at para 48

[260] ibid, at para 54

[261] for example in *Bonnington* and *McGhee*

[262] *Gregg v Scott* [2005] UKHL 2 at para 35

[263] ibid, at para 37

If Mr Gregg could only prove his case to 51% then he would recover all his damages. The defendant could not then deduct 49% from total damages. As Horton Rogers noted, if we allow a person with a 30% chance of recovery 30% of his damage, the other side of the coin is that we could not refuse to reduce the damages of a person with a 70% chance of recovery.[264] This was recognised by the claimants in *Gregg v Scott*.[265]

Lord Hope for his part also allowed recovery. Interestingly, he took the position that the case was not only about loss of chance. It was, rather, about loss and damage caused by the enlargement of the tumour due to the delay in diagnosis: reduction of prospects of a successful outcome being consequential on the enlargement.[266]

Lord Phillips entered into a detailed discussion of statistics and challenged the interpretation of the evidence. He criticised the expert's model from which statistical evidence was deduced as it included all ages and also people with other "unrevealed personal characteristics."[267] At the time of the hearing, Mr Scott was still alive. The expert put his chances of surviving then at 20-30% though normally anyone who had a second relapse as Mr Gregg had, only had chances of surviving of around one in six. His Lordship criticised the statistical evidence as it did not put Mr Gregg in a further sub-category. We can see then how judges often have to enter into the minutiae of causation and should indeed scrutinise reports in this way. I shall consider statistics in more detail later.

Lord Hoffman is in the majority opinion here. He recites a chronology of loss of chance[268]before saying that

> One striking exception to the assumption that everything is determined by impersonal laws of causality is the actions of human beings.[269]

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[264] B KOCH (ed) *Medical Liability in Europe: a Comparison of Selected Jurisdictions*, p183

[265] [2005] UKHL 2

[266] ibid, at para 117

[267]ibid, at para 148

[268]ibid, at para 76

[269]ibid, at para 82

This was part of the reason, he posited, why we treat non-medical loss of chance different from medical loss of chance cases. [270]The law treats humans as having free will and the ability to choose different courses of action, however strong the reasons may be for them to choose one course rather than another.[271] He opined that

> …the true basis of these cases is a good deal more complex. The fact that one cannot prove as a matter of necessary causation that someone would have done something is no reason why one should not prove that he was more likely than not to have done it.[272]

He also noted that academic writers have suggested that in cases of clinical negligence, the need to prove causation restricts liability and that Mr Scott should have a remedy. He suffered a wrong which should be put right. Lord Hoffman's opinion is that adopting such rules would mean the jettisoning of a lot of authority.[273]

I think we see the essence, however, at the end of his judgement. Lord Hoffman noted there that adopting possible rather than probable causation would be such a change to the determinants of liability as to require parliament to intervene. He also argued that this would have a serious effect on insurance companies and the National Health Service. In *Hotson* it was simply a matter of proof as to whether there were enough blood vessels at a given moment. In *Gregg*, we must posit a hypothetical. The chances in *Allied* were nonetheless valued and able to be assessed in a way that medical chances were not.

Baroness Hale's approach is that a defendant would always be liable as the other side of the coin in a loss of chance case. At paragraph 223, she gives an example of A's negligence probably causing B's loss of a leg. A pays B the value of the leg, £100,000. If A probably did not cause the loss, A pays B nothing. If a loss of chance approach were used, she argued, A's negligence probably caused a reduction

[270]ibid

[271] ibid

[272] ibid at para 83

[273]ibid at para 85

in the chance of B's keeping his leg less the chance it would have happened anyway. So, if the chance of saving the leg were very good, say 90%, the claimant would get £90,000. If the chances were relatively poor, say 20%, the claimant would get £20,000. She saw both scenarios as unsatisfactory as the claimant would get less than full compensation and the defendant could end up paying a substantial sum for which by definition, he cannot be shown to be responsible.

The logical extension of this is that a defendant would almost always be liable for something.[274] There would be more complex expert testimony and negotiations and trials would become a great deal more difficult. There would also be consequences for the insurance industry and such a great policy change as this could not be introduced in the United Kingdom at this stage. Yet perhaps the irony in this case, as Baroness Hale rightly pointed out, was that the most serious of adverse outcomes had not happened.[275] Mr Scott had survived. What had the doctor's negligence caused in this case? Where was the damage?

The kernel of all this is that loss of chance claims are not permitted in the United Kingdom in medical negligence cases. They are permitted in France and Luxembourg as we shall see in later chapters. What is important is not whether they should be permitted or not but rather French courts and doctrine have a different understanding of what causation actually is. The case examples I have given above would, I am almost certain, be decided otherwise in France. Yet I have found in comparative textbooks (as I shall show in the comparative chapter) that many comparative lawyers are all too ready to disregard and discount these differences. The drafters of PETL in their commentaries also allow loss of chance but do not state it outright in the text. This is not an insignificant difference and in my opinion would result in a great divergence of decisions in the jurisdictions under consideration.

I shall consider now the burden of proof in tort cases in the United Kingdom. This is a procedural matter. Whether a plaintiff can prove his case plays a crucial role in whether he is likely to be successful.

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[274] ibid at para 225

[275] ibid at para 226

3.5 Burden of Proof

A plaintiff in the United Kingdom must prove that the defendant has caused him damage. Other than certain matters which do not require to be proved, such as matters within juridical knowledge, he must prove this on the "balance of probabilities", or to 51%. This is called the legal burden (or persuasive burden). It never moves.[276] If he can prove it, he recovers everything. If he cannot prove it, he recovers nothing at all. If, for example, he can only prove causation to 49%, he recovers zero. As we have just seen, there is no recovery for loss of chance in the United Kingdom that would allow for proportionate recovery. In addition, the burden of proof is never reversed no matter how seemingly grave or serious the fault may appear. There is, however, one device that resembles other procedural devices on the Continent: *res ipsa loquitur*. It is not a presumption but just a state of affairs that needs explaining. If a plaintiff can justify a *res*, then he tactically is well on his way to establishing causation. Second, I should like to consider statistics as expert evidence in the United Kingdom. Statistics often play a decisive role in determining whether it is likely that an outcome *b* was caused by action *a*. Both *res* and the use of statistics are valuable to a plaintiff who wishes to prove a causal link.

3.5.1 *Res ipsa loquitur*

The present approach to the doctrine in the United Kingdom can be found in the case of *Ratcliffe v Plymouth and Torbay Health Authority*[277] where it was held by Brooke LJ that

> (1) In its purest form, the maxim applies where the plaintiff relies on the "res" (the thing itself) to raise the inference of negligence, which is supported by ordinary human experience, with no need for expert evidence. (2) In principle, the maxim can be applied in that form in simple situations in the medical negligence field (surgeon cuts off right foot instead of left; swab left in operation site; patient wakes up in the

[276] F DAVIDSON, *Evidence* (W Green, Edinburgh, 2007), p92; here two other burdens are noted: the tactical or provisional burden and the evidential burden. The tactical burden is one which may come to rest on one party as the case progresses. This could be something like prima facie evidence as was suggested by Lord Denning in *Brown v Rolly Royce Ltd* 1960 SC (HL) 22 at 28. However, as he also opined there, "At the end of the day, the Court has to ask itself not whether the provisional burden is discharged but whether the legal burden has been discharged." (ibid). The evidential burden is that where a party has the burden of showing that there is sufficient evidence on a matter to warrant a court's consideration of it, eg the defence of self-defence.

[277] [1998] EWCA Civ 2000

course of surgical operation despite general anaesthetic). (3) In practice, in contested medical negligence cases the evidence of the plaintiff, which establishes "res", is likely to be buttressed by expert evidence to the effect that the matter complained does not ordinarily occur in the absence of negligence. (4) The position may then be reached at the close of the plaintiff's case that the judge would be entitled to infer negligence on the defendant's part unless the defendant adduces evidence which discharges this inference. (5) This evidence may be to the effect that there is a plausible explanation of what may have happened which does not connote any negligence on the defendant's part. The explanation must be a plausible one and not a theoretically or remotely possible one, but the defendant certainly does not have to prove that his explanation is more likely to be correct than any other. If the plaintiff has no other evidence of negligence to rely on, his claim will then fail. (6) Alternatively, the defendant's evidence may satisfy the judge on the balance of probabilities that he did exercise the proper care. If the untoward outcome is extremely rare, or is impossible to explain in the light of the current state of medical knowledge, the judge will be bound to exercise great care in evaluating the evidence before making such a finding, but if he does so, the prima facie inference of negligence is rebutted and the plaintiff's claim will fail. The reason why the courts are willing to adopt this approach, particularly in very complex cases, is to be found in the judgements of *Stuart-Smith* and *Dillon LJJ in Delaney v Southmead Health Authority*.[278] (7) It follows from all this that, although in very simple situations the "res" may speak for itself at the end of the day, evidence adduced on behalf of the plaintiff, in practice the inference is then buttressed by expert evidence adduced on his behalf, and if the defendant were to call no evidence, the judge would be deciding the case on inferences he was entitled to draw from the whole of the evidence (including the expert evidence), and not on the application of the maxim in its purest form.

The doctrine of *res ipsa loquitur* is a doctrine used in British courts with regard to evidence. It means literally "the thing speaks for itself". In theory, the burden of proof still remains with the plaintiff but the defendant cannot – should not - remain taciturn. The defendant ought to explain, justify or legitimise the evidence which the claimant has brought and if he does not, he stands a severe risk of losing his case. This was once seen as a complete reversal of the burden of proof and the view was

[278](1995) 6 Med LR 355

taken that such a thing would not happen without negligence.[279] Giesen gives some instances of where a *res* speaks for itself.[280] Some examples given are failing to dispense the proper medication,[281]causing injury to a healthy part of the body,[282]or performing an unnecessary mastectomy.[283] There have even been cases where doctors have operated on the wrong side of double organs or on the wrong patient altogether or have removed "large portions of the plaintiff's stomach, pancreas and the entire spleen" in the mistaken belief that an ulcer patient was suffering from cancer.[284] *Res ipsa loquitur* is not a special rule of law and it does not reverse the burden of proof. The initial presumption can either be strong or weak and this will affect the weight of the evidence that is required from the defendant to refute such hypothesis. There is no standard of proof which the defendant must fulfil in his rebuttal but it has been said that "The *res*, which previously spoke for itself, may be silenced, or its voice, may, on the whole of the evidence, become too weak or muted."[285]

In *Delaney v Southmead Health Authority*,[286] it was held that even if a case of *res ipsa loquitur* is made out in the first instance, it is always open to the defendant to rebut it either by giving an explanation of what happened which is inconsistent with negligence, or by showing that the defendants exercised all reasonable care.[287] In this case, the plaintiff had sustained a lesion of the brachial plexus [288] following a

[279] H ROGERS, *Cases on Medical Malpractice in a Comparative Perspective*, M FAURE and H KOZIOL (eds) (Vienna, Springer, 2001), Country Report England, p233

[280] D GIESEN, *International Medical Malpractice Law* (Dordrecht, Kluwer, 1988), 210

[281] *Collins v Hertfordshire CC* (1947) 1 All ER 633 (cocaine instead of procaine)

[282] *Arnold v Bonnell* (1984) 55 NBR2d 382 (chemotherapy treatment by injection; needle moving in patient's arm and drugs entering surrounding tissue, causing injury to patient's arm and requiring several operations)

[283] *Down v Royal Jubilee Hospital* (1980) 24 BCLR 296 (SC)

[284] *Wilson v Swanson* (1956) SCR 804

[285] *Lloyde v West Midlands Gas Board* [1971] 1 WLR 749 at 755 as per Megaw LJ

[286] 1995 6 Med LR 355

[287] as per Stuart-Smith LJ

[288] nerves running from the spine to the hand

cholecystectomy.[289] It was found that the anaesthetist's practice of positioning the arm at 45 degrees without supination accorded with good practice.

In some cases, however, the defendants made no explanation whatever. In *Cassidy v Ministry of Health*,[290] the plaintiff entered hospital for an operation on his left hand which required post-operational treatment. At the end of the operation, it turned out that his hand was useless. The trial judge had held that no negligence had been proven. On appeal, however, it was held that the onus lay on the hospital authority to prove that there had been no negligence on its part.

Important was the way Lord Denning phrased his summary of *res ipsa loquitur* in the case. He noted

> If the plaintiff had to prove that some particular doctor or nurse was negligent, he would not be able to do it. But he was not put to that impossible task: he says, "I went into the hospital to be cured of two stiff fingers. I have come out with four stiff fingers, and my hand is useless. That should not have happened if due care had been used. Explain it, if you can". I am quite clearly of the opinion that that raises a prima facie case against the hospital authorities...They have nowhere explained how it could happen without negligence.[291]

This is the characteristically simple language of Lord Denning. In extreme cases, a prima facie case is raised against the hospital authority. This is different from reversing the burden of proof. With *res*, some kind of explanation is called for. In *Cassidy*, none was provided: therefore the defendants were held liable.

In *Roe v Minister of Health*,[292] two patients were operated on the same day. Both operations were minor and the negligence here related to the administration of the anaesthetic. The anaesthetic itself had been stored in sealed ampoules which themselves had been stored in a solution of phenol. Both patients developed severe

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[289] the surgical removal of the gall bladder

[290] 1951 2 KB 343

[291] ibid, at 366

[292] (1954) 2 QB 66

symptoms of spastic paraplegia caused by the phenol. The phenol had entered the ampoules through "invisible cracks" that were not visible to the naked eye. It was held here that the hospital was not negligent as the medical staff had adhered to the standard of medical care required. I think, however, Lord Denning LJ summed up quite succinctly the doctrine of *res ipsa loquitur* in this case again. He opined

> The judge has said that those facts do not speak for themselves, but I think that they do. They certainly call for an explanation. Each of these men is entitled to say to the hospital: "While I was in your hands something has been done to me which has wrecked my life. Please explain how it has come to pass.[293]

His Lordship then proceeded to analyse negligence in itself here by considering duty of care, foreseeability and causation. As far as causation is concerned, he noted that causation often depended on what was foreseeable and indeed as we know, the chain of causation is broken if something unforeseeable occurs. What is intriguing here (even as far back as 1953) is that His Lordship noted that the ideas of duty, negligence, causation and remoteness run continually into one another and they are three different ways of looking at the same problem. I also think this farrago of norms does not help. I comment here not for its own sake but because it is relevant to causation. The extent to which these norms interplay (especially with causation) and how this links with our overall understanding is something I shall leave for comment in the final chapter. Lord Denning summarised by posing the question that negligence can be found in the answer to

> Is the consequence fairly to be regarded as within the risk created by the negligence? If so, the negligent person is liable for it: but otherwise not. [294]

This is telling: ideas of "within the risk" are concepts crucial to causation though make me think more of German notions of causation than British ones as we shall see below.

A policy element was similarly discernible in Lord Denning's judgement. This can be seen in the final paragraph of his judgement where he states that

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[293]ibid, at 83

[294]ibid, at 85

> One final word. These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.[295]

I think then we must always be aware of simple policy reasons in causation. Although Lord Denning may well have been known as reticent to allow claims against doctors, we must be aware of when a decision – and therefore causation - is policy-driven and at least here, it openly is.[296]

Therefore the plaintiff should normally submit a plea of *res ipsa loquitur* where there is a set of circumstances that require some explaining by the defendant. This will no doubt be backed up by expert reports. It is more a tactical and strategical device: the burden of proof is not reversed but it would be an ill-counselled defendant who remained mute. A defendant would do well to give a reasonable explanation of what has happened otherwise causation may be established.

3.5.2 Statistics as Expert Evidence

Using statistics to establish causation in medical negligence cases can be particularly contentious. Epidemiological reports are, of themselves, not evidence. Statistics are general so the problem remains in that a plaintiff must individualise the statistics to make them more relevant to her case. Experts must speak to epidemiological reports.[297]

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[295] ibid, at 87

[296] for example, see at 83 when Lord Denning states that "It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought to be on our guard against it, **especially in cases against hospitals and doctors**." (my emphasis)

[297] *H v Schering Chemicals* [1983] 1 All ER 849

Richard Goldberg argues, for example, that in the case of *Vadera v Shaw*[298]that the epidemiological evidence was not individualised.[299] In this case, a 22-year old Asian woman was put on a contraceptive, Logynon. She had a blood pressure reading of 150/100. The question before the court was whether a brain stem stroke which Miss Vadera had suffered was a result of Logynon or not. It was held that, from the epidemiological evidence available to the court, that nothing more than a relationship of chance could be established. Goldberg challenges this finding. He maintains that "insufficient scrutiny of the expert evidence appears to have taken place".[300] Although the trial judge may have considered the epidemiological studies, Goldberg argues that no attempt was made to "...particularise the evidence to the individual patient in question...".[301]]He criticises the decision as not enough scientific evidence was placed before the court. Goldberg argues that Logynon, combined with the ethnic factors of Miss Vadera's being Asian and the possible hypertension were cumulative *McGhee*-type factors for a classic application of *McGhee* where the ratio of increase in the risk should have been applied to allow causation. I think, however, that the issue of claimant-specific statistics comes into its own here and this was underlined by *McTear v Imperial Tobacco Limited*,[302] where it was held that epidemiological data cannot be used to draw conclusions about the cause of disease in any individual.[303] It was also held that using epidemiological models in such a way obscures the underlying heterogeneity of the population including genetic profile, socio-economic status, workplace, diet and other exposures that make a major contribution to disease occurrence.[304]In *McTear v Imperial Tobacco Limited*,[305] the defendant did not even accept that there was a general link between smoking and

[298] (1998) 45 BMLR 162 (CA)

[299] R GOLDBERG, "The Contraceptive Pill, Negligence and Causation: Views on *Vadera v Shaw*" (2000) *Modern Law Review* 316

[300] ibid, at 326

[301] ibid, at 331

[302] [2005] 2 SC 1

[303] ibid, at para 6.180

[304] ibid

[305] ibid

lung cancer.[306] The pursuers therefore had to be put to proof. Lord Nimmo Smith found that the court had to be taught how to do epidemiology and that although an association might be held to lie between smoking and lung cancer, it was also necessary to show a causal connection.[307] His Lordship criticised the pursuers for not having presented their case well and that in essence this was a missed opportunity for general causation to be established.[308] Of course, this case failed also the pursuers did not go from the general to the specific. It may have helped them if they had studied some logic.

Goldberg supports the use of Bayes' Theorem to personalise the general chance aspect of causation.[309] He writes that the Bayes' theory could be used to evaluate the probability, A, before the use of new data and the probability after the utilisation of new data by using a general formula to allow for specific information in a given case. So for *McTear*, individualising factors could be personality traits, family history of lung cancer, stressful lifestyle, oral infections of the respiratory tract, alcohol abuse, vitamin A deficiency, low socio-economic status and residence in an urban area in the west of Scotland. Therefore lawyers must be careful to individualise as much as possible their expert reports.

In *Wardlaw v Farrar*,[310] it was alleged that a doctor's delay in admitting a patient to hospital had reduced his survival chances. The statistics from the International Co-operative Pulmonary Embolism Registry showed that 85% of patients survived a pulmonary embolism. The patient in this case, however, had proven resistant to drugs in hospital and had subsequently died. It was argued that it was this delay in

[306] see generally R DOLL and AB HILL, "Smoking and carcinoma of the lung: Preliminary report" (1950) 2 *British Medical Journal* 739-48

[307] *McTear v Imperial Tobacco Limited* [2005] 2 SC 1 at para 6.158

[308] ibid, para 6.162

[309] R GOLDBERG, "Using Scientific Evidence to resolve Causation Problems in Product Liability", in R GOLDBERG (ed) in *Perspectives on Causation* (Oxford, Hart Publishing, 2011), p162 where he notes that Bayes is a formula where more individualising information can be entered and a more accurate probability can be arrived at. First, it calculates the probability of a given event happening anyway, A, and then the probability of another event, B, given A. It is expressed as $P(A/B) = P(A) \times (P(B/A)/P(B))$

[310] [2003] 4 All ER 1358

diagnosis and presentation to hospital which had allowed the thrombosis to grow and her later resistance to drugs should be ignored. The Court of Appeal held that this was incorrect and that all evidence must be taken into account and that a court should not "blind" itself to other evidence regardless of general probabilities.[311]

Dr Barton noted the case of *Hill v Tomkins*[312] where it was shown that when making a finding of generic causation a court had employed such biological criteria as (i) history of exposure; (ii) temporal relation; (iii) specificity of injury; (iv) plausible mechanism; (v) analogy; and (vi) exclusion of alternative aetiology. Yet it must be remembered that this is generic causation. As Dr Barton says, this is but a "condition precedent" to a finding of individual causation.[313]

In the case of *Sienkiewicz v Greif (UK) Ltd*[314] the issue of causation in mesothelioma was again considered. In this case, Mrs Costello worked in a factory where they made steel drums. This process involved the release of asbestos dust into the factory atmosphere. Although she worked mostly in the office, she spent time in the areas of the factory which were occasionally contaminated with asbestos. She was also the subject of general low level, non-tortious, atmospheric asbestos. The trial judge found that the defendants' exposure of Mrs Castello to asbestos over her working life at their premises "increased her background risk (of contracting mesothelioma) from 24 cases per million to 28.39 cases per million, an increase of risk of 18%". He held that Mrs Costello had failed to establish mesothelioma because "there is only one occupational cause for the mesothelioma the claimant has to prove it is the likely cause."[315] Therefore the rule in *Fairchild* could not apply and the claimant could not succeed, as, on the balance of probabilities, her exposure to asbestos had not materially increased the risk that she would contract mesothelioma. On appeal, and this is the crux of this case, Smith LJ held that

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[311] ibid, Bailli, para 35 per Lord Justice Brooke

[312] (17 Oct 1997, unreported), QBD

[313] M POWERS, N HARRIS, A BARTON, Clinical *Negligence* (4th ed, Haywards Heath, Tottel, 2008), (4th ed, Haywards Heath, Tottel, 2008), 25.60

[314] [2011] UKSC 10

[315] ibid, cited by Lord Rodger at para 199

> In my view, it must now be taken that, saving the expression of a different view by the Supreme Court, in a case of multiple potential causes, a claimant can demonstrate causation by showing that the tortious exposure has at least doubled the risk arising from the non-tortious cause or causes.[316]

The Supreme Court unanimously did hold otherwise. Lord Phillips said that the conclusion of a relevant risk ("**RR**") above 2 would be a tenuous basis for concluding that the probable statistical cause was also the probable biological cause. Lord Phillips left much to the future of aetiology of mesothelioma. Reverting to the old *Fairchild* rules, he stated that had the trial judge considered an 18% increase in risk de minimis, he would have said so.

Lady Hale began her judgement in *Sienkiewicz*, "I pity the practitioners as well as the academics who have to make sense of our judgements in difficult cases."[317] It is true that it may be difficult to predict the Supreme Court's decisions with regard to causation. With regard to risk, she uses the oft-quoted example of the yellow and blue taxis in a given town. If there are twice as many blue as yellow taxis on the roads, then it may double the risk that if I am run over by a taxi, it will be blue rather than yellow. She then adds the caveat "...when I am actually run over it does not prove that it was a blue taxi rather than a yellow one...". In addition, it should also be remembered that the sense of "prove" here is not in the scientific sense, but rather on the balance of probabilities. She is quite scathing of judges' assessment of "overall probabilities"

> Why should what a (always middle-aged and usually middle class and male) judge thinks probable in any given situation be thought more helpful than well-researched statistical associations in deciding where the overall probabilities lie? As it seems to me, both have a place. [318]

I would agree with this approach and in short with Lord Mance's approach when he opined

> That epidemiological evidence used with proper caution, can be admissible and

[316] ibid, para 23

[317] ibid, para 167

[318] ibid, para 172

> relevant in conjunction with specific evidence related to the individual circumstances and parties is, however, common ground and clearly right. [319]

Lord Rodger opined that he did not want to discourage statistics' use in court.[320] On the contrary, he noted that epidemiology was behind much of the evidence that a court would use when determining whether or not any given exposure had materially increased a risk. Such evidence was therefore an important element in the proof of causation. He quoted from *Phipson on Evidence* which notes that

> Where there is epidemiological evidence of association, the court should not proceed to find a causal relationship without further, non-statistical evidence.[321]

I would also agree with Goldberg when he suggests that without scientific evidence of causation there should be no question of overcoming the burden of proof of causation in such cases.[322]

A plaintiff should use statistics with care. He should not rely on statistics alone but they should be an adminicle of evidence backed up, where possible, by experts' reports, individualising evidence and why not Bayes' theorem if it proves workable?

Epidemiology and statistics must be open to the greatest scrutiny and it is therefore why I highlight their use in this chapter. The one proposition I make in this paper is with regard to experts and their scientific evidence. I am prone to favour the cross-examination of such statistics, a course generally not favoured in Continental procedural law, where courts often (though not always) just order their own reports. Therefore again, there is not just one approach to establishing causation: there are a number and there is no underlying principle as to how this should be done.

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[319] ibid, para 191

[320] ibid, para 161

[321] 17th ed (2010) para 34-37

[322] R GOLDBERG, "Using Scientific Evidence to resolve Causation Problems in Product Liability", in R GOLDBERG (ed) in *Perspectives on Causation* (Oxford, Hart Publishing, 2011), p178

3.6 Conclusions: United Kingdom

In the United Kingdom then there are, in theory, two tests that must be overcome for the plaintiff to establish causation: a factual test and legal test. I have shown how courts generally treat factual causation. If the plaintiff's loss "would have happened anyway", then the defendant cannot be held liable. This is not, however, so simple as it prima facie seems, and as the drafters of the PETL seem to think it is when they introduced the conditio sine qua non as their first principle in causation. First, it is not always clear what to introduce into the hypothetical world when positing the counterfactual. Sometimes evidence from witnesses is not clear.[323] Also, should we, for example, substitute non-negligent behaviour or behaviour *in concreto*? Second, the conditio sine qua non test was unsatisfactory in that it did not produce the justice sought in all situations that came before the court. It therefore had to be modified. In *Wardlaw*, we saw perhaps the first dilution of the "but for" test where the House of Lords allowed for a "material contribution" to the disease to establish causation and then this was taken further in *McGhee* with a "material increase in the risk". Assessment of probability is also fraught with difficulty, as I have set out. There are experts' reports to consider, epidemiology, aetiology and so on.

If the "test" of factual causation is passed (whichever test is used), then the courts will then look at legal causation. In the United Kingdom, this is often based on a test of reasonableness and precedent should govern future decisions. I have given examples of these. Sometimes there can be an overlap between what is factual causation and what is legal causation. This was seen in *Chester*. Here there was uncertainty as to the counterfactual and Miss Chester did not, therefore, establish causation. Yet quite clearly on policy grounds, Miss Chester could not be left without a remedy so there was causation – there was hardly agreement among the Law Lords but I would expect nothing else when faced with such puzzling and perplexing factual situations as were demonstrated in this case.

Linked somewhat to factual causation and somewhat, I think, to legal causation is the issue of loss of chance. We have seen how the United Kingdom refuses recovery for

[323] *Chester v Afshar* [2004] UKHL 41

loss of chance in medical negligence cases. It was in *Gregg v Scott*[324] that loss of chance was rejected only by a majority of 3:2. It was rejected as the claimant was unable to show that on the balance of probabilities the delay in treatment caused his premature death. Lord Hoffman went so far as to say that a change from possible to probable causation would require a "legislative act".[325] Grubb, Laing and McHale argue[326] that there could be room to invoke a loss of chance argument where there is a significant medical uncertainty as to what the outcome would have been in the absence of negligence and where medical treatment has resulted in an adverse outcome and negligence increased the chance of that outcome. It is a possibility. However, I think there is a reason why loss of chance has been permitted in non-medical liability cases and has not yet been accepted in medical liability cases. There remains the problem of statistics. It is difficult to individualise and thereby to assess the counterfactual. Yet whatever arguments there may be for or against loss of chance, I wish to concentrate on the fact that there is this division on opinion. Even in Britain there is division. When the United Kingdom is compared with the other jurisdictions here, we shall see how practice in France diverges significantly from the United Kingdom, which differs significantly from Germany.

So as I hope to have shown, often the dichotomy between what is factual causation and what is legal causation in medical negligence is not an easy one to make and it can be extremely difficult to predict the outcome of a case – even with a system of precedent – in the United Kingdom. It is an area fraught with uncertainty as we can see with the separate judgements that are given in the United Kingdom. There can be no idea of common sense causation.

Inextricably linked to theory and substantive law of causation in the United Kingdom, as in all jurisdictions, is the procedure. Procedure includes who has the burden of proof at any given moment and governs to what standard a plaintiff must

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[324] [2005] UKHL 2

[325] ibid at para 90

[326] A GRUBB, J LAING, J McHALE, *Principles of Medical Law* (2nd ed, Oxford, Oxford University Press, 2004), p347

prove his case. The burden of proof can determine causation and thereby who wins the case. It determines only legal causation. It does not determine what was the actual cause scientifically but rather what the law will accept as the cause. In the United Kingdom, a plaintiff must show probable causation and not possible causation only. If he shows probable causation (*res ipsa loquitur* may help him in this regard) then the plaintiff will recover all his damages. If he shows less than 50% likelihood, then he will recover nothing, loss of chance not being permitted in the United Kingdom for medical negligence. Procedure can therefore determine causation.

As evidence, experts will often speak to their reports. There will usually be experts for both sides and they can be examined and cross-examined. As we have seen, statistics can be used in court but there is a warning about just using generalising statistics – without something more, then they are not particularly valuable. What is interesting is the analytical enquiry and breakdown of these statistics in the United Kingdom. They are scrutinised by judges in their written judgements much more so than in the other jurisdictions. There were divergences on opinion as to the use of statistics as we saw – even the right of judges in the United Kingdom given their social background to make such determinations on probability was called into question![327] This makes for fascinating and controversial reading which I imagine will continue to stimulate and fuel argument in this area for time to come. It can be seen then that there are many pertinent variables when deciding an issue of causation in a "typical" medical case in the United Kingdom. There is much uncertainty. I do not find this surprising, as there is much uncertainty concerning the science the human body itself.

To summarise then, to say that there are principles or rules which courts attempt to follow when solving a causal problem is true. The important ones are generally factual causation, legal causation combined with procedure hurdles. Factual causation started off with the conditio sine qua non. Yet this was unsatisfactory in all cases so the courts had resort to ratios such as the "material increase of risk" or "material contribution to injury". As we have seen, however, it is not clear what

[327] as per Baroness Hale in *Sienkiewicz v Greif* [2011] UKSC 10 at para 172

factual causation actually means. Many of the cases that I cited above in causal theory were decided by a bare majority for example, *McGhee* and *Chester*. This does not bode well for any "common sense" concept of causation, be it factual or legal. I believe this shows there is not one true understanding of what these concepts mean. So it is all very well to use ideas such as the "conditio sine qua non" test but when it comes to be applied in practice, it is difficult to say what it is. This, together with procedure and related evidential issues I specified above, lead me to believe that projects such as DCFR in tort and PETL may be laudable in their ultimate aim, but their application is going to be so divergent in result that the paragraphs which seek to expand on causation, serve nothing.

Chapter 4: France and Luxembourg

4.1 Introduction

Showing a causal link between a legally recognised injury and fault is an essential requirement in French tort law. What should be noticeable when considering how France treats problems of medical causation is how much more unresolved and noncommittal courts are with regard to causal theory and how much more victim-friendly the courts seem to be. Judges will decide as per the facts before them and will not worry so much about precedent. This comes from the important French principle that the judge has the "sovereign appreciation of the facts". Nonetheless, this does not mean that French judges have carte blanche to decide as they will. If they do, a superior court will surely censure them. What is perceptible, however, is that courts do not even purport to find themselves bound even by theory as will become apparent. Some cases accept equivalence theory, others adequacy theory. In summary here, I believe it is the unpredictability of case law in France in the area of causation which makes it impossible to garner general principles of causation even in France; how much more difficult therefor to attempt to formulate what does not exist into a kind of project for higher principles of tort at a European level. I hope the evidence I present here will show that.

For the reader who has little or no knowledge of the French legal system or its principles, I should just like to explain two essential concepts which I shall refer to again and again: the difference between public and private hospitals and *obligtions de résultats* and *obligations de moyens*.

First, if a medical negligence incident happens in a private hospital or clinic with a private doctor then the rules of contract under the French civil code will apply. If in a public hospital, then French administrative law will govern the case. The principles developed by the civil and administrative jurisdictions differ in some important respect[328] and there are also two discrete sets of procedure. Administrative liability lies with the administrative courts, that is the *tribunaux administratifs*, the *Cours*

[328] S TAYLOR, "Clinical Negligence Reform: Lessons from France?", (July 2003) 52 *International and Comparative Law Quarterly* 737 at 740

d'appel administratives and the *Conseil d'Etat* as the supreme court.[329] Their decisions do not serve as precedents but they have strong authoritative weight.[330] Any litigation for private bodies lies with the *tribunal d'instance* or *de grande instance*, *Cours d'appel* and the *Cour de cassation*.

Second, there can be no full understanding of French contract law - the doctor/patient relationship is generally in contract law - without an understanding of the difference between what is an *obligation de résultat* and what is an *obligation de moyens*.[331] The difference between the two is that with the former a certain guaranteed result has been promised the creditor. A simple example would be a mechanic who promises to make a broken down car roadworthy again. A physician's duty in contract, on the other hand, is only to act conscientiously and attentively in accordance with medical science when treating a patient. He is under no obligation to cure his patient.[332] This is important as far as causation is concerned. With an *obligation de résultat*, the plaintiff need only show that the promised result has not been achieved and then there is a presumption of fault.[333] Where there is only an *obligation de moyens*, then no presumption is raised. It is for the plaintiff to prove that there has been fault. It is prima facie more demanding therefore for a plaintiff to prove medical negligence as it is an *obligation de moyens* than if it were an *obligation de résultat*. The plaintiff must establish that the care provider has acted in a way that a reasonable doctor of the same experience and training *in abstracto* would not have acted that the victim is likely to obtain damages provided causation can be proven. Negligence need not be proven in the British sense of the word. *Une faute légère* is enough.[334] The Cour de cassation in France has confirmed that

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[329] Essay of S GALAND-CARVAL dealing with France in M FAURE and H KOZIOL (eds), *Cases on Medical Malpractice in a Comparative Perspective* (Vienna, Springer, 2001), p101

[330] C van DAM, *European Tort Law* (2nd ed, Oxford, Oxford University Press, 2014), p55

[331] R DEMOGUE, *Traité des obligation en général*, t V (Paris, Rousseau, 1925), n°1237 who essentially invented the distinction; for an interesting appreciation, see, M DIERRAT, "De la distinction entre obligations de moyens et obligations de résultat: pile ou face?", (2011) 15 *Journal des tribunaux Luxembourg* 61

[332] see infra

[333] Although a debtor can rebut this presumption by showing that he merely acted as a "reasonable man" or *bon père de famille* would have acted

[334] Lux 31 January 1990, n° 60/90 I

> l'obligation de résultat emporte à la fois présomption de faute et présomption de causalité entre la prestation fournie et le dommage invoqué[335]

The notion of *obligations* has an effect on the causal conclusion in a given case. If there is one of *de résultat* then there is, in effect, a causal presumption. This means then that in an ordinary case of medical liability, there would not generally be a presumption of causation. However, in certain situations, it has been held that there is an *obligation de résultat*. For example, it has been held that a nurse who carries out an intramuscular injection has an *obligation de résultat*.[336] A pharmaceutical laboratory also has such an obligation to provide blood free from vice and to have the qualities that one can expect that such blood has in the circumstances.[337]

The use of ideas of *obligations de résultat* and *de moyens*, together with other presumptions as shall be seen below, has to some extent come to dilute a pure causal finding as the man in the street might understand it in individual cases of physician responsibility.

[335] CC 1 16 Feb 1988, Bull n° 42; *Revue trimestrielle de droit civil* 1988.767, obs P JOURDAIN

[336] CC 1 17 June 1980, Bull n° 187; *Revue trimestrielle de droit civil* 1981.165, obs G DURRY

[337] JCP 1991.II.21762

4.2 Causal Theory in France and Luxembourg

Before considering the detail of causation in medical negligence problems in France and Luxembourg, I think it opportune here to consider some of the philosophical theory which is considered to be the background of much of the French case law depending, of course, to what extent it is accepted the courts actually make use of causal theory in France rather than just "common sense feeling" to problems.

The search for what causation in law actually is may never be theoretically found. It is a complex problem. Resort is had sometimes simply to feeling or "sentiment".[338] Positive law in the form of the Civil Codes of both France and Luxembourg is of little help when it comes to finding a clearer definition of what is meant by "causation" or "cause". Article 1382 of the French Civil Code relative to delictual liability uses the verb *causer* and no further elucidation is given. Article 1151 of the Civil Code (in the chapter referring to contracts) is often cited in case law and with academic writers.[339] It states that

> Dans le cas même où l'inexécution de la convention résulte du dol du débiteur, les dommages et intérêts ne doivent comprendre à l'égard de la perte éprouvée par le créancier et du gain dont il a été privé, que ce qui est une suite immédiate et directe de l'inexécution de la convention.

This is often invoked for causal problems in delict too.[340] The idea, however, behind this article is not strictly one of causation.[341] It is one of damages. The damages themselves cannot go further than providing the plaintiff with what are the immediate and direct damages as a result of the breach of contract. Now it is suggested, and as I mentioned in the United Kingdom chapter, that this comes down to the same thing. What a court is only ever stating is whether a plaintiff caused the damages sought be they "indirect" or "direct" damages. When applying article 1151 of the French Civil Code all that has been recovered is necessarily direct damages.

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[338] H and L MAZEAUD, A TUNC, *Traité théorique et pratique de la responsabilité civile délictuelle et contractuelle*, volume 3 (5th ed, Montchrestien, Paris, 1958) 1471; B STARK, H ROLAND, L BOYER, *Les Obligations*, (Litec, Paris, 1992) 1197

[339] F TERRE, P SIMLER and Y LEQUETTE, *Les obligations* (Dalloz, Paris, 2005) 860; B STARCK, H ROLAND and L BOYER, *Obligations*, 1200

[340] B STARCK, H ROLAND and L BOYER, ibid

[341] ibid

Therefore in every case where a plaintiff has been successful in France, it can be said that causation has allowed him to recover such damages as were direct. It follows then that only direct causation is recognised and anything short of this will result in a claim's being dismissed. This is a legal not a scientific distinction.

France does not enter into the causal discussions in their case law that are often found among German and British jurists in this area. German influence in French causal theory is, however, widely admitted.[342] Judges in France tend to take a more "common sense" or empirical approach – at least, that is what they like to think they are doing, and they constantly remind us that is what they are doing.[343] This would be in line with judges having a sovereign appreciation of facts and rendering justice as appropriate in the circumstances. Although there have been certain judicial nods to and acknowledgements of the equivalence theory in France where it was noted by the Cour de cassation with regard to an accident that

> ...le dommage ne se serait pas produit, alors que si des fautes successives imputables à des auteurs différents ont pu jouer un rôle causal sur ce poste de préjudice...cette pluralité de causes...n'est pas de nature à faire obstacle à l'indemnisation de l'entier dommage par l'auteur initial, par application du principe de **l'équivalence des causes** dans la production du même dommage en matière de responsabilité délictuelle.[344]

Certain writers hold that French case law seems to favour an adequate cause approach. This adequate cause theory in France

> …[elle] s'efforce donc de rattacher le dommage à celui de ses antécédents qui, normalement, d'après la suite naturelle des événements, était de nature à le produire, à la différence d'autres antécédents du dommage, n'ayant entraîné celui-ci qu'en raison de circonstances exceptionnelles.[345]

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[342] H and L MAZEAUD and A TUNC, *Traité*, 1424

[343] ibid, 1197 where they note that answers to causal problems have not found a theoretical answer but they have in practice; again, H and L MAZEAUD and A TUNC, *Traité*, 1422 where the authors note that causation is a complex problem that is often resolved by "sentiment".

[344] CC 2, 27 Mar 2003, Bull n°76

[345] F TERRE, P SIMLER and Y LEQUETTE, *Les obligations*, 860

Mazeaud, Mazeaud and Tunc describe an application of the adequate cause as "seules peuvent être considérés comme causes d'un préjudice les événements qui devaient normalement le produire."[346] Quézel-Ambrunaz describes it as "la cause est une condition qui était objectivement de nature à produire le type de dommage qui est survenu".[347] A further requirement here then is that it is the type of damage that is important not the actual damage which occurred.[348] What this means is that adequate causation will not consider "le dommage réel dans sa specificité, mais un type abstrait ou généralisé de dommage".[349] This is particularly important in medical negligence. When examining whether a particular damage was caused by the negligence of a care-provider, in theory, probability should be taken into account. So, for example, if a medical practitioner is negligent in carrying out a particular operation, the question of whether (say) paralysis was probable as a result of such negligence should be addressed. Such theoretical niceties are, however, dispensed with when it suits the court.[350] However, what is also salient about the adequate cause theory is that it is a generalising theory. This means that it will not take account necessarily of the individual propensities in patients.[351]

Planiol is also among those French authors who rightly refer to German authorities (although he does not name them) when reflecting on the origins of French causation. He refers to the equivalence, adequate and causa proxima theories but perhaps to have a better idea of how such problems are solved in France, he notes

> Quand on veut fonder la responsabilité uniquement sur la causalité, il y a là un problème à peu près insoluble. La jurisprudence française, fidèle à la théorie de la faute, ne paraît guère embarrassée par cette difficulté. Il lui suffit que la faute figure

[346] *Traité*, 1441

[347] C QUEZEL-AMBRUNAZ, *Essai sur la causalité en droit de la responsabilité civile*, thesis, (Paris, Dalloz, 2010) 80

[348] ibid

[349] ibid

[350] for example, see *aléas thérapeutiques* infra

[351] See HLA HART and T HONORE, *Causation in the Law*, Part III for generalising and individualising theories; essentially a generalising theory suggests that a cause is generally connected with some other kind of event, eg "smoking causes cancer"; individualising theories divide into "necessity" and "efficiency" theories; a necessity theory would hold that cancer necessarily follows from smoking (which is false) whereas an efficiency theory would allow for different degrees of causal potency in the causal link.

> parmi les causes du dommage, quitte à déclarer qu'il y a une *faute commune* au cas où plusieurs personnes sont intervenues, ou si la victime a elle-même commis une faute.[352]

However, it should be noted that French courts have not expressly rejected either theory. Galand-Carval notes that the case law would seem divided between the equivalence theory and the adequate cause theory.[353] The theories of a causa proxima and the protective purpose rule also appear to have been rejected in France.[354] What courts often look for is whether the act has "joué un rôle" or "contribué" to the result and can therefore be considered among its causes.[355]

Even academic writers do not appear to agree on which is the accepted causal philosophy in France. Terré, Simler and Lequette write that case law has shown a marked predilection for adequate causality[356] whereas Ravarani writes that the theory of the equivalence of conditions has been well received in France.[357] I suggest that neither of these is a necessarily accurate reflection of reality. Viney and Jourdain appeared more accurately to sum it up when they stated

> Il y a longtemps qu'entre partisans de 'l'équivalence des conditions' et de la 'causalité adéquate', les points ont été comptés. Pourtant le bilan n'est pas décisif…C'est donc plutôt d'après leurs résultats pratiques que l'on peut espérer départager les deux théories.[358]

This would seem to be realistic and also corroborates what Galand-Carval has stated in that French courts have never categorically favoured one of the theories over the

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[352] M PLANIOL, *Traité élémentaire de droit civil conforme au programme official des facultés de droit avec collaboration de G RIPERT* (Paris, LGDJ, 1935), 869

[353] S GALAND-CARVAL, *Unification of Tort Law: Causation* (The Hague, Kluwer, 2000), p54

[354] ibid, p55 and G VINEY and P JOURDAIN, *Traité de droit civil*, 340

[355] ibid and CC Ch Crim 29 March 1977, Bull Crim de Cour de Cassation Chambre criminelle n°115 P. 281; D 1977 IR, p440, obs C LAROUMMET

[356] F TERRE, P SIMLER and Y LEQUETTE, *Les obligations*, 860

[357] RAVARANI G, *La responsabilité civile,* 903

[358] G VINEY and P JOURDAIN, *Traité de droit civil*, 342

other.[359] In the case law I read from France, although my research was not focused on which of the two theories was more accepted in France, I also found that sometimes a court would refer to equivalence and sometimes to adequacy, without one theory dominating over the other.

After an analysis of the two principal theories of causation that have been received into France, I would agree with Viney and Jourdain when they note that notions of "necessary condition" and "objective foreseeability" (or reasonable foreseeability for the common lawyer) are effectively used to define and establish a causal link in theory.[360] They note that

> ...il paraît légitime de recourir à la notion de probabilité ou de "prévisibilité objective" du dommage par rapport au fait dommageable, car s'il existe une probabilité suffisante, cela permet raisonnablement de présumer que le fait générateur a été effectivement une condition nécessaire à la survenance du dommage. La proabilité ou la prévisibilité objective engendre ainsi une présomption de fait en faveur de la causalité.[361]

They also note that even the precautionary principle, far from restraining the idea of causes, objective foreseeability actually enlarges the potential causes that could be considered as actual legal causes.[362] It is not evident from the case law that there is necessarily a probability analysis made, rather resort is had simply to other causal devices or theories, be it loss of chance, risk theory or even the use of certain presumptions.[363]

From the above, it can be seen then that this idea of probability is indeed what was conceived in the original formulation of the adequate cause theory. However, this conception is criticised by Viney and Jourdain as they say it can be difficult to know which kind of probability to chose; is resort to be had to an "objective probability",

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[359] see infra

[360] G VINEY and P JOURDAIN, *Traité de droit civil* 340-1

[361] ibid; they also give the example of someone who after living next to a nuclear factory contracts a disease that is provoked by radioactivity; it may have been so caused but it is normally rare.

[362] ibid

[363] See *Bouygues Telecom,* CA Versailles, 4 February 2009 08/08775 Legifrance, D 2009, 1369

or a "subjective probability" taking into account the state of the defender?[364] They note that the supporters of the adequate cause theory would hold that only objective probability is to be considered but that

> pratiquement la distincition [entre la prévisibilité objective et la prévisibilité subjective] est bien difficile à faire. L'analyse de la causalité en fonction de la "prévisibilité" est nécessairement tendancieuse dans la mesure où elle ramène indirectmement la causalité à la faute.[365]

It can be impenetrable to extract what this means in practice and the cases must be studied.[366] Even the courts in France have resort to notions of *prévisibilité* when, it is suggested what they should be referring to is causation.[367] Personally, I find it difficult sometimes to divorce one idea from the other.

It can readily how different causal analysis appears to be in France. There is a theory that is adopted in France that is not used in the United Kingdom: the adequacy theory and in France even the seriousness of the fault itself can be used to establish causation – something which strictly speaking cannot be done in the United Kingdom.[368] Germany again has other theoretical notions.

I have considered here causation in France in theory and from first principles. I shall turn now to a legal mechanism that is used both in France and in Luxembourg but has been specifically rejected in the United Kingdom (in medical negligence cases) and Germany (totally). It is loss of chance.

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[364] this reminds me of Traeger who favoured the "optimal observer".

[365] G VINEY and P JOURDAIN, *Traité de droit civil*, 344c

[366] CC 2 11 July 1966, Bull n°772; even suicide does not necessarily break the chain of causation

[367] G VINEY and P JOURDAIN, *Traité de droit civil,* 343

[368] H and L MAZEAUD and A TUNC, *Traité*, 1443, "La gravité de la faute n'est qu'une element de [la] causalité."

4.3 Loss of Chance (*Perte d'une chance*)

One way that France overcomes the often unfair burden placed on a plaintiff of having to prove his case to the point of *conviction intime* (the high standard of civil proof in France) is of allowing recovery for loss of chance.[369] As Ravarani notes, many decisions use this idea to lighten the burden of proof when causation is a problem for the plaintiff.[370] But this is not strictly speaking its purpose. Loss of chance should constitute a head of damage in itself if it is to be recognised at all.[371] What exactly then is the loss of a chance? In short, it considers the behaviour of a defendant that has deprived the plaintiff of a chance to avoid a loss (*damnum emergens*) or he has lost the chance of a gain (*lucrum cessans*).[372] In medicine, this can either be the loss of chance of survival or the loss of chance to recover. The definition of the loss of a chance has been defined as "la dispiration actuelle et certaine d'une eventualité favourable".[373] Courts have said the chance must not be illusory but rather it must be *réelle* and *sérieuse*.[374] If a causal link can be established between the loss of chance and the defendant's act, then the plaintiff should be awarded an amount representing not full damages, as it is impossible to know whether the plaintiff would actually have fallen into the category of those who would benefit if it were not for the fault of the defendant. Perhaps somewhat paradoxically, as loss of chance is considered as a separate head of damages in France, the judiciary believes it is awarding the entire amount: not a percentage. This is logical. Courts use probability to determine whether the idea of loss of chance is suitable and the amount of the reparation.[375] Only France and Luxembourg among the jurisdictions under consideration here allow for recovery of a lost chance. In medical negligence Penneau noted that

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[369] G RAVARANI, *La responsabilité civile*, 1009; L KHOURY, *Uncertain Causation*, p37 and pp93 et seqq

[370] G RAVARANI, ibid

[371] Lux CA 21 Apr 2004, Pas Lux, p476

[372] F TERRE, P SIMLER and Y LEQUETTE, *Les obligations*, 700

[373] G RAVARANI, *La responsabilité civile*, 1009 and CC 1 21 Nov 2006, Bull 2006 n°498; JCP 2006 IV 3475, JCP 2007 I 115 n°2, observed by P STOFFEL-MUNK; this case concerned the loss of chance of a client to obtain a judgement in his favour in the Cour de cassation.

[374] *Revue trimestrielle de droit civil* 1963, p334, obs A TUNC; CC 2 1 Apr 1965, Bull n° 336; 8 Nov 1971 D 1972.667, note C LAPYADE-DESCHAMPS

[375] F TERRE, P SIMLER and Y LEQUETTE, *Les obligations*, 701; obs by P JOURDAIN *Revue trimestrielle de droit civil* 1992, 109

> il existe un abîme profond entre les chances statistiques d'évolution d'une affection donnée et les chances individuelles du patient atteint par cette affection; or chaque espèce déterminée, ce sont les chances individuelles qui sont en cause.[376]

As Khoury notes, causal analysis in loss of chance involves the consideration of one of two hypotheticals: first, the hypothetical prognostic, the hypothetical used to asses the present if the past had been different; and the simple prognostic, the assessment of the future based on the present.[377] As far as evaluation of chance is concerned, what ought to be considered are the individual chances of that particular patient. While generalising statistics might play some role, what must be considered and evaluated is the actual plaintiff's loss of chance.

Quézel-Ambrunaz notes that the French courts often use the following formula
I=A(C-C')

where I is the recoverable damages, C is the initial chance of survival, C' is the chance of survival following the defendant's tortious act and A is the total damages recoverable on death.[378]

Loss of chance should also be differentiated from simply just taking a risk. If someone undergoes an operation (and let us assume he was warned of the risks) and a risk eventuates then the surgeon has not caused a loss of a chance of survival. The patient took his risk and it eventuated. The loss must lie where it falls.

Courts have also had recourse to the loss of chance doctrine when considering cases of mis-diagnosis. These cases have usually been analysed as the loss of a chance to avoid certain consequences following on from the mis-diagnosis. I shall consider such cases here also.

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[376] J PENNEAU, CC 27 March 1973 DS 1973, p595

[377] L KHOURY, *Uncertain Causation*, p96

[378] C QUEZEL-AMBRUNAZ, *Essai*, 189

4.3.1 Loss of Chance: Case Law

As far as the case law is concerned, a case that is often referred to in French writing as the starting point of the loss of chance notion is that in Grenoble of 1961.[379] In this case the plaintiff injured his wrist. He went for a radiography but no injury was detected and he immediately resumed his work. A few years later when he was lifting a heavy object, he experienced some pain and went back to his doctor who told him that on the X-ray, a fracture could in fact have been detected. The plaintiff sued the doctor. The court held indeed that the doctor had deprived the patient of the chance of recovery on which he should normally be able to rely. This was followed with other decisions approving this including one where it was held that although it could not be established that the death of the patient was the fault of the surgeon, it was held nonetheless that he had deprived the patient of a chance of survival.[380] Thereafter the Cour de cassation often used the term "perte d'une chance de guérison" or "de survie" making it clear that it was authorising only a partial compensation.[381]

Another case in this area that is often mentioned in French academic writing is that of 17 November 1982 which has been regarded as interrupting the idea of loss of chance in France.[382] In this case, a doctor punctured a bone wall and notwithstanding the appearance of a haemorrhage, injected air. The patient fell into a coma. An expert's report tried to determine the cause of the accident. It was noted that the injury to the blood vessel was not considered as a fault. With regard to the air in the blood (causing embolism), however, it could have been caused by either air in the syringe or extant air in the sinus. The *juges du fond* stated here that there was no causal link between the doctor's fault and the subsequent incapacity of the plaintiff. The judges of the *première chambre civile* nonetheless found the doctor liable for half the damages. The Cour de Cassation quashed this judgement and stated that the loss of chance could only concern the evaluation of damages. This is a case where there

[379] *Inédit*, v obs A TUNC, *Revue trimestrielle de droit civil* 1963, p334

[380] CC 1 18 Mar 1969, JCP 1970.II.16422, note A RABUT

[381] CC 1 25 May 1971, JCP 1971.II.16859 and CC 1 9 May 1973, JCP 1974.II.11643, note R SAVATIER; also see G VINEY and P JOURDAIN, *Traité de droit civil*, 370 et seqq for a chronology on the case law

[382] CC 1 17 Nov 1982, Bull n° 333; JCP 1983.II.20056, note M SALUDEN; G VINEY; p201 and *Revue trimestrielle de droit civil* 1983 547

was no causation between the fault of the doctor and the final damage. This decision was seen as revolutionary at the time and it was thought that loss of chance's days were numbered. I think this case can be seen rather as loss of chance's not being the "trump card" in the event that there is a lack of causation[383] and it also illustrates that using loss of chance can only be relied on when there were strong chances of avoiding the damage and not when alternative causes of damage existed.[384] So the doctor's acts (or omissions) must have been at some stage causal. As Khoury writes, this position contradicts the view that loss of chance can be seen as an autonomous head of damages and the argument that causation must be proven between that head of damage (not the final outcome) and the fault.[385] Yet loss of chance came quickly back in favour in France and was used when causation was uncertain.[386] Notwithstanding this decision, French courts still use loss of chance and indeed it remains the French courts' preferred method when faced with scientific causal uncertainty.[387]

Loss of chance has also been used in France to deal with the situation where doctors have not sufficiently informed their patients of risks. In one case,[388] where a physician in France failed to inform a patient of a risk associated with a particular procedure (in this case a sinus decompression), it was held that this failure deprived the plaintiff of a chance to avoid a loss (perhaps by taking a more sagacious and informed decision). It was also held in this case that the loss of chance is a head of damages which is quite distinct from any bodily harm that was caused. This would then seem to put into doubt the causal formula used by courts referred to above.[389]

In a further case, a doctor continued in a diagnosis of sciatica of Mr Rocq. In fact, the correct diagnosis was phlebitis and he had to be operated on urgently. His front

[383] G VINEY and P JOURDAIN, *Traité de droit civil*, 372

[384] L KHOURY, *Uncertain Causation*, p112

[385] ibid

[386] G VINEY and P JOURDAIN, *Traité de droit civil*, 372

[387] L KHOURY, *Uncertain Causation*, p113

[388] CC 1 7 Feb 1990, Bull, n° 39

[389] see supra

left foot had to be amputated as this had developed an acute ischemia.[390] The initial doctor was held at fault not for an incorrect diagnosis but for not carrying out further enquiries by virtue of an investigation by way of a Doppler examination. The Court of first instance at Rochefort held that there was no causal link established on the basis of the first report it had ordered between the diagnosis and the amputation. A second report was ordered. The report noted that had an anti-coagulant treatment been begun 48 hours earlier then the phlebitis should not have occurred or at least should have been much less severe in its effects and that the chances of avoiding an amputation would have been much greater. The Court of Appeal held nonetheless that loss of chance could not be used but not for substantial reasons but rather for procedural reasons. It held that "aucune demande chiffrée pour perte de chance n'avait été formulée par M Rocq." The Cour de cassation held, however, that a plaintiff simply has to state his quantum and then it was for the

> juge consistant alors à en apprécier le bien fondé et à déterminer, par une appréciation souveraine, la fraction de ces préjudices correspondant à la perte de chance de les éviter si le médecin n'avait pas commis une faute.

So it would appear then that the court can allocate damages "par une appréciation souveraine".

However, the case law in France has encountered some strains. In one case, where a doctor arrived late at a labour and this resulted in the baby's severe brain damage, it was held that the doctors could be held **entirely** responsible where an expert's report said that such damage would "normalement" have been avoided if they had been there on time.[391] The Cour de cassation criticised the Cour d'appel for only allowing for recovery of a lost chance. So there is uncertainty. What does the word "normalement" mean? Here the courts were at variance and it is this divergence I wish to highlight.

[390] a restriction of blood supply to tissue

[391] CC 1 1 June 1976, JCP 1976 II 18483

4.3.2 Commentary

On the one hand, the doctrine of the loss of chance does lighten the burden of proof for plaintiffs in that where a plaintiff cannot prove convincingly that the defendant's act caused the damage, he may have resort to the idea of a loss of chance. It can be another weapon in the plaintiff's litigious armoury. Yet it has been used simply where it is difficult to prove a causal link.[392] Resort to loss of chance is indeed a helpful alternative for a plaintiff in medical negligence cases. It has more perhaps to commend it to an intuitive sense of justice that the "all or nothing" approach adopted in the United Kingdom. Yet as I have stated, not all the jurisdictions accept loss of chance and this is the essence of this paper. The acceptance of loss of chance, is, in my opinion, a major difficulty in arguing that there can be any kind of harmonisation of tort law either in some common principles or by the ECJ. The PETL have more or less accepted loss of chance as shall become clear in my final chapter yet two of the other major jurisdictions of Europe have not. There is a problem. Similar cases do not have similar answers and it is this I shall address in the comparative chapter.

[392] C QUEZEL-AMBRUNAZ, *Essai*, 194 warning of the dangers of this in a non-medical case: CC 15 May 2007, inédit n°05-15246; G VINEY and P JOURDAIN, *Traité de droit civil*, 372

4.4 Nosocomial Infections and Medical Accidents

Another area where causation is of interest for comparison is that of nosocomial infections and medical "accidents". In France, both the Cour de cassation and the Conseil d'Etat have both come to the same position, even if this has taken some time. The Conseil d'Etat has now held that if an infection is contracted in a hospital then a cause étrangère must be shown to avoid liability.[393] Up until then, a hospital could argue that the patient's germ was *endogène*, namely that the patient had arrived at the hospital with the germ, to avoid liability. This is not longer acceptable. The same principle applies now for private hospitals and the hospital will be held strictly liable.[394] Private hospitals and doctors now have an *obligation de sécurité de résultat* that can only be rebutted by showing a cause étrangère.[395] After five years then, the position of the public and private hospitals is now the same.[396] As for medical accidents, the Cour de cassation and the Conseil d'Etat have differed in their approaches and I shall also consider this.

4.4.1 Nosocomial Infection

A nosocomial infection was defined in a Health Ministry Circular of 13 October 1988 which stated that it was to be understood as:

> toute maladie provoquée par des micro organismes:
> -contractée dans un établissement de soins par tout patient après son admission, soit pour hospitalisation, soit pour y recevoir des soins ambulatoires;
> -que les symptômes apparaissent lors du séjour à l'hôpital ou après;
> -que l'infection soit reconnaissable aux plans cliniques ou micro-biologiques, données sérologiques comprises, ou encore les deux à la fois.

[393] CE, 10 Oct 2011, n°328500

[394] CC 1 29 June 1999, JCP 1999.II.10138

[395] Art 1147 French Civil Code

[396] F LAMPIN, avocat au barreau de Lille, "Revirement de jurisprudence du Conseil d'Etat sur les infections nosocomiales endogènes", Alin&As, Feb 2012, n°1: http://cclin-sudest.chu-lyon.fr/Newsletter/2012/01/Juriste.pdf

Commentators have noted that such infections can be divided into what have been called endogenous and exogenous types.[397] The former can be seen when the patient is infected by his own germs but this infection is caused by a medical manipulation or intervention of some kind on the patient; the latter are typically the result of cross-contamination of instruments or infection from medical staff. The questions which arise are often ones of proof and therefore causation.

4.4.1.1 Nosocomial Infections and *droit commun*

At *droit commun* in 1996, the Cour de cassation replaced what was simply an *obligation de moyens* with a reinforced obligation in that a clinic

> est présumée responsible d'une infection contractée par un patient lors d'une intervention pratiquée dans une salle d'opération, à moins de prouver l'absence de faute de sa part.[398]

Then in 1999, the Cour de cassation brought its case law into line more or less with the administrative jurisdiction when it held that health centres and doctors were now under an *obligation de securité de résultat.*[399] With such an obligation, a hospital can only absolve itself if it proves a cause étrangère. The administrative court had already held there was a presumption but did not go far as saying it could be rebutted only by a cause étrangère. On 29 June 1999, the Cour de cassation handed down three cases with important implications with regard to nosocomial infections, two of which are important for purposes of causation. [400]

In the first case, a patient was in hospital having a prosthesis fitted to her knee. Following its fitting, the patient developed a staphylococcus aureus at the knee in hospital. This necessitated an operation and the re-fitting of the prosthesis. She was forbidden from carrying out any professional activity. Although the doctor failed in his obligation to inform the patient about the non-negligible risks of nosocomial

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[397] see in particular the report of P SARGOS at JCP.II.10138 commentating on the three cases and leading case law before this date. This report was published in 1999, before the coming into force of the law of 4 March 2002.

[398] CC 1 21 May 1996, Bull n° 219; see also JCP. 1996.I.3985, obs G VINEY

[399] CC 1 29 June 1999, Bull n° 220 et 222; JCP 1999.II.10138, report P SARGOS

[400] ibid

infections to allow the patient properly to choose whether or not to go ahead with the operation, the Cour de cassation confirmed

> Attendu que le contrat d'hospitalisation et de soins conclu entre un patient et un établissement de santé met à la charge de ce dernier, en matière d'infection nosocomiale, **une obligation de sécurité de résultat** dont il ne peut se libérer qu'en rapportant la preuve d'une cause étrangère.[401]

In the second case, the victim underwent an arthroscopy on her knee but 48 hours later developed an infection in the hospital. This necessitated further surgery even up to two years later. The Cour de cassation referred to the last case in its ratio and held the doctor and the medical centre liable in solidum.[402] The implications of these cases are the following. First, the presumption of fault is now replaced by an *obligation de sécurité de résultat*. The law now is that only a cause étrangère, something much more difficult to prove, can absolve the physician or hospital and this shall be considered below. The principle that can now be seen both at *droit commun* and has been abrogated to a certain extent at statute in that doctors in their own practice are not liable *de iure* for nosocomial infections.[403] Fault must still be shown.

In another case, similar to the one considered above, a patient underwent a knee operation and then developed a staphylococcus aureus at the knee in the hospital.[404] A Cour d'Appel dismissed the claim of the victim stating that it was an *aléa thérapeutique* and that the nosocomial infection could be attributed to a cause étrangère. However, the Cour de cassation held that given it was a known risk, the infection could not come from a cause étrangère. The physician may not have been at fault but it was nonetheless a decision for which the health centre was responsible. It is important then to consider briefly what could be a cause étrangère in these circumstances. Jourdain tackles the question.[405] He notes from the above case and

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[401] my emphasis

[402] The third case does not raise any interesting implications from a causal point of view.

[403] Art L 1142-1 *Code de santé public*, France

[404] CC 1 18 Feb 2009, n° 08-15.979, Bull 2007 n° 132

[405] P JOURDAIN, "Effets de la responsabilité" (2009) *Revue trimestrielle de droit civil* 543

another[406] that if the risk is known, then there is an element of foreseeability which necessarily excludes cause étrangère. I suggest this is correct. He also notes interestingly that given an infection is linked to medical intervention itself and the migration of germs during the procedure then it is the procedure itself which has rendered such "migration" of germs possible. So the invasive act is always a necessary condition. This has been confirmed by the Cour de cassation.[407] I approve of the terminology used by Jourdain here. He notes that the intervention is indeed a "necessary condition". I find this helpful given the nature of what is happening if it is remembered that a **condition** can be differentiated from a cause in that a condition is something akin to a background or a stage upon which the causal actors play out their part. It is the medical involvement which **causes** the germs to migrate thereby leading to the effect of a nosocomial infection. Jourdain then goes on to consider the possibility of an epidemic's being considered as a cause étrangère. He said it would. I would tend to agree here. There is no link as such between a medical act in the establishment and the nosocomial infection. An epidemic, I would suggest is also unforeseeable and certainly exterior to the hospital.[408] An infection as a necessary consequence of a cutaneous necrosis has also been held to be cause étrangère as exterior to the activity of the doctors.[409]

From a policy point of view, there is also the intangible question of preferring to compensate victims rather than send them away from court empty-handed. This is indeed difficult to quantify but I think, from the reading of French case law, it can be said that the impetus of the case law is certainly victim-friendly.[410] This approach to hospital acquired infections finds no counterpart in the United Kingdom. I submit therefore this is yet another aspect which shows that no common principles can be deduced from a "common" European case law or understanding of the subject.

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[406] ibid at p544; CC 2 Apr 2006, *Revue trimestrielle de droit civil* 2006.567

[407] ibid

[408] along with "irresistible", the three of the conditions required to establish a cause étrangère

[409] Cour d'Appel, Paris, 16 Nov 2007, n° 05/17960

[410] See P JOURDAIN, *Revue trimestrielle de droit civil* 1999.841: "Cette jurisprudence de la Cour de cassation trouve une justification non seulement dans *l'évidente* volonté de faciliter l'indemnisation des nombreuses victimes d'infections nosocomiales..." Me JOURDAIN provides no evidence for this. The italics are mine.

In 2011, the Conseil d'Etat brought the administrative case law into line with that of the private case law.[411] In this case the patient had died of pneumococcal meningitis. The Conseil d'Etat held, referring to the provisions of L1142-1 *Code de santé publique* (**CSP**) that it did not matter with the infection was *exogène* or *endogène*. Accordingly after five years, the two jurisdictions appear to be aligned.

I shall now consider the question of *aléas thérapeutiques*.

[411] CE, 10 Oct 2011, n°328500

4.5 Causation and *aléas thérapeutiques*

One area in which administrative law has differed from private law in matters of medical causation is that the Conseil d'Etat has in some circumstances allowed claims for what are called *aléas thérapeutiques* or medical "accidents" or "hazards". Medical accident is a loss that is not attributable to the patient's initial state of health or to its foreseeable evolution.[412] Terré, Simler and Lequette give some examples of what could constitute the same.[413] The hazard that results must be sudden and not be an evolution of an illness that the patient already has. It is some sudden event. They give examples of a total paralysis or serious nervous trouble following a simple operation, dying under anaesthetic or even contracting an infection.[414] In the famous *Bianchi* case, a patient sued a hospital after she became paralysed following an operation under general anaesthetic. The Conseil d'Etat in their famous ratio set out the conditions to be fulfilled for recovery. It is worth quoting in full

> Lorsqu'un acte médicale nécessaire au diagnostic ou au traitement du malade présente un risque dont l'existence est connue et dont aucune raison ne permet de penser que le patient y soit particulièrement exposé, la responsabilité du service public hospitalier si l'exécution de cet acte est la cause directe de dommages sans rapport avec l'état initial du patient comme avec l'évolution prévisible de cet état, et presentant un caractère dêxtrême gravité.[415]

The hospital was liable here because the injury occurred as a result of the medical act. This is strict liability and based on a risk,[416] albeit a remote risk. The Cour de cassation has not accepted this idea yet. It has confirmed that

> La réparation des conséquences de l'aléa thérapeutique n'entre pas dans le champ des obligations dont un médecin est contractuellement tenu à l'égard de son patient.[417]

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[412] S GALAND-CARVAL, *Cases on Medical Malpractice*, p108

[413] F TERRE, P SIMLER and Y LEQUETTE, *Les obligations*, p979

[414] ibid

[415] *arrêt Bianchi*, JCP 1993.II.22061,

[416] S TAYLOR, "Negligence Reform: Lessons from France?" (July 2003) 52 *International and Comparative Law Quarterly* 737 at 741

[417] CC 1 8 November 2000, Bull 2000, n° 287; JCP 2001.II.10493

Some commentators say, however, that it is only a matter of time before the two courts harmonise their approach.[418] Some have also suggested that one way of identifying *aléas thérapeutiques* are that they have "rien à voir avec l'aléa dans l'exercise de médecine".[419] Viney and Jourdain would even go as far as to say that

> Il serait plus rationnel de fonder sur une obligation de sécurité distincte de l'oligation de moyens la nécessaire indemnisation des accidents médicaux. Bien entendu,...cette obligation sera de résultat.[420]

This idea of having an *obligation de securité* reinforces the idea that a hospital is responsible for the patient as soon as he enters the building. This would essentially make proof of fault easier for the plaintiff. This means that hospitals or doctors would have an *obligation de résultat* in this respect. *Aléas thérapeutiques* are not concerned with fault.

However, there have been definitions of *aléa thérapeutique* other than in the *Bianchi* case. Other commentators have suggested that perhaps it is "dommages accidentels sans faute prouvée résultant non de l'état du patient, mais de l'acte médical lui-même"[421] or even "dommage accidentel ayant un lien de causalité certain avec un acte médical, mais dont la réalisation est indépendante de toute faute".[422] Larroumet in his article states that the damage must result from the manifestation of the *aléa.*[423] Writing before the implementation of the law of 4 March 2002, Larroumet also discusses the reasons for allowing recovery for an *aléa*. Recovery for *aléa* must lie without anyone being liable. It is, so to speak, just one of those things to expect from medicine as it is not an exact science. Jourdain also forwards some arguments in

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[418] S TAYLOR, "Negligence Reform: Lessons from France?" (July 2003) 52 *International and Comparative Law Quarterly* 737 at 741

[419] C LARROUMET, "L'indemnisation de l'aléa thérapeutique" D 1999 chron 33 and chron 35 n°8

[420] G VINEY and P JOURDAIN, "L'indemnisation des accidents médicaux: que peut faire la Cour de cassation?" JCP 1997.I.4016

[421] P SARGOS, "Réflexions sur les accidents médicaux et la doctrine jurisprudentielle de la Cour de cassation en matière de responsabilité médicale" D 1996 chron p365 n°8

[422] C LARROUMET, "L'indemnisation de l'aléa thérapeutique", D 1999 chron 33 and chron 35 n°8

[423] ibid

favour of recovery for aléa. These are clearly policy arguments. He notes that recovery should be allowed in the interests of justice. Society benefits from medical progress and not everything is understood therefore why should someone who is harmed by an aléa be left without reparation when we all eventually benefit?[424]

In other case law, it was held that a surgeon was responsible for all consequences of maxilla bone surgery, namely a total blindness in the right eye.[425] A direct causal link was held between the bone disjunction and the vascular accident resulting in the blindness. It was held that the doctor was not in any way at fault and in particular he had fulfilled his *obligation d'information* towards the patient as the eventuation of blindness was "jusqu'à présent inconnue des publications scientifique". It was held that the doctor was liable for damage due to the *obligation de securité* that was owed to the patient. The judgement was framed in terms of

> le docteur est responable de la cécité survenue à Mlle R au cours de l'intervention et résultant selon le rapport d'expertise, d'un accident vasculaire causé par le disjonction osseuse...les experts ayant éliminé tout pathologie préexistante ou tout cardiopathie emboligène, et qui ne constitue pas une évolution prévisible de l'affection pour laquelle elle était traitée.

I wonder though how helpful (or indeed correct) it is to speak of the doctor's responsibility in this case. Certainly there was a causal link between the medical intervention and the subsequent blindness but it surely not valid to say that the doctor was responsible therefor. To aver that the doctor in any way breached an *obligation de sécurité* I find intuitively wrong and to hold him "responsible" I find is simply inaccurate. This must be some kind of strict liability.

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[424] P JOURDAIN, "L'ndemnisation des accidents médicaux: que peut faire la Cour de cassation?" JCP 1997.I.4016 at p183 where he writes "L'indemnisation des accidents médicaux s'impose essentiellement pour des raison de justice. Les progress de la medicine qui profitent à l'ensemble de la collectivité, s'accompagnent d'un accroissement des risques créés par certaines techniques médicales, notamment par celles qui sont encore mal maîtrisées, mais qui sont parfois les plus prometteuses."

[425] CE, 15 Jan 1999, JCP 1999.II.10068

What would appear to be a more absorbing question, as Jourdain has addressed in an article, is what is actually fault and what is an *aléa thérapeutique*.[426] In one case, a patient undergoing a coloscopy suffered a tear of the intestine during an examination. The court of first instance held for the plaintiff patient but the Cour d'appel held that the proof of fault lies with the patient and that the tear of the intestine was a risk inherent in the procedure. It therefore refused to allow the surgeon to bear the consequences of, what the Cour d'appel saw, as an *aléa thérapeutique*. This was rejected, however, by the Cour de cassation as a coloscopy does not imply the tearing of the intestine and, assuming that there are no such predispositions of the patient, the Cour d'appel should have held that the surgeon committed a fault. This follows previous case law which held that a physician is liable for carelessness and therefore is not liable for any risk inherent in a medical procedure.[427] Jourdain notes that given that physicians deal with the human body, they should be subject to a higher standard of care, indeed he calls this an "obligation de précision".[428] This would then tend to raise a presumption of fault as far as the tearing or other harm or scarring to an organ in the course of a simple medical procedure. The surgeon then has to show that it was not his fault or, in other words, that he did not cause it: for example, as the Cour de cassation left open the possibility, of showing that the victim had some kind of predisposition. So the proposition is that some kind of fault would constitute a presumption of cause.

As far causation and fault are concerned, provided that the patient has been adequately warned of risk and such a risk is inherent in the procedure (and it cannot be attributed to the physician), then a plaintiff cannot recover on the basis simply that this was a risk he chose to take: *volenti non fit iniuria*.[429] The caveat to this is, however,

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[426] P JOURDAIN, "Responsabilité médicale: quelle critère distinctif de la faute et de l'aléa thérapeutique en cas de lesion consecutive à une intervention chirurgicale?", *Revue trimestrielle de droit civil*, January/March 2009, 123

[427] CC D 2007.189, rapp P SARGOS and note D THOUVENIN

[428] P JOURDAIN, "Responsabilité médicale: quelle critère distinctif de la faute et de l'aléa thérapeutique en cas de lesion consecutive à une intervention chirurgicale?", *Revue trimestrielle de droit civil*, January/March 2009, 123 at 124

[429] P JOURDAIN, "Responsabilité médicale: quelle critère distinctif de la faute et de l'aléa thérapeutique en cas de lesion consecutive à une intervention chirurgicale?", (January/March 2009) *Revue trimestrielle de droit civil*, 123 at 125

aléa thérapeutique. A patient is obviously not warned about this. The *aléa* must further not be related to the initial medical intervention. If it turns out that it is sufficiently serious then at *droit commun*, the plaintiff could recover if treated in the public sector.[430] Statute further provides that if there has been a "medical accident" of sufficient gravity then recovery can be made from the national solidarity fund.[431] If the plaintiff does not reach the severity of gravity required then the loss must lie with the plaintiff.

Aléas thérapeutiques have no counterpart in either United Kingdom or German law. There is no kind of strict liability in this regard. Policy is different. I suggest again therefore that this is a further example showing how jurisdictions treat the subject, making it impossible to have any common understanding of causation. I submit that this further supports my contention that there is no need to expand on notions of causation in any European projects for harmonisation in European tort law.

It falls now to consider the law of 4 March 2002 in greater detail with regard to causation.

[430] see supra, CE 3 Nov 1997, JCP 1998.II.10016, note J MOREAU; D 1998.146, note P CHRESTIA

[431] see infra

4.6 Loi no 2002-303 of 4 March 2002

4.6.1 Nosocomial Infections and Medical Hazards

The law 2002-303 of 4 March 2002 (loi Kouchner) inserted article L-1142-1 I and II into the CSP. It has been criticised for its imperfections.[432] It is not the purpose of this paper to enter into this debate but rather to consider how this law changes our idea of causation in the medical domain. This law[433] inserted into the CSP that

> Art. L. 1142-1. - I. - Hors le cas où leur responsabilité est encourue en raison d'un défaut d'un produit de santé, les professionnels de santé mentionnés à la quatrième partie du présent code, ainsi que tout établissement, service ou organisme dans lesquels sont réalisés des actes individuels de prévention, de diagnostic ou de soins ne sont responsables des conséquences dommageables d'actes de prévention, de diagnostic ou de soins qu'en cas de faute.
> Les établissements, services et organismes susmentionnés sont responsables des dommages résultant d'infections nosocomiales, sauf s'ils rapportent la preuve d'une cause étrangère.
>
> Lorsque la responsabilité d'un professionnel, d'un établissement, service ou organisme mentionné au I ou d'un producteur de produits n'est pas engagée, un accident médical, une affection iatrogène ou une infection nosocomiale ouvre droit à la réparation des préjudices du patient au titre de la solidarité nationale, lorsqu'ils sont directement imputables à des actes de prévention, de diagnostic ou de soins et qu'ils ont eu pour le patient des conséquences anormales au regard de son état de santé comme de l'évolution prévisible de celui-ci et présentent un caractère de gravité, fixé par décret, apprécié au regard de la perte de capacités fonctionnelles et des conséquences sur la vie privée et professionnelle mesurées en tenant notamment compte du taux d'incapacité permanente ou de la durée de l'incapacité temporaire de travail.

This law's basic premise is still fault. Health professionals and hospitals are liable for nosocomial infections unless they bring evidence of a cause étrangère and that is confirmed by the latest case law. This law aimed at harmonising the rules of

[432] P MISTRETTA, "La Loi no 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système du santé, Réflexions critiques sur un droit en pleine mutation," JCP 2002.I.141, 1080; P SARGOS, "Le nouveau régime juridique des infections nosocomiales, loi no 2002-303 du 4 mars 2002" JCP 2002 Actualité, 1117

[433] at art 98 thereof

recovery in the public and private domain for iatrogenic complaint (*affection iatrogène*), nosocomial infection and medical accident. The last one of these should cover *aléas*. There had been calls for reform for over 30 years.[434] In essence, medical professionals are only liable for fault. There is no expansion on what fault means and it would appear that any plaintiff would have to continue to use the *droit commun* in this regard.

What can be seen here then is that with both nosocomial infections and medical accident, the normal approach to causation is diluted, if not disregarded altogether. For the former there was a convergence in the reasoning of the Cour de cassation and the Conseil d'Etat with regard to causation in that it was presumed unless a hospital could show otherwise. However, the Cour de cassation then developed its case law to impose on hospitals or doctors an accessory *obligation de securité* for nosocomial infections allowing only a cause étrangère to absolve it. For medical accidents, there was little convergence. Indeed there was divergence and the law of 2 March 2002 had to be enacted as it was unfair that recovery depended on whether the *aléa* manifested itself in a public or private hospital. The idea of causation has been abrogated in this law and causation has been replaced by one of direct *imputabilité* where recovery is sought from the national solidarity fund. If a claimant fails to meet the criteria of recovery from the national solidarity fund however, he must fall back on *droit commun* if he wants to try to bring a case against a public sector hospital. There would be no kind of recovery in the private sector for *aléa thérapeutiques*. How long the separate jurisdictions can maintain this difference has been questioned and I would tend to agree with such questioning.[435] Success or otherwise cannot be based on whether the plaintiff suffered her injury in public or private hospital alone. If the plaintiff wishes to recover from the national solidarity fund, then he need show that a medical accident, or hospital acquired infection is *imputable* (only) to the hospital. So causation is being further watered down here. This is simply a policy decision in this area. This shall be considered in the

[434] C EVIN, "L'indemnisation des accidents médicaux" (2001) *Révue générale de droit médicale* 71

[435] S GALAND-CARVAL, *Cases on Medical Malpractice*, p108 where she notes, "At the time being, the Cour de cassation still seems hesitant to recognise such a liability. It will be difficult for it, however, to stand in this position for a very long time since the Conseil d'Etat has already introduced a no-fault liability for therapeutic risk in the field of public law." This is following the 1993 *Bianchi* case.

comparative chapter. I suggest this is yet further evidence that any common notion of causation to be extracted at a European level is impossible to find.

4.7 Disclosure Malpractice

The obligation incumbent on a doctor to inform his patient of the risks involved in any medical procedure or intervention was established in French law in 1942.[436] The risks inherent in a medical situation must also be considered from a causal point of view. A patient must know to what she is consenting. If she does not know then the question arises, would she have consented if she had known?: an essential causal question. If she is not fully informed as the law requires, this could also constitute an attack on her bodily integrity. In France, a physician must give her patient information that results in the "consentement libre et éclairé du patient".[437] Causally, what is being hypothesised here is the behaviour of a patient in the event that the person had been given more information on which to base her decision. What we are interested in here is imagining a possible world where the plaintiff would not have taken the decision to go ahead with a given procedure.[438]

Courts may consider that where the patient has not been properly informed that he has lost a chance to refuse treatment.[439] Any recovery could potentially be limited to a particular percentage of the final loss. The court would take into account the full state of the victim and try to assess what he would have done if he had been fully informed; this is where causation is important.[440]

If the victim had been in terrible pain for years and his chances of surviving without the offered treatment were small, then a court might simply dismiss a claim as "illusory".[441] Where, on the other hand, the patient had (say) the option of whether to undergo a high-risk aesthetic surgery or an operation not seen as necessary then the courts might take another view. A patient must be given a complete picture of the risks including those which, although minor, if they eventuated, could result in

[436] CC req 28 Jan 1942, D 1942.63

[437] G VOGEL, *Les grands principes du droit medical et hospitalier* (2nd ed, Luxembourg, Promoculture, 2001) 193

[438] or perhaps not gone ahead with it at a given moment, see *Chester v Afshar* (2004) UKHL 41

[439] CC 1 7 Feb 1990, Bull n° 39

[440] CC 1 20 Jun 2002, Bull n° 193; D 2000 Somm 471

[441] Angers CA 11 Sept 1998, *Dalloz*, 1999, 46 note M PANNEAU

serious consequences for the patient. A physician must give fair, clear and appropriate information on serious risks even if they are of an exceptional occurrence. Each case must therefore retrospectively be considered on its merits with regard to the seriousness for the patient.

A surgeon must also draw a patient's attention to any serious risks which could have mortal, aesthetic or disabling consequences having regard to the patient's psychological and social circumstances if such consequences would be of a nature such that they affect or influence the patient's consent.[442] So where, for example, a defendant is informed only of paralysis in a patient consent form, when the risk is in fact paraplegia, then this would be an adminicle of evidence towards proof that the patient had not been adequately informed.[443] This is only an adminicle. A standardised form, for example, would not in itself constitute consent especially where the document is not sufficiently clear and its terms are not understandable by the non-initiated.[444] The patient must understand in a global sense and this will be established by further evidence.

4.7.1 *Obligation d'information*: Case Law

In a case from the Angers Court of appeal, where the plaintiff had been suffering from an ulcerative colitis, it was shown that a doctor had not informed his patient of a serious risk which eventuated relative to an intestinal perforation following a coloscopy for the removal of a polyp.[445] The loss of a chance to refuse treatment can only be indemnified if it can be shown that, duly informed, the patient would **probably** not have gone ahead with the medical intervention and it is the *juges du fond* who assess this.[446] Yet what criteria then should they use? This case held that judges should

[442] CC 1 14 Oct 1997, Bull n° 278; JCP 1997 II 22942

[443] S GALAND-CARVAL, *Cases on Medical Malpractice*, p110

[444] G VOGEL, *Les grands principes du droit medical et hospitalier*, p199

[445] CC 1 20 June 2000, Bull n° 193

[446] P JOURDAIN, "Sanction de l'obligation d'information du médecin sur les risques d'un acte médical" (2000) *Dalloz* n° 44, p471

> ...rechercher, en prenant en considération l'état de santé du patient ainsi que son évolution prévisible, sa personnalité, les raisons pour lesquelles des investigations ou des soins à risques lui sont proposés, ainsi que les caractéristiques de ces investigations, de ses soins et de ces risques, les effets qu'aurait pu avoir une telle information quant à consentement ou à son refus.

This can be seen then as a causal guide for judges when establishing the logical possible world for any given patient. Jourdain notes that it is a pity that the Cour de cassation did not refer to the "necessity" of the treatment as, if the treatment were not necessary, then a refusal would be less likely.[447] Penneau notes that the test is one of reasonableness.[448] What would have to be considered then is the attitude of a reasonable patient, or the abstract "bon patient". I would argue this is true to a certain extent but the Angers case did say the personality of the patient should be taken into account so there is a certain margin of appreciation: in short, the court must take the attitude that we do not have a death wish. The test then is, I would argue, one of subjective probability within reasonable limits given that the court stated that no reparation can be granted where it is "…improbable qu'il eût refusé le traitement...". The case might well be different where a patient suffers simply from an irritation or a discomfort. In such a case, a more in depth analysis would have to be made of the possible world and of the patient's likely reaction.

In another case, an ablation of a nodule situated in the thyroid gland was followed by an exceptional complication.[449] The precise reason for this was unknown but it lay in the lesion of a nerve. The surgeon had committed no fault but the patient argued that the surgeon had not warned her of the risks of the operation. The Court of Appeal rejected her argument on the basis that it was not shown that even if she had been informed she would have refused the operation. In the expert's report it was confirmed that the operation was necessary even taking into account the risks. The

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[447] ibid

[448] M PENNEAU, "Le défaut d'information en medicine", D.1999, *jurisprudence,* p48; he notes at p50 that "On Remarque que cette appreciation suppose la recherche du patient confronté à l'information telle qu'elle aurait dû lui être donné. C'est la reference à un standard abstrait du "bon patient" ni plus, ni moins réaliste que celle du 'bon père de famille' ou celle du 'bon professional.'"

[449] CC 1 13 Nov 2002, Bull n° 265

Cour de cassation, approving this decision, held that the patient had not shown the necessary prejudice and that this prejudice is "souverainement constatée par les juges du fond". Jourdain criticises this judgement in that he notes that the control here by the Cour de cassation is somewhat "woolly" (*lâche*).[450] He states that it must be quite difficult to prove as the prejudice consists not in the risks that have eventuated but in the chance to refuse the operation, ie the possibility to refuse. This, however, contradicts what he writes in a previous article where he states that to recover for loss of chance, it is necessary that the patient show that he would have refused the operation if he had been correctly informed.[451] It would seem to me that if recovery is sought for loss of chance then strictly speaking only the doctor's breach of the *obligation d'information* need be shown. Yet in such cases, if inquiry is had to the possible world where the patient had been informed then it is a fiction to allow recovery for loss of chance so I would not necessarily agree with Jourdain on his criticism of this case. Also in this case, the operation was indeed necessary. To hold that the patient is only seeking recovery for loss of chance, I think, may be pushing the boundaries of this concept too far and allowing the patient recovery where the logical possible world would deny it. If the possible world just has a "caractère illusoire" then I think Penneau put it best when he wrote "le dommage existe, dans son principe, mais il est nul quant à son contenu".[452]

There are a number of criteria that judges take into account including the health of the patient, his personality, the reasons and the risks inherent to the operation when assessing whether a patient would actually have refused an operation or not.[453] Even with these criteria, causation will remain uncertain. It is a protean concept that will

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[450] P JOURDAIN, "Obligation d'information médicale: le recul de la sanction", (2003) *Revue trimestrielle de droit civil*, p98

[451] P JOURDAIN, "Sanction de l'obligation d'information du médecin sur les risques d'un acte médical" D.2000.471 where he writes "Il est vrai que la perte d'une chance de prendre une décision de refus de l'intervention – préjudice qui est habituellement réparé en cas de manquement à l'obligation d'information – ne peut être indemnisée s'il est acquis que, dûment informé, le patient aurait donné son consentement, ce que les juges du fond apprécient souverainement."

[452] M PENNEAU, "Le défaut d'information en medicine", D.1999, *jurisprudence*, p48; he notes at p50; in this case he notes that the court will look at the attitude of a "reasonable patient" in the circumstances.

[453] CC 1 20 Jun 2000, Bull n° 193

always be adaptable: and that is why, it is submitted, it is unsuitable for any kind of codification.

4.8 Burden of Proof

Continental procedure in fact-finding differs most apparently form the common law in its inquisitorial approach. The common law generally takes an adversarial approach but no system is purely adversarial or inquisitorial.[454] Generally on the Continent, it is true to say that there is really no law of evidence as such.[455] It may come as a surprise but hearsay is admitted, past convictions and even illegally obtained evidence.[456] I would not go so far as to say there is no such thing as cross-examination but its use is certainly more limited than it is in the United Kingdom. I do not comment on the pros and cons of each system in the round save for one recommendation I make at the end of this paper with regard to cross-examination and scientific evidence.

4.8.1 Causal Presumptions: Theory

In general, in France there is as such no set standard of proof but rather the judge must have an *intime conviction* for the truth.[457] So even though it might appear prima facie more difficult for a plaintiff to prove his case in a French court because the court is looking for a standard of proof that satisfies a judge's *intime conviction* to near certainty,[458] the use of judicial presumptions often eases the burden for the plaintiff in ways that are not mirrored in the common law. French and Luxembourg law have resort to certain presumptions[459] which if established by the plaintiff make it extremely difficult for a defendant doctor, hospital or laboratory to defeat. This in itself, as I shall show, can often make it easier for a plaintiff to recover in France or Luxembourg than would normally thought to be the case given the high standard of

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[454] see generally F DAVIDSON, *Evidence*, p11 et seqq

[455] ibid ; there is certainly not, at the University of Luxembourg anyway, an undergraduate course called "Evidence" as I had as an undergraduate

[456] F DAVIDSON, *Evidence*, p11 et seqq

[457] This is nowhere stated in the French Civil Code or the Code of Civil Procedure. However, interestingly Art 304 of the French Code of Criminal Procedure requires each juror of the Assize Court to swear "to remember that the accused is presumed innocent and that he has the benefit of the doubt; to decide according to the charges and defence arguments following your conscience and your **innermost conviction**." (my emphasis)

[458] See R WRIGHT, "Proving Facts: Belief versus Probability" in the *Tort and Insurance Law Yearbook*, *European Tort Law 2008*, (Vienna, Springer, 2008)

[459] ibid

civil proof. This is especially relevant in the areas of blood transfusions, hospital infections and the link between multiple sclerosis and the hepatitis B vaccine. As Kinsch notes, even the "absence d'une autre cause apparent" can be a relevant factor.[460] The plaintiff must, of course, bring enough evidence to establish these presumptions and such presumptions must be *graves*, *précises* and *concordantes*.[461] This is relevant for causation in that if a prima facie case is made out then the tortfeasor's actions will be the origin of the damage and hence will have caused the damage in the legal sense. These presumptions can almost be seen as a tactical or procedural burden.[462] For example, it will be shown that if a plaintiff has contracted a disease that is typically contracted following a blood transfusion then depending on the temporal factors, the blood transfusion will often be seen to be the *cause génératrice*, that is, at the origin of the damage and therefore have legally caused the damage. Only if the blood transfusion centre can actually prove that it was not at the centre of the damage (by say finding the blood donors and showing that they were not infected at the time of giving blood) that it will be able to absolve itself. Again and again it must be remembered that these are only **legal presumptions**. It does not mean that the blood actually and in reality caused the damage scientifically but courts are not always dealing with truth. Judges must consider other factors of policy. It will also be seen that policy in France that statute applies certain legal presumptions apply for a number of diseases.[463]

The burden of proof under French law rests with the plaintiff and any defence must also be proved.[464] The general principle in France is that the plaintiff must prove the causal link between the damage and the fault.[465] If he does not, his case should be dismissed as a matter of course. The plaintiff need only prove that the defendant's

[460] P KINSCH, "Probabilité et certitude dans la prevue en justice" (2009) 2 *Journal des tribunaux Luxembourg* 37

[461] art 1353 French Civil Code

[462] see supra

[463] loi 2002-303 of 4 March 2002, art 102 for hepatitis C

[464] Art 9 French Code of Civil Procedure "Il incombe à chaque partie conformement à la loi les faits nécessaires au succès à sa pretention."

[465] G VINEY and P JOURDAIN, *Traité de droit civil*, 362 "En l'absence de présomption légale, c'est le demandeur qui doit établir le lien de causalité entre le fait reproché au defendeur et le dommage."

fault was one of a number of causes that can be imputed to the defendant not that it was the "real" cause.[466] However, this means in practice, of course, that the determination of cause is one for the courts and that in principle any doubt over causal relation should profit the defendant.[467] This is, in any case, the basic principle. In France, it has succumbed to many an exception both at *droit commun* and at statute.

Another way in which the French traditions differ to a considerable extent from the British and German traditions is the way in which causation is used to prove fault. Judicial presumptions were mentioned above but there are also certain causal presumptions which would not have any counterpart in the common law. There are perhaps less relevant for medical liability but they should be understood. The *gardien* of a *chose* is presumed responsible for any harm he causes.[468] For example, the causal presumption will apply if my neighbour is the *gardien* of a frisbee that he throws to my injury. The frisbee is at the origin of the damage. My neighbour may be at fault here. This will be decided after a proper consideration of the facts. My neighbour could point to my walking through his garden as my contributory fault in order to reduce his responsibility. Now although the final decision of a Luxembourg and an English court may be similar, the processes of arriving at this decision stand in stark contrast to each other. In France there would be a presumption of responsibility and thus causation.[469] To cite Ravarani here

> Certaines catégories de personnes sont soumises à une **présomption de *faute***. Si la présomption de *faute* a tendance à disparaître en matière délictuelle, elle reste d'actualité en matière contractuelle. – Pour une seconde catégorie, il ne s'agit pas d'une présomption de *faute* qu'il serait possible de combattre par la preuve d'un comportement normalement diligent et prudent du présume fautif, partant par la preuve de l'absence de *faute*, mais d'une présomption de responsabilité, autrement dit **de causalité**. Le comportement….est présumé être à l'origine du dommage.[470]

[466] ibid and CC 1 31 May 1988, Bull n° 161

[467] ibid; Orléans, 5 Jan 1966, JCP 1966.II.17721

[468] art 1384 Luxembourg Civil Code

[469] G RAVARANI, *La responsabilité civile*, 900

[470] ibid, emphasis is the original author's

What Ravarani says here then is that there is a presumption of responsibility in contract, or, what is important for the purposes of this paper, a presumption of causation. The fault that is being considered is said to be the *cause generatrice*. This is an intriguing insight for a common lawyer. In the common law, it would be difficult to find such presumptions in causation other than those set out in statute. This shows then in France and Luxembourg how causation overlaps procedural law and how presumptions of fault, responsibility or causation are much more readily assumed by dint of the Civil Code. Indeed, Wright even commented that this *de iure* shift of the burden of proof here "…effectively converts civil code provisions basing liability on fault into strict liability regimes."[471]

I do see his point and such a reaction from a common lawyer is understandable. There is, in effect, a strict liability for all those who are considered a *gardien* of *choses* and this does cover a large amount of tort law.

4.8.2 Causal Presumptions and Inferences: Case Law

The use of presumptions in French case law, I suggest, has often resulted in decisions in favour of the victim which would not necessarily have been followed in the United Kingdom or indeed in Germany. The causes that shall be considered here include a case concerned with Creutzfeldt-Jakob disease, the hepatitis B[472] vaccination and multiple sclerosis,[473] hepatitis C,[474] and HIV/AIDS.[475] To begin, three cases that were decided on the same day are worthy of attention.

The first case is concerned with the development of Creutzfeldt-Jakob disease.[476] Here it was held that where there was doubt about who supplied a defective growth

[471] R WRIGHT, "Proving Facts: Belief versus Probability" in the *Tort and Insurance Law-Yearbook*, *European Tort Law* 2008 (Vienna, Springer, 2008) 79 at 81

[472] an infectious disease affecting the liver

[473] a disease disrupting the flow of nervous cells to communicate

[474] an infectious disease affecting the liver

[475] HIV causes HIV infection causing ultimately AIDS

[476] a degenerative neurological disorder that currently has no cure and is terminal; CC 1 24 January 2009, Bull n° 34

hormone then certain *graves*, *précises* and *concordantes* presumptions could be formed. In this case, the deceased had previously been asymptomatic. All patients who had been diagnosed with Creutzfeldt-Jakob disease had been treated with a growth hormone emanating from France hypophyse. The Institut Pasteur further treated the same growth hormone.[477] With regard to the causal link, it was not sufficient to show the simple administration of a drug and the subsequent development of a pathology. Something more was required. It was held that there it was essential to take all precautions that were necessary with regard to the extraction, purification and composition of the growth hormone and that

> les précautions recommandées n'avaient pas été suivies d'effet; qu'elle **a pu en déduire l'existence d'un lien de causalité certain et direct** entre les manquements à la prudence imputés à l'Institut Pasteur et le préjudice de contamination subi par Pascale Y...[478]

So what can be seen here then is that if certain precautions have not been taken within a clinic then courts are willing to hold that a causal link exists, should a pathology later develop. This would not necessarily be the case in the United Kingdom.

The second case handed down by the Cour de cassation on the same date was relative to the drug Isoméride used as a treatment for obesity.[479] Ms Y was prescribed the drug and one year later developed primitive pulmonary arterial hypertension (HTAPP) necessitating bi-pulmonary transplant and heart surgery. This judgement was interpreted according to article 1147 of the French Civil Code[480] "in the light" of article 4 of the Product Directive 1985 where it is for the victim to prove the damage, the defect and the causal relationship resulting from a defective product. On the one hand, the judgement momentarily seemed to favour the laboratories in that HTAPP had been mentioned as a potential side effect. Such side effects were only "co-incidences" according to the epidemiological and

[477] as opposed to the Kabivitrum growth hormone

[478] my emphasis

[479] CC 1 24 January 2006, Bull n° 35

[480] which inter alia provides that a debtor pay damages for the non-performance of an obligation provided it cannot be attributed to an external cause

pharmacological studies which could occur even in someone who was not taking the medication; so far so good for the laboratories. The Cour d'appel did not even approach the subject of whether Isoméride was a triggering factor (*facteur déclenchant*) and by taking an approach based on probabilities or possibilities, breached article 1147 of the French Civil Code which provided that the victim must show a direct causal link between the taking of the drug and the infection of which she complained.[481] However, in the same studies it stated that dexfenfluramine, a component of Isoméride, was "un facteur favorisant HTAPP même si elle n'en était pas la cause exclusive". Not only this but also the fact that Ms X had a satisfactory state of health in 1993, the court report stated that Isoméride would have been a direct and partial cause in someone who had a predisposition to HTAPP and an adequate cause (*cause adéquate*) in the absence of any other explanation. There was no other explanation and the Cour d'appel should have drawn *graves*, *précises* and *concordantes* presumptions from this report. Further the fact that the medicine made no reference to a risk of HTAPP allowed the Cour de cassation to approve the Cour d'appel's finding that the product was defective.[482] I again emphasise that there is a difference between scientific and legal causation. A balance has been struck. The judgement has a scientific basis (not perfect) and a legal one (other societal values taken into account). Yet I wonder to what extent such a decision would have been similar in the United Kingdom given courts' strict requirement that the plaintiff prove his case to 51% or more. The fact that there could have been multiple agents causing the HTAPP here[483] could further complicate matters in a British court.

In the third case, again decided by virtue of article 1147 of the French Civil Code as interpreted "in the light" of the Product Directive 1985, concerned a Ms Y who was vaccinated against hepatitis B in September 1995. She then developed Guillain-Barré syndrome (a peripheral neuropathy).[484] The Cour de cassation noted that the Cour d'appel had decided on the defective nature of the vaccine by the fact it

[481] "...et en s'en tenant ainsi à des possibilités ou probabilités de causalité, a violé le texte susvisé."

[482] The characteristics of the product mentioned were "...seulement que des cas d'hypertension artérielle avaient été rapportés chez des patients généralement obèses sans qu'aucun lien de causalité n'ait été établi avec la prise d'Isoméride."

[483] "même si elle n'en était pas la cause exclusive"

[484] CC 1 24 Jan 2006, Bull n°33

mentioned as side effects "très rarement, des neuropathies périphériques." Steinlé-Feurbach notes in her commentary that this case should allay the fears (at least momentarily) of drug producers.[485] The judgement held that

> Qu'en déduisant le caractère défectueux du vaccin litigieux de ces seules constatations, la cour d'appel a violé les dispositions susvisées.

So it is important to note then that if there is an omission of side effects on a patient information notice on a drug, this could render a product defective. Causation could then be established on the basis of causal presumptions as described in the cases above. It would not be enough that the side effects are mere co-incidences. The previous state of health of the victim is also an important factor to take into consideration.

Without commenting on the procedural aspects of these three cases, what strikes me immediately is the Cour de cassation's concentration on expert reports, temporal considerations between drug administration and onset of disease, previous state of health of the victim and warnings, if any, that were given to patients as to the side-effects of certain drugs. It is interesting that even though the Cour de cassation does state that the causal link between the taking of the drug and the appearance of the disease must be "direct and certain",[486] the way of establishing directness and certainty are anything but that. Directness and certainty are arrived at, for example, by considering whether there is enough evidence to establish prima facie presumptions which are *graves*, *précises* and *concordantes* putting a plaintiff at a significant procedural advantage. This is not because he has established causation with any scientific certainty: rather procedural manoeuvres are used to create this legal fiction. France is able to use procedure to allow for presumptions in establishing legal causation when scientific causation cannot be established with any great deal of certainty. There is a clear separation of law and science in France when it comes to stating a causal link. Indeed Radé is quite forthright in his views that ideas of

[485] M-F STEINLE-FEURBACH, "La responsabilité des fabricants de medicaments", (February 2006) 61 *Journal des Accidents et des Catastrophes*, to be found online at http://www.iutcolmar.uha.fr/internet/Recherche/JCERDACC.nsf/5c85f87385ea3be0c125677d003a11b5/d95345738393a8c2c12570f5004e8854?OpenDocument

[486] as in the Isoméride case, CC 24 Jan 2006, Bull 2006, n° 35

causation in defective products should be decided on in law and not in science.[487] He notes that notions of law and science should work together where they can but in law there are other norms to be satisfied such as the legitimate expectation of the consumer and notions of vice and danger.[488]

With regard to the uncertainty of the causal link between the hepatitis B vaccination and the development of multiple sclerosis, there are three judgements which would allow for the possibility of recovering against laboratories. The important cases here are of 28 May 2008.[489] Even though courts had tried to favour victims who developed multiple sclerosis following their vaccination,[490] the Cour de Cassation had quashed those decisions on 23 September 2003[491] stating it was impossible to prove a causal link between vaccination and disease. These three cases changed that.

In the first case of that date[492] the victim, MB, a health employee, developed multiple sclerosis shortly after receiving a vaccination against hepatitis B and was initially refused damages on the grounds that scientific proof of a causal link between the damage and the defective product was impossible to prove as no-one could know how the vaccination itself could provoke multiple sclerosis

> l'arrêt retient que la preuve scientifique absolue est impossible puisque l'étiologie de la sclérose en plaque n'est pas connue...

The Cour de cassation held that statistical evidence could be used (even in the absence of scientific evidence) to show presumptions if they were sufficiently *graves, précise et concordantes*. The Cour de cassation quashed the decision of the Cour d'appel as they had not given a legal basis to their decision. The Cour de cassation interpreted this decision in the light of articles 1382, 1383 and the Product Directive. The Cour de cassation in particular criticised the

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[487] C RADE, "Vaccination anti hépatite B et sclérose en plaques: le tournant" (July-August 2008) *Revue responsabilité civile et assurance* 8 at 10

[488] ibid

[489] there were in fact six but three are of interest here

[490] CA Versailles, 2 May 2001 on 98/06839

[491] CC 23 Sept 2003, Bull n° 149

[492] CC 1 22 May 2008, Bull n° 148

> approche probabiliste [of the Cour d'appel] déduite exclusivement de l'absence de lien scientifique et statistique entre vaccination et développement de la maladie, sans rechercher si les éléments de preuve qui lui étaient soumis constituaient ou non, des préseumptions graves, précises et concordonates.

In a second case, it was held that a laboratory was not liable for putting a vaccination against hepatitis B on the market without having mentioned at all any reference to multiple sclerosis.[493] There was no epidemiological research showing any causal relationship between the vaccination and multiple sclerosis. The Cour de cassation referred to the Vidal dictionary 1994[494] which stated that multiple sclerosis could be an exceptional side-effect of the vaccination and consequently the Cour d'appel did not properly appreciate the causal relation between the vaccination and multiple sclerosis.[495]

In the third case,[496] it was found that if there were again certain facts that allowed for presumptions to be found that were sufficiently *graves*, *précises* and *concordantes* then such presumptions could form a proof overcoming in the strict sense the need for causation. In this case, facts that were considered were the victim's previous state of good health and the victim's contracting multiple sclerosis only some months after the vaccination.

The Cour de cassation was probably encouraged to take such positions on causation in 2008 by the decision of the Conseil d'Etat in 2007 where it was held that a nurse who developed multiple sclerosis following an obligatory vaccination could obtain damages notwithstanding the fact that there was no scientific causal link.[497] It held inter alia that

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[493] CC 1 22 May 2008, Bull n° 147

[494] this is a pharmaceutical reference book used in France: http://www.vidal.fr/les-produits-professionnels/dictionnaire-vidal

[495] again reference was made to articles 1382 Civil Code and the Product Directive

[496] CC 1 22 May 2008, Bull n° 149

[497] CE 9 March 2007 D 2007, p2004, note L NEYRET

> dès lors que les rapports d'expertise s'ils ne l'ont pas affirmé n'ont pas exclu l'existence d'un tel lien de causalité, l'imputabilité au service de la SEP[498] de Mme A doit être regardée comme établie [due to certain factors such as the] bref délai ayant separé l'injection de l'apparition du premier symptôme cliniquement constaté de la SEP [and] bonne santé de l'intéressé et absence chez elle de tous antécédents de cette pathologie.

The Cour de cassation was probably also aware of the right of resort to the national solidarity fund further to article L 3111-9 CSP which fully compensates those who have suffered prejudice from a compulsory vaccination. This was brought in by the law of 17 December 2008.[499]

Medical studies do not support at the time of writing a causal link between the administration of the hepatitis B vaccine and the onset of multiple sclerosis.[500] Recent case law seems to follow the patterns set down by the cases above whereby even though there might not be scientific proof on the causal link between the hepatitis B injection and multiple sclerosis, courts will consider facts before them on a case by case basis taking into account the time between the injection and its onset,[501] family history, ethnic origin,[502]and the number of injections taken by the patient. Co-incidence or correlation is not scientific causation. If it were shown scientifically that the vaccine did not cause multiple sclerosis, then, of course, the courts would have to respond to this. For the moment, however, courts have taken this policy decision to decide in a plaintiff-friendly way. I do not believe such would be the approach of British or German courts.

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[498] *sclérose en plaques*, multiple sclerosis

[499] loi 2008-1330

[500] see the Australian National Centre for Immunisation Research and Surveillance Factsheet at http://www.ncirs.edu.au/immunisation/fact-sheets/hepb-vaccine-ms-fact-sheet.pdf ; It states the following answer: "Does hepatitis B vaccine cause multiple sclerosis? No, the weight of all the currently available scientific evidence shows no association between hepatitis B vaccine and multiple sclerosis." However, D Le HOUEZEC has suggested in an article in 2015 that the correlation between hepatitis B vaccine and multiple sclerosis may indeed be causal. He suggests further studies; see D Le HOUEZEC, "Evolution of Multiple Sclerosis in France since the beginning of the Hepatitis B Vaccination", (2015) 60 *Immunologic Research* 219.

[501] see in particular CC 10 July 2013, Bull n° 157 which stated that a delay of 6 years should have been enough to "exclure tout lien entre le vaccin et cette pathologie".

[502] Ibid, where epidemiological evidence was brought to show that the frequency of those suffering from multiple sclerosis in Senegal was lower than that in Western Europe

4.8.3 Conclusion

In these French cases about multiple sclerosis, scientific causation is actually replaced by presumptions. Neither the Conseil d'Etat nor the Cour de cassation is hiding the fact. What is interesting about this is how these presumptions are formed. The courts find that multiple sclerosis may have been brought about in certain cases by a victim's personal disposition or, indeed, even due to an exceptional side effect. This allows us to cross the bridge of causation and hold that, legally in any case, a causal link between the vaccination and multiple sclerosis exists. There is legally a causal link between the hepatitis B vaccination and multiple sclerosis if certain presumptions are established and the laboratories in question are unable rebut these presumptions. This is not necessarily how causation might be thought of by the man in the street. France has clearly made certain policy decisions in this regard. It shows also how divided opinion is on causation. Scientific causation is different from legal causation. While I would not go as far as Mislawski, however, where he states

> A quoi sert, dans certains cas, la vérité factuelle si elle ne satisfait pas le sens de la justice, voire si elle y fait obstacle.[503]

,there does indeed appear to have been a rejection of scientific acribia to prove legal truth in France. This certainly in the opinion of Radé and it appears to be true.[504] Judges must be concerned with the search of presumptions that are *graves*, *précises* and *concordantes*. Radé is particularly critical of courts insisting that they use their own "logique" when setting out "notions" of causation and that the right to do this belongs to the courts and not experts whomsoever. He does not deny mutual-reliance.[505] The absence of scientific certainty or near-certainty then does not

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[503] R MISLAWSKI "Vaccin contre l'hepatite B et sclérose en plaques: retour sur la causalité", (2010) *Médecin et droit* 105-109 at 108

[504] C RADE "Vaccination anti-hépatite B et sclérose en plaques: le tournant" (July-August 2008) *Responsabilité civile et assurance* 8 at 9

[505] at p10; unfortunately he then goes on to compare the notion of products with defects with consumer products when he says "C'est également pour cette même raison que la notion de produit défectueux fait plus référence aux attentes légitimes du comsommateur qu'à la notion de vice ou de danger, et que des données subjectives peuvent parfaitement prendre l'ascendant sur des considérations purement objectives."; while recognising that cases are brought under the Product Directive, I am uncertain that such language should be used for defective medical products. When I buy a consumer good, for example, a washing machine, I know what its purpose is; when I buy a medicine, is it fair to say my subjective expectation should trump what the drug can actually do? I suggest not.

constitute in itself an obstacle to the establishment of such presumptions.[506] Courts will assess the plaintiff's whole background asking questions like: was the person at risk? What was his lifestyle?

In any case, the point to all of this case law is that it is here where I find there would be a significant difference from a functionalist point of view with the United Kingdom. Not to have any scientific evidence and to rely only on the evidence I set out above in showing causal connections, I think would be unwise for a plaintiff in a British court. There must be at least some kind of expert report that shows a causal link scientifically unless there is some kind of exceptional circumstantial evidence. Currently there is no such scientific report. I submit such French decisions underline how differently the two jurisdictions treat causation.

[506] CC 1 24 Jan 2006, Bull n° 35

4.9 Experts and their Reports

A judge in France may order one or several expert reports in his search for the truth.[507] The *expertise*, as the report is known, is there to evaluate the evidence that has been brought by the party that seeks reparation.[508] In his report, the expert must only respond to questions that have been put to him by the court. On any other aspect, he must keep maintain a silence.[509] Courts in France, unlike the procedure in the United Kingdom, will tend to rely on a court-ordered report. Vayre, Palquelle and Fabre in their article on reports suggested that "seul l'expert peut se prononcer sur l'imputabilité pour que le juge constate le lien de causalité."[510]

I am not entirely sure this is accurate. The *imputabilité* is not really for the expert to decide. This is essentially a legal question. An expert's report should simply aver on causal likelihood and this should be reflected in words that import notions of probability via certain presumptions.[511] All that need happen in some cases is that certain facts be established.[512] I tend to prefer the attitude of Penneau who states that as far as experts are concerned

> On mélange autrement le fait et le droit. Il faut entendre que sur le terrain particulier du fait technique, où il est en règle générale radicalement incompétent, la compétence de l'expert s'impose au juge. Mais sur le terrain du droit, la compétence du juge reprend toute sa plénitude, et le rapport d'expertise ne devient qu'un élément particulier de l'ensemble sur lequel le juge fondera sa décision.[513]

This would lead one to believe then that there are other considerations which must clearly be put into the scales before arriving at any decision. These may well be social, economic and risk-based considerations to be taken into account. We have

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[507] Art 263 et seqq, French Code of Civil Procedure

[508] G VOGEL and E RUDLOFF, *Lexique de droit medical et hospitalier* (Luxembourg, Promoculture, 2009), 377

[509] ibid, 380

[510] P VAYRE, D PLANQUELLE and H FABRE, "Le lien de causalité en matière de responsabilité médicale", (2005) *Médecine et Droit* 72 at 78

[511] ibid, at 79

[512] For example, that the plaintiff contracted a disease 30 days after having been discharged from hospital

[513] J PENNEAU, *Faute et erreur*, 99

seen already that France is willing to do this. In the event that there is a difference of opinion on causation in experts' opinions then in France it would appear that the court can decide on which to prefer.[514]

There are, however, certain criteria that ought to be commented on in any expert report to allow a judge to establish causation. The Vayre, Planquelle and Fabre article does state these and there would not appear to be anything controversial in them.[515] First of all, a description of the damage is required. Second, the scientific aetiological probability must be commented on. It might also be interesting for a judge to note the delay between the medical intervention and the taking of a drug (for example) and the appearance of the symptom or damage-causing illness. Patients' pre-disposition to a particular illness may also be noted. If the expert believes that there is partial medical causation then Vayre, Planquelle and Fabre say that the expert ought then to ask himself three questions, viz

> (I)quelle aurait été l'volution du traumatisme sans l'état antérieur ou sans les prédispositions?;
>
> (II)quelle aurait été l'évolution de l'état antérieur ou des prédispositions sans le traumatisme?;
>
> (III)quelle a été l'évolution du complexe "état antérieur-accident"?

They then go on to state that after having answered such questions that an expert should be able to state that causation played a *rôle déclanchant*, *accélérant* or *aggravant*. Unfortunately, I do not believe the answering of such causal questions is that simple. Strictly, had the *Fairchild* scenario followed recommendations in the drafting of experts' reports, how could the experts possibly have determined that on the basis of time working at one of the negligent employers, one of these adjectives is suitable? Science worked on the basis that it was simply one "guilty" fibre that entered the lungs to cause mesothelioma. There would be uncertainty in legal causation. It is submitted here that France may have resort to the theory of the *création fautive d'un risque* or increase of risk.[516] Theories of equivalence and adequacy must also be

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[514] L KHOURY, *Uncertain Causation*, p64; J PENNEAU, *Faute et erreur* 54-55

[515] P VAYRE, D PLANQUELLE and H FABRE, "Le lien de causalité en matière de responsabilité médicale", (2005) *Médecine et Droit* 78 at 79; they give suggestions as to what the expert should write on his report according to his findings.

[516] CC 1 5 Feb 1991, D 1991.som 358, note anon

reported. A medical expert should preferably also have some knowledge of legal causation. In one case a victim was left with disabilities resulting from a road accident in 1971.[517] There was then a fire ten years later in 1981 and he died from burns as he could not run from his bed to escape the fire. His death was held not to have been caused by the first road accident, ie there was no imputation and the causation was indirect. This is an example of how time-lapse is important in answering such questions. Two further examples are given in the Vayre, Planquelle and Fabre article but I shall cite one only.

Example 1

A patient commits suicide after he has been told that one of his legs will have to be amputated four years after a motorcycle accident which caused a complicated fracture. This fracture became infected and there were numerous negligent treatments which were incapable of eradicating the infection.[518]

The authors say here that the wrongdoers should be liable in solidum and that the tortfeasor would have a right of recourse against the negligent medical practitioners in as much as they had aggravated the damage.[519] It would appear prima facie that what is being said (although the authors do not explicitly state it) is that both the driver and the doctors legally **caused** the suicide. The patient's family would have a right of recourse against the doctors. So where the man's life is valued at (say) EUR 100,000, the victim's family can claim all against the driver. The court would be saying to the victim's family that the driver caused the death of the man fully. He was fully responsible. Yet on the other hand, by providing this right of recourse, it may turn out that the driver only caused say 20% of the suicide. So by this procedural manoeuvre, the court is saying two different things at once. Yet it must surely be a paradox with which we can live. It is right that the victim's family should not have to go to the trouble of dealing with multiple tortfeasors and the risk must lie

[517] CC 8 Feb 21989, JCP 90-21544

[518] P VAYRE, D PLANQUELLE and H FABRE, "Le lien de causalité en matière de responsabilité médicale", (2005) *Médecine et Droit* 72 at 83

[519] ibid

with the joint tortfeasors.[520] It is perhaps inconsistent to say that the driver caused the patient's suicide legally but then provide a right of recourse: but this is a policy decision and is the essence of joint and several liability with which courts deal on a daily basis.

From my own experience in preparing for medical negligence cases for trial, such reports are typical in the sense that independent consultants when presented with a file do not often wish (or they cannot) to state anything definitively. It is often impossible for them to comment categorically on causation. This does, however, leave the plaintiff with a problem. The seriousness of the fault in itself does not justify a reversal of the burden of proof.[521] However, as we have seen, France has been ready to allow either a reversal of the burden of proof or causal presumptions in many cases. Also in France there is recourse to the "loss of chance" doctrine even if this loss can be difficult to quantify.[522]

In France then, it is the report that can contribute to whether certain presumptions have been established provided they are sufficiently *graves*, *précis* and *concordantes* further to article 1353 of the Civil Code. The expert's report is of the essence in such cases and it is essential that it be written in clear language to enable a decision-maker to decide in an informed way. Experts should try to use percentages as much as possible and avoid language like "probable" or "possible" or "likely" as that leaves the judge with an unenviable task at best or too much discretion at worst. I shall consider reports further in the final chapter and it is the only area under consideration in this paper where I shall make a recommendation.

[520] indeed the French draft of the Civil Code states at article 1378 that "Tous les responsables d'un meme dommage sont tenus solidairement à reparation. Si tous les co-auteurs ont vu leur responabilité retenue pour faute prouvée, leur contribution se fait en proportion à la gravité de leurs fautes respectives…"

[521] S GALAND-CARVAL, *Cases on Medical Malpractice*, p115

[522] CC 1 8 July 1997, JCP II 1997, 22921, rapport P SARGOS

4.10 Conclusion

France then has a number of headings in medical causation which should interest the comparative tort scholar. In general, France is a victim-friendly jurisdiction. The case law shows this. What stands out immediately in any comparison with the United Kingdom and Germany is the use made France of presumptions and sanctioning recovery for loss of chance. France also allows reparation for medical accidents or hazards, in a way that has no counterpart in either the United Kingdom or Germany. In these jurisdictions, a patient must assume the as yet unknown risks of an operation assuming he has been made aware of the disclosable ones. France's *obligation de securité* exists along side a hospital's other obligations. This helps a plaintiff who wants to recover for a nosocomial infection. This does not exist in the United Kingdom though it does in Germany. I am particularly interested in these solutions for the purposes of this paper as that given it is often suggested that causation's answers should lie in "common sense" - I suggest there is none. From the universal functionalist approach, solutions are not the same and this creates problems for those who wish to codify or deduce common principles from case law. I think this in itself advances my proposition that there can be no common idea of causation in medical liability (and I do not think the man on the Clapham omnibus is so different in his outlook from the man on the Paris metro). I shall keep a fuller consideration of this for the final comparative chapter.

Chapter 5: Causation in Germany

5.1 Introduction

Many of the problems encountered in the area of medical causation in Germany are similar to those found in the other jurisdictions. As in France where the analysis is nominally contractual, so too in Germany; and, as in France also, many notions of tort law have been retained in the German approach. The essence is that the patient must prove that the treatment caused his damage and not that it came about adventitiously. The German system remains fundamentally fault-based. The *Gesetz zur Verbesserung der Rechte von Patientinnen und Patienten* 2013 (the "**Improvement of Patients' Rights Act 2013**") in some way codifies the contract that is entered into between the doctor and patient.

Germany makes use of procedural devices that can effect causation. For example, the burden of proof is reversed completely when a doctor has been "grossly negligent" or where he has breached an obligation of which he is expected to have "full mastery". What exactly is meant by these concepts shall be considered herein. As ever, I have found that the delineation between substantive and procedural law is often blurred. On procedure, I think it is germane to note that one of the most striking differences between the United Kingdom and Germany is that the burden of proof in Germany in civil cases is prima facie much higher than in the United Kingdom. Although §286 of the *Zivilprozessordnung* ("**ZPO**"), the German Code of Civil Procedure, states that the court should freely interpret the evidence, case law has held that the court must be "overwhelmingly convinced" of its facts (*Überzeugung des Richters*).[523] Perhaps this might be expected because of the inquisitorial approach that Germany adopts in contrast to the adversarial approach of the United Kingdom.[524] This also would lead to, at least in theory,

[523] §286 ZPO "(1) Das Gericht hat unter Berücksichtigung des gesamten Inhalts der Verhandlungen und des Ergebnisses einer etwaigen Beweisaufnahme nach freier Überzeugung zu entscheiden, ob eine tatsächliche Behauptung für wahr oder für nicht wahr zu erachten sei. In dem Urteil sind die Gründe anzugeben, die für die richterliche Überzeugung leitend gewesen sind"; see BGH, 17 February 1970, BGHZ 53, 245 (256) also quoted in M STAUCH, *The Law of Medical Negligence*, p65

[524] ibid, M STAUCH

more cases' being not proven in Germany than in the United Kingdom.[525] Yet I would add a word of caution here. This standard of proof is not fixed in stone. A canny lawyer will look to a stratagem involving either the lessening to total reversal of the burden of proof. Such tactics are not insignificant for a plaintiff and I suggest it will often play a pivotal rôle in medical cases where causation is the only or one of the issues at stake. *Anscheinbeweis* or prima facie proof, for example, is one way in which a lawyer may attempt to have the burden of proof placed **temporarily** on the defendant requiring the defendant to explain conditions that would not normally occur in the absence of negligence. This shall be considered further herein together with the abundant case law relative thereto.

I shall consider the essence of German causation from a medical perspective. This will include theory, case law and procedure. First, I shall outline a brief introduction to the German theory of torts.

[525] ibid, though Stauch does not appear to have any data for this

5.2 Introduction to German Tort Law

It has been said that German tort law is a kind of halfway between French tort law and English tort law in that the French system of general rules and the English system of specific rules can be found in §§823 I, 823 II and 826 *Bürgerliches Gesetzbuch* ("**BGB**"), the German Civil Code.[526] I think this description is reasonably accurate and a certain "ticking of boxes" is required at each stage of German tort law before moving to the next box. There are five requirements for liability. These are (a) breach of a normative rule (*Tatbestandwidrigkeit*); (b) unlawfulness (*Rechtswidrigkeit*); (c) fault (*Verschulden*); (d) causation (*Kausalität*); and (e) damage (*Schaden*).[527]

Without entering into any of these more than is necessary, German tort law shows that it is not possible to bring a claim based solely on negligence. It is necessary to show a breach of one of the norms (*Tatbestand*) set out in the BGB.[528] This is clearly different from the French Civil Code's article 1382 which sets out simply that any damage caused to another requires the one who caused it to make it good. If there has been a breach of one of the norms, then there is prima facie unlawfulness (*Rechtswidrigkeit*). As in English law, this can be justified by a defence such as self-defence.[529]

German law provides a definition of negligence (*Fahrlässigkeit*) but has left it to the courts to the courts to define intention. §276 II BGB states that negligent conduct is such conduct that does not live up to what society would expect. Negligence cannot be established if it would have been impossible to recognise and avert the risk.[530] A court will pay no account of any lack of knowledge, ability, tiredness or dejection that could be imputed to the defendant when coming to its decision.[531]

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[526] C van DAM, *European Tort Law*, p79

[527] ibid

[528] ibid; §823 I relates to the protection of rights relating to life, body, freedom and property; §823 II relates to the violation of statutory rules and §826 relates to intentional unethical conduct. §253 II now allows for recovery for non-pecuniary loss in contract cases following the 2002 reform. Non-pecuniary loss can now be recovered in medical negligence cases.

[529] C van DAM, *European Tort Law*, p80

[530] ibid, p232

[531] ibid

Sections 249-254 BGB establish general rules for the payment of damages regardless of the legal foundation and sections 842-845 BGB contain provisions specifically applicable to tort law.

With regard to damages, §249 BGB provides for restitution in kind or *Naturalrestitution* as a first principle; if this is not possible, §249 II provides for restitution in money where damage has been recognised. In principle there is no recovery for non-pecuniary loss[532] unless statute so provides save for loss relating to a breach of the plaintiff's bodily integrity, freedom, health or sexual determination.[533] The reform of 2002 now means that damages for non-pecuniary loss can be claimed for breach of contract in medical negligence cases.[534] Although the relationship between patient and doctor is strictly in contract, most of the notions of causation, as in France, have been imported from delict. It is these I shall consider presently.

[532] They read "**Section 249: Nature and extent of damages:** (1) A person who is liable in damages must restore the position that would exist if the circumstance obliging him to pay damages had not occurred.(2) Where damages are payable for injury to a person or damage to a thing, the obligee may demand the required monetary amount in lieu of restoration. When a thing is damaged, the monetary amount required under sentence 1 only includes value-added tax if and to the extent that it is actually incurred."

The German Justice Ministry has helpfully translated the provisions of the BGB (among other pieces of legislation) into English; see http://www.gesetze-im-internet.de/englisch_bgb/englisch_bgb.html#p0745

[533] §253 I BGB

[534] C van DAM, *European Tort Law*, p356

5.3 Causal Theories in German Law

In German law, there is an analysis similar to that in the United Kingdom: factual causation and then legal causation. Both of these are based on theories that I have already explained. Separately (and what would probably be considered as legal causation in the United Kingdom) there are policy tests to be considered if these do not provide a satisfying result. I shall consider each in turn. Traditionally causation is determined by virtue of the *hinwegdenken* approach. This means literally "to think away". To cite fully Hart and Honoré's translation of Glaser

> If one attempts wholly to eliminate in thought the alleged author (of the act) from the sum of the events in question and it then appears that nevertheless the sequence of intermediate causes remains the same, it is clear that the act and its consequences cannot be referred to him...but if it appears that, once the person in question is eliminated in thought from the scene, the consequences cannot come about, or that they can come about only in a completely different way, then one is fully justified in attributing the consequences to him and explaining it as the effect of his activity.[535]

I shall consider first factual causation in German law.

[535] HLA HART and T HONORE, *Causation in the Law*, p443, where they cite Glaser's *Abhandlungen aus dem österreichen Strafrechte* I, 298; see supra for the original German

5.4 Factual Causation

As has been noted, the first test that German courts purport to apply in cases where causation is an issue is that of ascertaining whether, through their performing the exercise of *hinwegdenken*, the result or conclusion of the defendant's act will remain the same. After this exercise has been performed, there is a further dichotomy to be made in the area of factual causation itself; this is between *haftungsberündende Kausalität* and *haftungsausfüllende Kausalität*. The former "geht es um die Ursächlichkeit der schädigenden Handlung für die Rechtsgutverletzung" while the latter "betrifft den Kausalzusammenhang zwischen der Rechtsgutverletzung und dem eingetretenen Schaden."[536] Klunzinger gives the example of a punch (*Faustschlag*) causing a broken nose.[537] Here we can see the *haftungsbegründende Kausalität* or, as Stauch calls it, "liability-grounding causation".[538] This cardinal inceptive test establishes the link from the act to the breach of the protected right under §823 BGB. The protected right in this case would be the §823 I BGB right to bodily integrity and its breach would be the punch itself. From there, the link must be made to other damage resulting therefrom, for example, medical costs and loss of earnings. Klunzinger says such a causal link can be made by way of *haftungsausfüllende Kausalität* or "liability-completing causation" as Stauch calls it.[539] More or less the same definition is found with Larenz and Canaris who note that there must be a particular causal link between a given act and the result. For example,

> ...einer Handlung des Ersatzpflichtigen under der Verletzung des Körpers oder der Beschädigung einer Sache des Verletzten. Dieser, zum Tatbestand die Haftpflicht begründenden Norm gehörendelenden ist der "haftungbegründende".[540]

With *haftungsausfüllende* causation, it is necessary theoretically to look further along the causal chain. I think it is analogous to ideas of remoteness of damage in the common law. As Lorenz by contrast, further notes, for *haftungsausfüllende* causation to be established it is necessary to find the causal nexus between

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[536] E KLUNZINGER, *Einführung in das Bürgerliche Recht*, (Munich, Vahlen, 2007) p232

[537] ibid

[538] M STAUCH, *The Law of Medical Negligence*, p50

[539] E KLUNZINGER, *Einführung in das Bürgerliche Recht*, (Munich, Vahlen, 2007) p232; M STAUCH, ibid

[540] K LARENZ and CW CANARIS, *Lehrbuch des Schuldrechts* (Munich, CH Beck, 1994), p432

> ...der Verletzung des Körpers oder der Beschädigung der Sache und den daraus weiter enstehenden Schadensfolgen...[541]

Magnus has written that the difference between *haftungsbegründende* and *haftungsausfüllende Kausalität* is not a far-reaching one and does not concern the basic notion of causation.[542] Stauch too shies away from overly insisting on the doctrine.[543] I have also found this division to be merely of theoretical or philosophical interest. It has not fallen into desuetude as cases today refer to it still. Yet as Stauch has noted with regard to treatment malpractice, the distinction is important for purposes of proof and therefore procedure. Once *haftungsbegründende Kausalität* has been established to "effective certainty",[544] *haftungsausfüllende Kausalität* need only be established to the lower standard of proof of §287 ZPO, more or less the balance of probabilities.

This procedural separation was confirmed in a recent case.[545] This makes explicit reference to "Primärschaden...im Sinne haftungsbegründender Kausalität...". In this case, a doctor omitted to immobilise a finger further to an X-Ray he took on 14 October 2002 following the patient's hitting his finger with a hammer the previous day. The court held that

> Welche weiteren Schäden sich hieraus entwickelt haben, ist eine Frage der haftungsausfüllenden Kausalität.

And this secondary harm can only be taken into account "wenn [der] eine typische Folge der primärverletzung ist." This would then be a question for experts to comment on.

So as can be seen, Germany uses the conditio sine qua non test in theory at the first step but then it is broken down into two sub-tests: that of *haftungsbegründende* and

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[541] ibid

[542] U MAGNUS, "Causation in German Tort Law", in J SPEIR (ed), *Unification of Tort Law: Causation*, (The Hague, Kluwer, 2000), p64 at p65

[543] M STAUCH, *The Law of Medical Negligence*, p51

[544] C van DAM, *European Tort Law*, p312

[545] BGH NJW 2008, 1382

haftungsausfüllende Kausalität. Neither of the other jurisdictions in question has this theoretic division. It is also unknown to the European projects and the ECJ when considering causation. So there is a conceptual difference here. This does not necessarily mean there is a difference in outcome but it might play a role in any difference. What shall be considered next is how Germany deals with the question of legal causation.

5.5 Legal Causation

Similar to the United Kingdom which recognises the distinction between factual and legal causation, and similar to France which uses (in principle) adequacy theory, Germany has also adopted the notion whereby the damage must have been caused in a legal sense.[546] As Medicus and Lorenz point out

> die Theorie der äquivalenten Verursachung können zu einer unerträglich weiten Schadenszurechnung führen.[547]

One of the problems with relying solely on the equivalence theory is that it would lead to an almost infinite number of causes making the identification of a relevant cause impossible. This is why then it must be checked to a certain extent by adequacy theory.

The adequacy theory, as has been discussed above, holds that causation exists

> wenn das Ereignis im allegemein und nicht nur unter besonders eignenartigen, unwahrscheinlichen und nach dem gewöhnlichen Verlauf der dinge ausser Bertracht zu lassenden Umständen geeignet ist, einen Erfolg dieser Art herbeizuführen.[548]

Interestingly in this case adequacy was referred to as the "Filter der Adäquanz". These calculations of probability and chance eventually led to the notion of the "optimal observer" or "optimal Beobachter".[549] There has been some dispute as to whether the rule of the optimal observer should actually be used. Markesinis and Unberath, quoting Lorenz, question how much knowledge should be imputed to this optimal observer. They note the case of a plaintiff who is slightly injured by the defendant but who dies as a result of a heart condition from which he is already suffering. I quote

> For the "optimal observer" described by the Bundesgerichthof, almost nothing is secret; he is practically omniscient. For the omniscient, the actual course of events is always foreseeable, however abnormal it may have been. If one takes the

[546] B MARKESINIS and H UNBERATH, *The German Law of Torts*: *a Comparative Treatise* (Oxford, Hart Publishing, 2002), p106

[547] HC MEDICUS and S LORENZ, *Schuldrecht I*, (Munich, Beck, 2008) 637

[548] BGH NJW 1995, 126 (127); BGHZ 7 198 (204)

[549] HC MEDICUS and S LORENZ, *Schuldrecht* I, 638

> Bundesgerichthof's standard of the optimal observer seriously, then the criterion of adequacy loses most of its ability to limit the area of responsibility of the person liable.[550]

As Stauch would appear justifiably to report, adequacy theory would never seem to exclude liability in its own right.[551] It would indeed seem that the optimal observer test will always be satisfied given such an observer's omniscience. This test has been much criticised.[552]

The adequacy theory is indeed a value judgement. Yet ideas of frequency and probability are still referred to in case law. Arguably therefore, the idea of the omniscient observer is quite unrealistic and impractical. A defendant would always be held liable. I would tend to agree with those writers referred to above who state that there would ultimately be no limitation on liability. German case law has also recognised this in that

> One must not forget the starting point of the inquiry: namely the search for a corrective that restricts the scope of the purely logical consequences, in order to produce an equitable result to the imputable consequences….it is a question here not really of causation but of the fixing of the limits within which the originator of a condition can equitably be presumed liable for its consequences, and therefore of establishing in reality a positive condition of liability.[553]

This is quite a frank and honest comment on theory. The court is even shying away from causation to equity, and, ultimately, policy – another corrective on causation. It falls now to consider some of the cases in medical negligence which have dealt with adequacy theory.

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[550] B MARKESINIS and H UNBERATH, *The German Law of Torts*: *a Comparative Treatise* (Oxford, Hart Publishing, 2002), p108; see also K LARENZ, *Lehrbuch des Schuldrecht*, 354 et seqq translated by A von MEHREN in A VON MEHREN and J GORDLEY, *The Civil Law System* (2nd ed, Boston, Brown and Co, 1977), p585 where Larenz speaks that it is only accidents where a defendant will not be responsible: "The burden of such wholly unusual consequences ought not to fall on the defendant but ought to be borne by the person on whom they fall as accidental losses."

[551] M STAUCH, *The Law of Medical Negligence*, p55

[552] U MAGNUS, *Unification of Tort Law*, p65

[553] BGHZ 3, 261

5.5.1 Case Law

One case where there is a detailed consideration of the adequacy theory dates from 1953.[554] In this case, orphan plaintiffs sought damages from a doctor for injury they suffered from their mother's death as a consequence of an abortion that the defendant doctor had carried out. The doctor misunderstood the structure of the womb and left afterbirth inside the womb. Following the doctor's departure from the home, the mother complained of severe abdominal pains. The doctor came back to the mother's house one hour later but her condition had worsened. A gynaecologist was called who arranged for immediate transfer to hospital. He noticed a large tear in the womb and also that the artery had been severed. The plaintiffs sought damages in contract and delict for medical expenses together with an annuity payment and a declaration that they had a right to all further damage.

It was held by the court of appeal that the defendant doctor had caused the death of the mother but that he was not at fault as such in causing the injury. The reason for this was that it was shown that even the most conscientious and experienced medical man could have inflicted these injuries. Such an injury could have but need not have come about from the incorrect use of instruments.

The court of appeal, however, found that the doctor was at fault in neglectful conduct **after** the operation. He should have sent the patient to a hospital and his not doing so, according to the experts, was "unintelligible".[555] However, no liability was inferred as causation had been denied. It held that death might have occurred even if the mother had gone to hospital immediately and that it could not

> mit einer an Sicherheit grenzenden Wahrscheinlichkeit feststellen, dass der Bekl durch pflichtgemasses Verhalten gleich nach dem Eingriff oder gar noch auf Grund der ihm von Sp überbrachten Nachricht, dass sich bei der Patientin Schmerzen bemerkbar machten, das Leben der Frau S erhalten hätte.

[554] BGH NJW 1953, 700

[555] "unverständlich"

The BGH then criticised the court of appeal for an errant application of §287 ZPO.[556] The BGH said that the court of appeal would not have been prevented from finding an adequate causal connection even if there was a reasonable doubt that the damage could have occurred without the defendant's fault.[557] The question the court of appeal ought to have asked itself, as far as adequate causation was concerned was

> ob diese Unterlassung im allgemeinen und nicht nur unter besonders eigenartigen, ganz unwahrscheinlichen und nach dem regelmässigen Verlauf der Dinge ausser Betracht zu lassenden Umständen zur Herbeiführung eines Erfolges geeignet war.

Such a result, that is death, was to be contemplated in the **ordinary course of things**.[558] The BGH underlined this point in its judgement when it held that as soon as the mother was faced with a danger to life then no "unwahrscheinlicher Umstände" were required to lead to death; on the contrary, it states, medical skill was required to counteract the danger. In short

> ob die Aussichten für den Erfolg dieser Rettungsversuche mehr oder weniger gross waren, kann nichts daran ändern, dass ein Misserfolg die adäquate Folge der eingetretenen Lebensgefahr ist.

So I think it would be safe to say that in the case of an omission, and one that is at least "incomprehensible", the BGH will be quick to find that any damages that have come about following from such omission will be held to have been caused by the omission even if it cannot be said without reasonable doubt that the damage would have occurred without the tortfeasor's omission. I think the focus of the BGH in this case on procedure, ie its reference to §287 ZPO highlights once again how causation is, and must remain, an autonomous legal concept. Certainly there is a causal question in the factual (or natural) sense in that it is not entirely certain that the damage would have occurred without the tortfeasor's omission but legally, the court

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[556] as referred to already above, this relates to the burden of proof

[557] "Das Gericht ist im Rahmen des §287 ZPO nicht gehindert, die freie Überzeugung von einem adäquaten Ursachenzusammenhang auch dann aus dem Ergebnis der Beweisaufnahme und den Umständen zu gewinnen, wenn nicht mit an Sicherheit grenzender Wahrscheinlichkeit die Mögglichkeit ausgeschlossen werden kann, dass der Schaden ohne das schuldhafte Verhalten des Täters hätte eintreten können."

[558] it will be remembered this is how France has interpreted adequacy theory also.

of appeal erred by permitting such doubt to affect the causal chain. The BGH pays lip-service to adequate causation in as much as it notes that there were no "unwahrscheinlicher Umstände" (note the language of probability) but as a matter of policy, or equity, could the court have found otherwise? Yet for all the theoretical bases mentioned above, I did not read in this law report any mention of natural causation or *haftungsbegründende* or *haftungausfüllende* causation. Here the court simply treated the omission and the consequent damage as a question of adequacy. What would be *haftungsbegründende* causation in this case? Would it be the omission to send the mother to hospital? If so, this brings us back to the problem of "total substitution" in the case of omissions. The BGH is replacing the defendant doctor's behaviour with proper behaviour by assuming that another doctor would have transferred the mother to hospital. The expert described the defendant's not doing this as "unintelligible". Yet it cannot be said with certainty that even if we have this total substitution that the mother would have been saved. This was recognised in the court of appeal's decision but this was, as we have seen, criticised by the BGH. The mother's death was a result that was to be contemplated in the ordinary course of things and, I suggest, certainly one which an "optimal Beobachter" would have contemplated. I assume rather in this case that all elements of causation were considered together. It does somewhat appear to go against case law which has held that there can only be liability in omission cases where there has been a duty to act and that acting in accordance with that duty would have prevented **with certainty** the occurrence of the harm.[559] Simply there was a question of legal causation and it had to be decided on; did the doctor's omission legally (as is always the case) cause the mother's death? The answer, simply, was yes.

Another case from 1955 shows the reach of adequacy theory in Germany.[560] In this case a husband and father underwent a typhus inoculation in 1946. He had three inoculations in all. He then suffered illness and malignant swelling developed. On 27 February 1948 he died. The plaintiffs claimed compensation from the state for breach of official duty and loss of their right to support from the father. The lower

[559] as translated by H KOZIOL in H KOZIOL "Natural and Legal Causation" in *Causation in Law* L TICHY (ed), Prague, E Rozkotova, 2007) p53 at p57 referring to case BGHZ 34, 206

[560] BGHZ 18, 286

courts held the claim justified in principle but otherwise dismissed the action. The defendant's application for review failed. Causation was challenged in that the typhus inoculation caused the death in a scientific and legal sense. No dispute was made to the facts that following the inoculation itself, a staphylococcus suppuration appeared. Within two years of its appearance, death resulted.

The BGH held that the development to a fatal sarcoma was, although rare, not unknown to all medical experience. It could therefore be described as an adequate cause. Interestingly the court noted that adequacy is not just about statistics but rather it is a value-judgement to which liability for the consequences of a condition can be equitably imputed to its originator. As death did not lie beyond the bounds of experience, there was therefore an adequate connection. This shows how the court truly applied the notion of the "optimal observer". Even though the result was extremely rare, it was not unheard of, and therefore the state was liable.

Another area where the issue of adequate causation in medical negligence can be seen is in the area of pre-natal injuries with regard to an *in utero* foetus. The question is whether the actions of a third party, although they may have caused injury to the mother, will be sufficient to recognise causation to the child's injury.

In one case of these cases, as translated by Markesinis and Unberath, a child was born a spastic following a car crash when the child was *in utero*.[561] The child sued but it was disputed whether the car crash caused the injuries to the mother. After spending some time on whether the child could actually sue as he had not yet been born when the alleged damages had been sustained,[562] the court addressed the causal question. It is worth quoting the dictum in full here. The BGH held that

> It cannot be doubted that these consequences are connected by a link of adequate causation with the accident for which the defendant is to blame....the defendant's negligence extended not only to the injuries suffered by the mother but also to those of the embryo and therefore of the child. This does not follow simply because the defendant is to blame for having injured the mother and is therefore liable for all consequential damage suffered by her. However, the child need not prove that the

[561] NJW 1972, 1126; B MARKESINIS and H UNBERATH, *The German Law of Torts*, p144 et seqq

[562] the court allowed him to sue

> defendant could foresee the possibility of injuring a pregnant woman or embryo as such...it need not be foreseeable what form the damage would take in detail and what damage might occur.

Adequacy holds that if one causes physical injury to a pregnant woman then one is likely to injure the embryo also. It can be seen here then that although the defendant could not necessarily foresee damage to the embryo, he is held liable therefor. This is a species of the eggshell skull rule and it shows us how the courts are willing to use doctrines of causation to justify, what is in essence, a decision of policy. Similarly, this goes to the heart of foreseeability of damages. If the form of damage or its precise nature is not to be second-guessed but only some damage is foreseeable then the scope of liability in Germany is potentially quite wide.

In a similar case from the 1950's a doctor had infected a mother (and ultimately the unborn child) with syphilis as he had not followed the guidelines of the then Reichsminister in 1940. Here the defendant hospital argued that it was not liable for syphilis contracted by a child following a blood transfusion given to a mother. The blood was infected with syphilis. The defendant hospital argued that the infection of the child was indirect and therefore, it was not liable. The BGH disagreed and held, referring explicitly to adequate theory. The court held that if the act causing the damages violates directly or indirectly one of the protected interests or absolute rights set out in § 823 I BGB then the defendant will be liable provided **only that a causal nexus exists in the meaning of the theory of adequate causation between the act creating the damage and the resulting violation of the protected interest**. And, indeed,

> ...it is common experience that an infection of a married woman with syphilis is likely to transmit this illness later on to a child conceived by her.[563]

So as can be seen the charges against the adequacy theory as it has been adopted in Germany are several. First, that it does not act as a limit or "filter" to causation proper as for the optimal onlooker, everything is foreseeable. The idea of limiting casual consequences is not readily combined with this theory. Certain cases may

[563] BGH NJW 1953, 417 as translated by Professor MARKESINIS and to be found online in English at The University of Texas Foreign Law Translations website: https://law.utexas.edu/transnational/foreign-law-translations/german/case.php?id=676

seem just such as the one about syphilis but what about having to warn patients of side-effects of a vaccination that only rarely occur? Might this not instil some kind of unnecessary fear and dread into an already nervous patient? Second that there is always a value-judgement to be made and that resort can rarely be had to statistics in themselves. I submit case law shows that it is uncertain how adequacy theory will be applied. Will it be based on statistics or a value-judgement or both? In some cases, as we have seen, mention is made only of the adequacy theory and none of *haftungsbegründende* or *haftungausfüllende* causation. I have to say that given my initial reading of the German jurisprudence referred to above, only a few cases referred to the *haftungsbegründende* or *haftungausfüllende* causal dichotomy before then moving on to adequate causation. Yet the distinction is made clear in every German introductory textbook to tort law that I consulted. So because of the limiting shortcomings of the adequacy theory, resort has often been had to other theories that are able to limit liability, that of the doctrine of protective purpose (*Schutzzwecklehre*) if not to the open application of policy considerations themselves (*wertende Überlegungen*) which shall now be considered. There are a number of decisions here of interest for this paper.

5.6 *Schutzzwecklehre* and *wertende Überlegungen*

It is often said that *Schutzzwecklehre* or *Schutzbereich der Norm* was first expounded by Rabel in relation to contract. [564] The essence of it is this

> dass jede gesetzliche Pflicht oder Vertragspflicht bestimmten Interressen dient und dass nur der Schaden, der diesen geschützten Interessen zugefügt wird, dem Schuldner zugerechnet werden soll.[565]

It is now also applied in tort. So the mischief or aim the norm or statute was designed to protect against should be sought. It is the same for acts and omissions.[566] If discovered, causation can then be established against the background of the purpose of the norm. This can be quite easy where a statute forbids certain behaviours but as far as the *Schutzzweck* test in medical negligence is concerned, I suggest this would have to be considered on a case-by-case basis.[567] What is the purpose of the treatment? I would not necessarily agree with Stauch who says it may always be seen broadly as "the protection of the patient's health".[568] For example, if a patient enters hospital for (say) the closure of an atrial septal defect (hole in the heart), then I would suggest that the surgeon's duties be limited to such closure and the prevention of nosocomial infections. Can we really say that the hospital should detect a hitherto undiagnosed liver infection? Plaintiff's argument would be expanded to the hospital's being negligent by not diagnosing the liver infection as the "protection of the patient's health" is the general *Schutzzweck* as Stauch suggests.[569] Defendant should argue then that liver infection was not to be diagnosed and not within the *Schutzzweck* – only the closure of the hole in the heart was.

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[564] E RABEL, *Das Recht des Warenkaufs Bd* 1, p 497 (Berlin and Leipzig, de Gruyter, 1936); note he mentions here that it was the common law lawyers who paved the way for this theory, "Soweit also bietet die angelsächsliche Vertragslehre eine sehr brauchbare Grundlage, von der wir allgemein zivilistischen Erkenntnissen gelangen könnten"

[565] ibid

[566] D MEDICUS and S LORENZ, *Schuldrecht* I, p312; H KÖTZ and G WAGNER, *Deliktsrecht* (Munich, Franz Vahlen, 2010), 215

[567] M STAUCH, *The Law of Medical Negligence*, p56

[568] ibid

[569] ibid

A number of real cases illustrate the point. Courts have used the *Schutzzweck der Norm* theory when considering wrongful conception cases. The court considers whether the purpose of a sterilisation is to avoid a risk (such as a disability) associated with a given pregnancy or whether it was for general family planning purposes. If either of the risks materialises then generally courts will allow recovery.[570] In the leading case in this regard of 18 March 1980, the BGB held for the plaintiff. Here there was a failed sterilisation and the mother went on to have twins. The mother applied for damages of maintenance costs for bringing up the children. Interestingly the defendants used the arguments that such costs were not recoverable and that having such a child was a "Wertverwirklichung". The court disagreed and held that the unwanted child was, from a family planning point of view, unwanted.

> …daß hier die Familienplanung gestört wurde, ist schon bei objektiver Betrachtung sehr naheliegend.[571]

In another case, a mother contacted a doctor for a rash she had developed and then purported to sue the doctor when her child was born severely disabled as the doctor had failed to diagnose rubella.[572] She had mentioned the pregnancy but this was not sufficient to hold the doctor liable. She said that had she known about the risk of having a disabled child, then she would have aborted. The court held that

> hatten nach allem die Behandlungsverträge mit dem Bekl nicht den Zweck, die Kl vor den folgen einer Unterhaltsbelastung zu bewahren, so hätte sich eine Beratung der Kl über die Möglichkeit eines Schwangerschaftsabbruchs allenfalls als Reflex und zudem nach der Beurteilung des gerichtlichen Sachverständigen nur bei einer maximalen hausärztlichen Versorgung der Kl ergeben.

So it can be seen then that the court will consider the point and goal of the contract between the doctor and the patient before allowing causation to be established for economic loss. Certainly in the second of these cases, the doctor's failure to diagnose certainly caused the economic loss in the sense it was a condition; it was a conditio

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[570] BGH NJW 2000, 1782; BGH NJW 1980, 1450

[571] in total contrast with the British decision of *MacFarlane v Tayside Health Board (Scotland)* [1999] UKHL 50; here it was held that having a child was a blessing; indeed it was a "priceless joy" as per Lord Millet

[572] BGH NJW 2005, 891

sine qua non and a cause in the natural or scientific sense. However, the *Schutzzweck* causal notion was applied as a filter and recovery was disallowed.

If adequacy cannot be used, then perhaps resort might be had to *Schutzzweck* to permit recovery. With medical negligence, it may be difficult to pin down exactly what the protective purpose is – even for the reasonable person. The protective purpose will have to be proven and there might be legal debate as to what this is in any civil proof. Consequently, care should be taken in a particular case before using this doctrine to establish causation.

It is an interesting adaptation of traditional causal theories. The United Kingdom does not openly endorse this solution and in France it has been rejected. I believe this contributes yet more to my argument that there is not one European idea of how causation should be understood legally.

5.7 Disclosure Malpractice

The Improvement of Patients' Rights Act 2013 sets out in general and specific terms the physician's obligations of information to be provided to the patient with regard to a procedure to which the latter is about to submit. This Act amended the BGB so that now, in a general sense, at §630c BGB

> (2) The treating party is obliged to explain to the patient in a comprehensible manner at the beginning of the treatment, and where necessary during the same, all and any circumstances that are relevant to the treatment, in particular the diagnosis, the anticipated health development, the therapy and the measures to be taken on the occasion of and subsequent to the therapy.

And at §630e BGB

> (1) The treating party is obliged to inform the patient of all and any circumstances which are relevant to consent. This includes in particular the nature, extent, implementation, anticipated consequences and risks involved in the measure, as well as its necessity, urgency, suitability and prospects for success with regard to the diagnosis or the therapy.

It would appear that this must be appreciated *in concreto* as the physician must take account of the patient's understanding.[573]

In a specific sense, it can be seen that the Act has adopted what case law had provided thusfar in that the physician must inform the patient of alternative treatments usually between non-invasive treatment with limited benefits and invasive surgical treatment with a higher risk but with greater benefits in the longer term.[574] These obligations incumbent on a German doctor are important from a causal perspective as the question arises what would the plaintiff have done had she known of all the disclosable risks.

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[573] §630e, (5); interestingly Shaw notes that it could be argued that the doctor's duty of disclosure comes from the constitutionally protected right of a person's personality under the *Grundgesetz* of 1948 where article 2(1) states that "everyone has the right to the free development of his personality". She notes that this could be said to be the most accurate manifestation with the law of tort of the fundamental right of self-determination: J SHAW, "Informed Consent: A German Lesson", (1986) 35 *International and Comparative Law Quarterly* 864 at 873

[574] the doctor must also inform the patient on the cost of the procedure together with an obligation in the event of a "therapeutic fault". This need not detain us further for the purposes of causation.

Generally, a patient need not be informed of certain risks that he can be assumed to know: for example, like dying under anaesthetic. Moreover, the physician need generally only tell the patient "in general terms" (*im Großen und Ganzen*) with regard to each risk attaching to treatment.[575] What the eventuating would mean for that patient in particular is important. With disclosure malpractice generally, the patient is alleging some iatrogenic injury because he was not informed fully of the risks.[576]

From a causal point of view, the defence of hypothetical consent (*hypothetische Einwilligung*) or lawful alternative conduct *(rechtmäßiges Alternativverhalten*) is relevant here. This is difficult to show. With such a defence, a doctor tries to show that even if the patient knew about the risks, he would still have gone ahead with the operation. The doctor has the burden of proof in showing that the patient would have made the decision to go ahead with the procedure even if he knew about the risks.[577] Such claims, it has been stated, must be examined very critically when the procedure in question is not urgently necessary and especially when the patient states that he has real trouble in reaching a decision.[578] The dangers in allowing such a rule are that to a certain extent it makes the court a party to depriving the patient of his autonomy.[579] A patient must have time to consider the consequences of her actions and simply signing a consent form before an operation would not be sufficient.[580] However, as Katzenmeier writes, the court will consider the behaviour and necessities of the patient *in concreto.*[581] However, although Katzenmeier makes it clear that the plea of "Einwand rechtmäßigen Alternativverhaltens" is not excluded, the problem is often seen

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[575] BGH NJW 1986, 780

[576] interestingly, it has been held that even if the treatment was successfully performed, if there is lack of consent, this may allow for an action in damages: BGH NJW 1987, 1481

[577] BGH NJW 1996, 3074 and BGH NJW 1994, 2414

[578] OLG Koblenz NJW-RR 2002 816 (818) and BGH MedR 1991, 200 and generally M PARZELLER, M WENK, B ZEDLER and M ROTHSCHILD, "Patient Information and Informed Consent before and after Medical Intervention" http://data.aerzteblatt.org/pdf/DI/104/9/a576e.pdf , p10

[579]C KATZENMEIER, *Arzthaftung*, p348

[580] BGH NJW 1994, 3009

[581] C KATZENMEIER, *Arzthaftung*, p369

> durch Zuweisung der Beweislast an den Arzt und strenge Anforderungen an den von ihm zu erbringenden Nachweis, daß der Patient eingewilligt hätte, den dieser durch die plausible Darlegung eines Entscheidungskonfliktes widerlegen kann.[582]

This is not an easy task for the doctor and indeed as the same author noted in his last paragraph of his commentary on the subject

> Die Literaturansicht fördert demgegenüber die Tendenz, Schicksalsschläge mit der Rüge mangelhafter Aufklärung auf den Arzt abzuwälen.[583]

The defence is one that the doctor must raise and the court cannot enquire *ex proprio motu*. It is sufficient for the patient to show that he would have faced a significant dilemma (*ernsthafter Entscheidungkonflikt*). The BGH stated in a case from 1990

> Zu Unrecht vermißt das BerGer[584] genaue Angaben des Kl darüber, wie er sich tatsächlich entscheiden hätte. Das ist von ihm nicht zu verlangen und würde einen Patienten auch überfordern, weil auch er kaum anders als sein Arzt die Situation in der er sich seinerzeit befunden hat, schwerlich so rekonstruieren kann, daß er stets präzise Antwort darauf geben könnte, wie er sich wirklich verhalten hätte. Einsichtig machen kann und soll er nur, daß ihn die vollständige Aufklärung über das Für und Wider des arztlichen Eingriffes ernsthaft vor die Frage gestellt hätte, ob er zustimmen solle oder nicht.[585]

In this particular case, it was held that had the patient known of the risk of contracting hepatitis then he would have hesitated with the operation to have his hand amputated. This was enough to hold the defence of hypothetical causation established. Yet where there appears to be no basis at all for the dilemma, then it would be for the patient to come up with reasons as to why he would not have consented had he been properly informed.[586]

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[582] ibid

[583] ibid

[584] *Berufungsgericht*

[585] BGH NJW 1991, 1544

[586] B MARKESINIS and H UNBERATH, *The German Law of Torts*, p59

In another case, a colonoscopy was carried out on a patient but it was argued that he had not effectively agreed to it.[587] In the course of it he suffered a perforated sigmoid colon. He argued that he was not informed of risks. The doctors stated that it was not necessary to inform him of the risk of the tear of the colon as it occurred only extremely rarely. Although holding that, the patient's consent had not indeed been given as he had not been told about the disagreeable effects, it did not follow that the doctors were liable for the injuries. The causal question that had to be considered was that if the patient had been adequately informed, would he have gone ahead with the procedure? It was held in evidence here that he was not hypersensitive and so his allegation that he would not have undergone the procedure would not be accepted. As is to be expected, following the principle of "real behaviour", the court concentrated on the character and disposition of the plaintiff.

> Das ist weniger selbstverständlich [that the plaintiff had repudiated causation], wenn es sich um einen sonst nicht wehleidigen Patient handelt. Hier hat sich der Kl im Prozeß selbst als einen nicht gerade zimperlichen Mann bezeichnet...

So there is an application of the hypothetical real patient here in the court's analysis of the plaintiff's traits by its using the words "wehleidigen" and "zimperlichen". Also the court will consider the plaintiff's behaviour with regard to similar treatments in the past. For example, as was the case here, the plaintiff had undergone a prodigious number of similar diagnostic procedures within the last three years. The court was then slow to believe that he would in reality not have undergone this one. In another case, it was held that where treatment was not urgent, risks of one in 10,000-20,000 need be disclosed to the patient if their eventuation would result in grave consequences for the patient.[588] Also, in a case noted by Stauch, it was held that even where a particular form of radiotherapy offered the only way of curing the patient from cancer, a risk of 0.15 had to be disclosed.[589] Similarly, it has been held that the risks of general anaesthetic may have to be disclosed to a patient where the consequences of "heart failure" would be serious for that patient.[590] Here account

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[587] ibid, p126

[588] BGH NJW 1984, 1397

[589] M STAUCH, *The Law of Medical Negligence*, p109

[590] OLG Karlsruhe [1985] MedR 79 at 81 "Das Wissen um das Erfordernis einer Betäubung ist aber jedenfalls bei einfacheren Bevölkerungsschichten, zu denen auch die Mutter des MG gehört,

was taken of the woman's social status and what people at that particular level of education are expected to know…

§630h(2) BGB sets out that the doctor must show that the patient "would have consented" if he had been given more information. If the patient convinces the court that he would have had simply internal conflict as to how he would have decided then the onus is on the doctor to disprove it.[591] Moreover, I think the evidential requirement of only having to prove a dilemma is not so arduous and demanding as bringing evidence as to what a patient would actually have done.

The causal question that arises then is if the patient had known about these risks, would she have still gone ahead? We can see from German jurisprudence that it is for the doctor to show that the patient would still have gone ahead and the court would appear to put formidable hurdles in the doctor's path. It is sufficient in general that patient would hesitate. Any exercise which a court embarks on to ascertain the true behaviour of a patient in a counterfactual world must surely be speculative at best; it can never be known with certainty and there is ample room for evidential distortion and here the German approach differs from the British. As Stauch notes this subjective requirement of disclosure in Germany creates uncertainty and doctors are not confident as to the level of disclosure to which they will retrospectively be held. He notes this approaches a strict liability rather than fault.[592] Standards therefore in the different jurisdictions vary. Standards vary because in Germany the risks which must be disclosed are higher than in France or the United Kingdom. Therefore if more risks must be disclosed then the potential for disclosure malpractice and causal

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nicht gleichzusetzen mit dem Wissen um die mit einer Vollnarkose verbundenen (typischen) Risiken, über die daher aufzuklären ist"; this is to be compared with the law in the United Kingdom where it has been held that there is no obligation to inform patients about the risk of death from general anaesthetic in general: *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 at 661, per Lord Bridge ; also see more generally, M JONES, "Informed Consent and Other Fairy Stories", (Summer 1999) *Medical Law Review* 103, although it must be borne in mind that this article was written pre-*Montgomery v Lanarkshire Health Board* [2015] UKSC 11

[591] G SCHIEMANN, *Cases on Medical Malpractice*, p125; It reads: "The treating party is to prove that he/she has acquired consent in accordance with section 630d and provided information in accordance with the requirements of section 630e. If the information does not comply with the requirements of section 630e, the treating party may assert that the patient would also have consented to the measure had proper information been provided."

[592] M STAUCH, *The Law of Medical Negligence*, p112

inquiry is also greater. It could be mooted then that because of this emphasis of patient autonomy in Germany, that a victim may find a more sympathetic and understanding forum in Germany given its history and policy development on this issue. Causal questions concerning disclosure then would necessarily have diverging outcomes when considered under the laws of the various jurisdictions here. Consequently with regard to universal functionalism, there can be no "common sense" as there is no "common sense" solution with regard to the foundation on which disclosure malpractice and hypothetical causation is built.

5.8 Burden of Proof

In Germany, *haftungsbegründenden Kausalität* needs to be proved to the standard of § 286 ZPO. As we have seen, this has been held to be something approaching a "full judicial conviction" or the court must be "overwhelmingly convinced" of its facts.[593] In one case, cited by Stauch, the plaintiff was denied recovery in a mis-diagnosis case even though experts spoke to the fact that there was a 70% chance that had there been prompt treatment, then this would have prevented the injury.[594] While liability must be established to a particularly high proof, this does not mean that all doubts need be eliminated.[595]

Müller also confirmed this when he noted

> Allerdings verlangt auch diese Beweisführung keine unumstößliche Gewißheit im Sinn eines naturwissenschaftlichen Nachweises, sondern nur einen "für das praktische Leben brauchbaren Grad von Gewißheit, der Zweifeln Schweigen gebietet, ohne sie völlig auszuschließen."[596]

So it can be seen then that the plaintiff must prove liability-grounding causation (ie the primary damage) to a particularly high level of proof. This level of proof is, on the face of it, much higher than that of the United Kingdom in that plaintiff need only prove his case on the balance of probabilities. It will be seen, however, that there exists in Germany many instances where the court is willing either to lighten the burden of proof or to reverse the burden of proof altogether so that it is for the defendant doctor to prove that he did not commit a fault.

The lower standard of proof is used for *haftungsausfüllende Kausalität* or liability-completing causation and is based on § 287 ZPO. This provides for proof based on

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[593] BGHZ 53, 245 (256) and M STAUCH, *The Law of Medical Negligence*, p65

[594] BGH NJW 1999, 860

[595] M STAUCH, *The Law of Medical Negligence*, p65

[596] G MÜLLER, "Beweislast und Beweisführung im Arzthaftungsprozeß", (1997) NJW 3049 (3051) quoting BGH NJW 1984,1807

the balance of probabilities.[597] Schiemann has even gone so far as to say that the "mere possibility" [sic] would be sufficient but I doubt how accurate this is.[598] So for the two species of causation, there are two levels of proof: one higher and one lower. The plaintiff, in general, must prove that his protected right was invaded to a high standard but remoteness of damages need only be proven to the lower standard of probability.

A kind of "equality of arms" has been assured by the Federal Constitutional Court since 1979 where Article 103 I of the *Grundgesetz* was referred to in case law to ensure natural justice.[599] Here the notion that a patient should receive a general reversal of the burden of proof in his favour was rejected.[600] It had been stated also in an earlier case that a doctor also had proof difficulties and that although harm may occur as a result of negligence, it may also occur as a result of the vagaries of the human organism.[601]

> Anderseits steht der Arzt von der Schwerigkeit, daß Zwischenfälle, die in der Regel auf ärztliches Fehverhalten hindeuten, in vielen Bereichen infolge der Unberechenbarkeit des lebenden Organismus ausnahmsweise auch schiksalhaft eintreten können.

The court went on to say that the basic principle was equality of arms (*Waffengleichheit*). In certain circumstances, however, the German Constitutional Court has held that where the circumstances demand then the burden of proof should be shifted. Katzenmeier has said that

> In vielen Fällen wird der Kläger nicht mehr tun können, als auf den zeitlichen Zusammenhang zwischen einer ärztlichen Behandlung und einer eingetretenen Gesundheitsbeschädigung hinzuweisen, die generelle Behauptung aufzustellen, diese

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[597] C JANDA, *Medizinrecht*, (Konstanz, 2010, UVK), p317 "überwiegender Wahrscheinlichkeit nachzuweisen..."

[598] G SCHIEMANN, "Problems of Causation in the Liability for Medical Malpractice in German Law" in L TICHY (ed) *Causation in Law* (Prague, Rozkotova, 2007) p187 at p190

[599] M STAUCH, *The Law of Medical Negligence*, p66; Art 103 I states that "(1) Vor Gericht hat jedermann Anspruch auf rechtliches Gehör."

[600] BverG NJW 1979, 1925

[601] BGH NJW 1979, 1925

> beiden Sachverhalte stünden in enem ursächlichen Zusammenhang und die Behandlung müsse Fehler gewesen sein.[602]

It may indeed come down to this. The plaintiff might not be able to do other than point to the fact that he was treated by a doctor on a Monday and developed a health problem on a Tuesday. If this is the case, then it would seem that, given the high level of proof for liability-grounding causation that many of the cases that might otherwise be held proven in the common law, may be dismissed in Germany.

Yet what would appear to be a hard and fast rule of proof in Germany is often tempered by a number of special rules that have been developed over the years. These include *Anscheinbeweis* or prima facie proof, a reversal of proof when documents are missing, when there has been gross negligence or where what are considered the doctor's "fully-masterable risks" have been breached. These shall be considered presently.

[602] C KATZENMEIER, *Arztthaftung*, p436

5.9 *Anscheinbeweis*

Often in cases the full "Überzeugung des Gerichts" cannot be achieved. It is after all quite a high standard of proof. The idea of *Anscheinsbeweis* or prima facie *Beweis* is especially important in the area of causation as it can often help a patient establish the essential causal connection between the fault and the damages sustained.[603] Importantly, *Anscheinsbeweis* does not mean a reversal of the burden of proof but rather a lightening of the burden (something like *prima facie* evidence) and it will depend on each case.[604] It has been described as one of the most contentious and controversial ideas in the civil law procedure and at the same time as "die wichtigste Beweiserleichterung" that a plaintiff has.[605] Franzki said that

> Der Beweis des ersten Anscheins greift ein bei typischen Geschensabläufen, d.h. in den Fällen, in denen ein bestimmter Tatbestand feststeht, der nach der Lebenserfahrung auf eine bestimmte Ursache als maßgeblich für den Eintritt eines betsimmten Erfolges hinweist.[606]

So what is being looked for here is something atypical, something aberrant or freakish that cannot be explained according to normal life experience and that would tend to indicate negligence; it is a set of circumstances that calls for an explanation. The court may then consider an *Anscheinbeweis*.

This idea of prima facie evidence is based on factual experience. Does one fact generally lead to another? For example, if a patient suffers a sepsis following an intra-artery injection then it has been held as prima facie proof that the injection was administered erroneously.[607] It would appear that even the leaving of a foreign body in a patient would not in itself constitute the raising of the prima facie proof: it depends on the circumstances.[608] For example, the leaving of a cotton wool bud, a

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[603] E DEUTSCH and A SPICKHOFF, *Medizinrecht*: *Arztrecht, Arzeimittelrecht, Medizinproduktrecht und Transfusionsrecht* (Berlin, Springer, 2008) at p510

[604] ibid and M STAUCH, *The Law of Medical Negligence*, p73

[605] C KATZENMEIER, *Arzthaftung*, p431 and p436

[606] M KREß, *Die Ethik-Kommissionen im Systen der Haftung bei der Planung und Durchführung von medizinischen Forschungsvorhaben am Menschen*, p95 (Karlsruhe, Karl Eiser, 1990)

[607] BGH NJW 1989, 1533

[608] C KATZENMEIER, *Arzthaftung*, p438

gauze tissue or a tampon in a wound does not go far enough for the courts in what is otherwise a complicated and difficult operation.[609] Yet this prima facie proof can be rebutted with greater ease than a total reversal of proof. The doctor need just point to facts that state that there is another potential cause that need be considered.

It is always for the doctor to challenge - not rebut, as there is no reversal of proof - any *Anscheinsbeweis* by showing that the circumstances were atypical of fault; for example that an unexpected haemorrhaging would not be typical of doctor's fault.[610] *Anscheinsbeweis* has played a role in three important areas according to Deutsch and Spickoff: infections, risks in anaesthesia and sterilisation. I shall consider only the area of infections and nosocomial infections together as it provides fertile ground to compare with infections with France.

[609] RGZ 97, 4(5)

[610] E DEUTSCH and A SPICKHOFF, *Medizinrecht*, 519

5.9.1 Infections

The problem with proving causation with infections is that they can occur just as part of the natural course of things or, potentially, they can occur because of the fault of a care-provider. Like France, there is special legislation that may help a patient in Germany. Case law must be considered to help us gage when *Anscheinbeweis* may come to the aid of the patient. This is §2 of the *Infektionasshutzgesetz* which defines a nosocomial infection as

> eine Infektion mit lokalen oder systemischen Infektionszeichen als Reaktion auf das Vorhandensein von Erregern oder ihrer Toxine, die im zeitlichen Zusammenhang mit einer stationären oder einer ambulanten medizinischen Maßnahme steht, soweit die Infektion nicht bereits vorher bestand

As noted by Oliver Berg in his summary paper before *Groupe de Recherche Européen sur la Responsabilité Civile et l'Assurance* (GRERCA), [611] the law modifying the *Infektionsschutzgesetz* has introduced an additional way in which the burden of proof can be reversed.[612] I quote this before the rest of this section as hospitals' responsibility can still be found in case law. Nosocomial infections have for a long time succumbed to a reversal of the burden of proof in Germany given that hospital environments are to be regarded as *voll beherrschbares Risiko*, which I shall consider in more detail later.[613] Endogenous infections, as I shall show below, lead to a reversal of the burden of proof.[614]

The case law then gives us some idea of what could raise an *Anscheinbeweis* and what is less likely to effect a shift in the tactical burden of proof. Theses could be matters such as dysfunctional medical material,[615] negligence in sterilisation[616] or in the cleanliness of the products,[617] and even infections coming from medical personnel or

[611] GRERCA conference of 14 and 15 December 2012, paper "Les infections nosocomiales en droit allemand", held at the University of Louvain-la-Neuve, Belgium.

[612] see infra

[613] BGH NJW 1991, 2960

[614] BGH NJW 2007, 1683

[615] BGH NJW 1991, 983

[616] BGH NJW, 1982, 699

[617] BGH NJW 2007, 1683

other patients.[618] It is, of course, for the plaintiff to show that the risk was "fully masterable".

The hospital can show, however, that the breach is not "responsible" for the damage.[619] This it can demonstrate by showing that it took all organisational and technical measures to prevent it.[620] The courts admit that patients must take some kind of risk.[621] If all precautions are not taken then the presumption will not be rebutted. Berg quotes the case of a nursing auxiliary with hay fever giving an injection to a patient.[622]

The *Gesetz zur Verhütung und Bekämpfung von Infektionskrankheiten beim menschen* (*Infektionsscheutzgesetz – IfSG*) of 28 July 2011, modifying the law of 20 July 2000 introduces one way in which establishments can rebut the presumption. It holds that

> Die Einhaltung des Standes der medizinischen Wissenschaft auf diesem Gebiet wird vermutet, wenn jeweils die veröffentlichten Empfehlungen der Kommission für Krankenhaushygiene und Infektionsprävention beim Robert-Koch-Institut und der Kommission Antiinfektiva, Resistenz und Therapie beim Robert Koch-Institut beachtet worden sind.[623]

The Robert-Koch institute is the central federal institution responsible for disease control and prevention. In this regard, it issues recommendations to hospitals from time to time.[624]

So it can be seen then that in Germany, the victim does have an advantage when he alleges a nosocomial infection. Provided he can show that there was a "fully

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[618] ibid

[619] §280 BGB

[620] BGH NJW 2007, 1684

[621] BGH NJW 1991, 1542

[622] O BERG, GRERCA conference of 14 and 15 December 2012, paper "Les infections nosocomiales en droit allemand", p3, held at the University of Louvain-la-Neuve

[623] §23

[624] its remit can be seen, in English, on its homepage http://www.rki.de/EN/Content/Institute/institute_node.html

manageable risk"[625] (that is a risk arising out of the treatment environment[626]) then the hospital must really show that it has acted in conformity with the Robert-Koch and Anti-Infection Commission. The burden of proof is reversed (and I shall consider this in more detail below). This is more than an Anscheinbeweis. So causation in this area is different from what it is in the United Kingdom and in France. I shall comment further on this in the comparative chapter.

5.9.2 *Anscheinbeweis* and Infections: Case Law

If the patient cannot show that there has been a breach of a "fully masterable risk" and thus benefit from a reversal in the burden of proof then it might be the case that the patient could benefit from an *Anscheinbeweis*. I shall consider some of the case law presently.

Hepatitis B contracted in a children's clinic would not raise *Anscheinsbeweis* as this can be contracted in a number of ways.[627] If a patient contracts a wound infection during an operation then the *Anscheinsbeweis* will only operate if the patient shows that it was likely to happen in the circumstances. Further, he must also show that the infection was caused by a lack of adherence to hygiene standards.[628] There is no prima facie *Beweis* when a number of patients have developed Hepatitis B following novocaine injections or acupuncture even when these were in the same doctor's surgery.[629] In one case, many people between July 1978 and March 1979 had gone to see a dentist and they had all contracted hepatitis B. It turned out that, following a blood test, the dentist himself was infected with hepatitis B. It was shown also this particular dentist was working with unprotected chapped hands ("rissige Hände"). It was established that

> Da unstretig eine Vielzahl von Patienten des Bekl zu 1 in der Zeit von Juli 1978 bis Mitte 1979 an Hepatitis B erkrankten, kann nach den Grundsätzen des

[625] §630h (1) BGB

[626] M STAUCH, *The Law of Medical Negligence*, p45

[627] OLG Oldenburg VersR 1991, 1378

[628] BGH FesR 2006, 251

[629] OLG Düsseldorf VersR 1986, 494

> Anscheinbeweises als beweisen, angesehen werden, daß auch Kl von ihm angesteckt wurde, zumal eine andere Infektionsquelle nicht ersichtlich ist...[630]

Interestingly the court said here that it is within the general knowledge of a dentist that if he has such hand injuries then infections can pass to the patient. Further the court also held that it was no defence for a dentist to say that more was known about the transmission of hepatitis B today (1985) than was before.[631] The fact that many people contracted hepatitis B between two dates was something that needed explaining and it was for the dentist to do it the more so as he had the infection himself. I also had the impression that, although the court was indeed referring to *Anscheinbeweis*, it was also looking at protective purpose rule - perhaps indirectly. It criticised the dentist for working without protecting his hands and there seemed to be a causative protective purpose coming through in this judgement. So perhaps in Germany then both *Anscheinbeweis* and protective purpose can be combined.[632] Katzenmeier also noted that

> Aufgrund der Anscheinsregeln kann also nicht nur von einem festehenden Ereignis auf den Zusammenhang mit dem eingetretenen Erfolg, sondern auch umgekehrt von einem eingetretenen Erfolg auf ein bestimmtes Ereignis also Ursache geschlossen werden.[633]

So what he is saying here is that the courts have favoured a consequential analysis of the situation and considered the event preceding the result to imply causation. For example, there was one case where a patient was accommodated in a scarlatina ward and the patient subsequently contracted scarlatina; here it could be implied via *Anscheinsbeweis* that placing the patient in such a ward was the cause of the scarlatina.[634] The same has also been used for facial erysipelas.[635] *Anscheinbeweis* was

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[630] 23 OLG Cologne, NJW 1985, 1402

[631] reference was made to literature in English

[632] "Eine besondere Anstekungsgefahr ging vom Bekl. Zu 1 zusätzlich deshalb aus, weil er nach eigenem Zugeständnis ständig 'rissige Hände' hatte und jedenfalls zeitweise mit ungeschützten Händen arbeitete." ibid

[633] C KATZENMEIER, *Arzthaftung*, p434

[634] RGZ 165, 336 (339)

[635] an acute infection typically accompanied with skin rash; RG SeuffA 86, Nr 122

also used for a teenager who contracted tuberculosis after being in the same room as a patient who had it.[636] Other examples in the case law (and also cited by Katzenmeier and others) include pain and paralysis following an injection, the cause of the pain and paralysis being attributed to the injection.[637] In this last case, the deceased went to his doctor complaining of a pain in his right shoulder joint. The pain had not gone away one week later so he went to see an orthopaedic surgeon. X-Rays showed nothing and the patient was given an injection of cortisone and put in a "Collar and Cuff". The condition of the patient began to worsen and he developed fever and pain. After further tests, it was shown that the patient had a septic fever and he later died from multiple lung abscesses. The BGH held in its causal analysis here that

> Es entspricht ständiger Rechtsprechung, daß grundsätzlich auch der Ursachenzusammenhang zwischen einem ärztlichen Eingriff und dem Eintritt einer Komplikation im Wege des Anscheinsbeweises festgestellt werden kann. Das BerGer[638] hat dessen Voraussetzungen nicht verkannt. **Es stellt fest, das Auftreten eines Gelenkempyems wie bei dem Patienten sei eine typische Komplikation der intraartikulären Injektion. Hinreichende Anhaltspunkte für eine andere Ursache des Empyems und der darauf beruhenden Aeptikämie fehlten im Streitfall**.

So here we see the BGH criticising the lower court for not recognising the fact that the mere intervention and subsequent occurrence of a complication can lead to *Anscheinbeweis*.

A blood transfusion has also been held to cause syphilis where the receiver of the blood transfusion developed the disease following the transfusion.[639] Also interesting is the case of a patient who was never in any high-risk group of contracting HIV nor did the way he led his life expose him to any risk. He subsequently developed HIV following a blood transfusion. It was prima face evidence that the blood transfusion

[636] BGH VersR 1960, 416 (417)

[637] BGH NJW 1989 1533 (1534)

[638] *Berufungsgericht*

[639] BGHZ 11, 227

caused the HIV.[640] This is comparable to the case in France. In one case, it was denied where a palsy of vocal cords developed after a thyroid operation.[641] The court noted that such an experience occurs seldom.

Indeed Katzenmeier sounds a note of caution. He notes that given the unpredictability of the human condition and its reaction to particular stimuli, it can be difficult to ascertain what can be found from general life experience.[642] The court should not be there, even from reasons of equity, simply to help the patient.[643] Similarly, where an injection in a joint resulted in an infection, there was held to be no reversal of the burden of proof as a number of patients may develop infections following such injections.[644]

A successful submission of *Anscheinbeweis* is not common in Germany.[645] Perhaps not unsurprisingly, *Anscheinbeweis* is always allowed for HIV infections from an AIDS-infected blood donor.[646] If a patient undergoes a simple operation, however, then it is likely to be denied.[647] Perhaps of more relevance is the *grobe Behandlungsfehler*.

So *Anscheinbeweis* is something similar then to prima facie proof in the United Kingdom. It may be similar to the kinds of presumptions that can be drawn in France but the way the French courts approach this is different.[648] So although there is a high standard of proof in Germany, Anscheinbeweis can help a patient. Its success appears, however, to be low. I shall leave consideration of this idea to the comparative chapter.

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[640] BGHZ 114, 284 (290)

[641] NJW 1978, 1682

[642] C KATZENMEIER, *Arzthaftung*, p436

[643] ibid

[644] OLG München VersR 1986 496

[645] G MÜLLER, "Beweislast und Beweisführung im Arzthaftungsprozeß", (1997) *Neue Juristische Wochenschrift* 3049 (3051)

[646] BGH NJW 1991, 1948

[647] BGH NJW 1991, 1568

[648] L KHOURY, *Uncertain Causation*, p44

5.10 Gross Treatment Error

In certain cases in Germany, the burden of proof can be reversed. It means the care-provider must show he did nothing negligent. This, of course, helps the plaintiff who must establish causation. In medical negligence law, this is typically where a "gross" treatment error has been made. Stauch has said that this constitutes one of the most "original and defining features of German medical practice overall" and that this is one way where "The courts have...evolved rules to shift the risk of inability to prove causation from the patient to the doctor."[649] Schiemann considers that the "grobe Behandlungsfeheler" as the most important basis for the easing of the burden of proof.[650] As he says, it differs from other areas of law.[651] In this area of German medical malpractice law, there is an assumption of causation. Deutsch and Spickoff say that the reason for this causal presumption is to be found in equity.

> ...der Arzt kann sich nicht beschweren, wenn ihm mögliche Konsequenzen seines elementeraren Fehlers auf der Ebene des Beweises zugeschoben werden.[652]

By increasing the danger or risk to the patient, through his gross negligence even minimally,[653] the doctor has breached certain standards and therefore should not benefit from the norm that it is for the plaintiff to prove causation in such cases.[654] If the plaintiff can show "gross fault" then the burden of proof would be on the doctor to show that the damage was not a cause of the gross negligence.

A gross treatment error is simply that: something that is so fundamental that it went again the norms of medical practice. These a doctor is deemed to know. Such an

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[649] M STAUCH, *The Law of Medical Negligence*, p87

[650] G SCHIEMANN, Country Report Germany, in M FAURE and H KOZIOL (eds) *Cases on Medical Malpractice in a Comparative Perspective*, (Vienna, Springer, 2001), p143

[651] even with product liability, causation must still be proved Council directive 83/374/EEC, Art 1 states that "The producer shall be liable for damages **caused** by a defect in his product"; Art 4 goes on, "The injured person shall be required to prove the damage, the defect and the causal relationship between defect and damage."

[652] E DEUTSCH and A SPIKOFF, *Medizinrecht*, 530

[653] BGH NJW 2004, 2011

[654] note contributory negligence of itself does not exclude the rule; "Ein Mitverschulden des Patienten schließt nicht die Beweislastumkehr nicht aus."

error has been held to be one that doctors just simply ought not to make. To quote in its context

> Es muß vielmehr ein Fehlverhalten vorliegen, das zwar nicht notwendig aus subjecktiven, in der Person des Arztes liegenden Gründen, aber aus objektiver ärztlicher Sicht bei Anlegung des für einen Arzt geltenden Ausbildungs-und Wissenmaßstabes nicht mehr versädlich und verantwortbar erscheint, weil ein solcher Fehler dem behandelnden Arzt aus dieser Sicht "schlechterdings nicht unterlaufen darf".[655]

The court then noted that, for example, the making of a clear diagnosis not according to standard methods could constitute a gross treatment error. Katzenmeier also refers to this case when attempting a definition of gross treatment error.[656] It can be seen then that causation in medical negligence can be manipulated depending on what is defined as a "groben Fehler". Other examples include the withholding of an essential drug from a patient after an operation,[657] the non-correction of a baby's undescended testicle during a hernia operation[658] or the leaving of a drill-bit in a patient following an operation.[659] In another example, where a mother had lost one of her twins following a delay, it was held that the CTG-monitoring of the pregnant patient by an ordinary staff nurse was grossly negligent and that consequently the onus was on the hospital to prove that an earlier delivery would not have saved the child.[660] Although the doctrine has been part of German law for many years, it remains nonetheless controversial.[661] Whether a *Behandlungsfehler* is *grob* or not is a value judgement (*eine juristische Wertung*)[662]

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[655] BGH NJW 1998, 1782

[656] C KATZENMEIER, *Arzthaftung*, p442

[657] BGH NJW 1991, 1539 (1540)

[658] OLG München, VersR 1997, 577

[659] OLG Stuttgart VersR 1989, 632

[660] BGH NJW 1986, 2429

[661] E DEUTSCH and A SPIKOFF, *Medizinrecht*, p455

[662] ibid

> ...die dem Tatrichter obliegt, der sich dabei mangels Fachkentnisse der Hilfe eines medizinischen Sachverständigen zu bedienen hat.[663]

What we have here then is at least lip-service to the fact that what constitutes gross negligence is a legal judgement not a medical one. Notwithstanding this principle, however, there is recognition that the help of medical experts is ineluctable.[664] Yet although experts are important, the establishment of *grobe Behandlungsfehler* is for the judge.[665] The judge is not bound by an expert's report but he should give adequate and written reasons as to why he is not following it.

The doctrine has also been criticised on the grounds that the judiciary are encroaching on parliament's jurisdiction.[666]

As Stauch notes, in addition to a finding of "gross" error there are two additional conditions that must be satisfied before a court will reverse the burden of proof. First, the error must be one that is known to "create a non-negligible risk of the injury in suit."[667] In one case then where a claimant was born severely premature due to a doctor's failure to give drugs, the likelihood was that even if the drugs had been administered there would have been no appreciable difference in his disabilities.[668] So here the hospital was able to confute the causal presumption.

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[663] NJW 2008, 1381 (1383)

[664] the same case also noted how experts should draft their reports. It advised that "Das einzuholende Sachverständigengutachten muss vollständig und überzeugend und insbesondere frei von Widersprüchen sein. Unklarheiten und Zweifel zwischen den verschiedenen Bekungung des Sachverständigen hat das Gericht durch gezielte Befragung zu klären. Anderenfalls biete der erhobene Sachverständigenbeweis keine ausreichende Grundlage für die tatrichterliche Überzeugungsbildung."

[665] G MÜLLER, "Beweislast und Beweisführung im Arzthaftungsprozeß", *Neue Juristische Wochenschrift* 1997, 3053

[666] C KATZENMEIER, *Arzthaftung*, p455 "An dem Gesetzgeber vorbei sei von der Judikatur eine Regelung geschaffen worden, die mit Grundpositionen der Rechtsordung nicht in Einklang zu bringen sei.",

[667] M STAUCH, *The Law of Medical Negligence*, p89

[668] BGH 1995, 778; as noted also by ibid, M STAUCH

The second requirement is that regard must be had to the protective purpose of a rule to ascertain whether the doctor's behaviour was grossly negligent.[669] It has been held that where a patient was discharged early from hospital following a heart-examination with a catheter and then died of septicaemia, there was no reversal of the burden of proof.[670] The risk of septicaemia was too remote although the patient's discharge had been grossly negligent. This is fascinating and reminds me of the earlier questions with respect to the *Schutzzweck* analysis. This discharge was in itself grossly negligent in that the patient was discharged after 24-hours whereas a longer period of observation was required to guard against arrhythmias, blood and general circulation complications. The court noted that contracting septicaemia was rare and that this could not be "beherrschbar". Consequently, the doctor's behaviour with regard to the eventuation of septicaemia was not a "...*schwerer* Verstoß gegen die ärztliche Sorgfaltspflich...".[671]

So I think then, as far as gross treatment error in Germany is concerned, we must look at whether the risk that eventuated could be within the sphere, orbit or range of the risks which it is fair to allocate to doctor before we can state with certainty whether certain acts or omissions can be classified as grossly negligent.

The BGB has now codified its provisions on gross malpractice. §630h (5) states

> If gross malpractice has committed, and if this is susceptible as a matter of principle to cause an injury to life, limb or health of the nature which in fact took place, it is to be presumed that the malpractice was the cause of this injury. This is also to apply if the treating party omitted to take or record a medically-necessary finding in good time where the finding would with sufficient certainty have led to a result which would have given rise to further measures, and if failure to carry out such measures would have constituted gross malpractice.[672]

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[669] ibid, M STAUCH, *The Law of Medical Negligence*, p90

[670] BGH NJW 1981, 2513

[671] BGH NJW 1981, 2513 (2514)

[672] I refer to this also further below with regard to missing records

Reversal of burden of proof will only be employed with regard to the "primary" harm and not the "secondary" harm.[673] In the case where a disinfectant caused a skin reaction on a patient and this led also to inter alia kidney failure, the kidney failure and other disabilities remained for the patient to prove up to the lower standard of the balance of probabilities under §287 ZPO.

So again it can be seen that the doctrine of *grobe Behandlungsfehler* is an accommodation or a compromise between the conflicting interests on the one hand of the proof difficulties that a patient has and those interests which are worthy of protection as far as a doctor is concerned. It has also been suggested that the reversal of the burden of proof should depend to what extent the doctor has made the finding of a causal link more difficult (for example, by not taking adequate notes).[674]

So Germany is the only jurisdiction under consideration here actually to reverse the burden of proof in certain cases. Neither the United Kingdom nor France does that though France may come close with allowing presumptions that can only be rebutted with evidence close to certainty. So again as far as procedure is concerned, and I believe that procedure plays a pivotal role in the establishment of causation, Germany stands out here among the jurisdictions in examination in this paper.

[673] BGH VersR 1963, 67

[674] K-H MATTHIES, "*Anmerkung*: Beweislastumkehr im Arzthaftungsprozeß" NJW 1983, 335"

5.11 Fully Masterable Risks and *überzogene Verkehrspflichten*

It does not translate exactly but *Verkehrssicherungspflichten* is an idea that has been developed by the German courts.[675] It generally means that anyone who by his activity in everyday life creates a potential danger that could affect or harm another should ensure the protection of that person.[676] As we shall see, the idea plays an important role in the area of medical causation. With regard to medical liability, it can be seen as somewhat akin to an *obligation de securité.* Without entering too much into theory, Katzenmeier has described it

> ...als Verwirklichung einer typischen Gefahr erscheint, die dem von dem Beklagten **beherrschten** Verantwortungs - , Einstands oder Risikobereich enstammt, dies aber das Zurechnungsprinzip der Gefährdungshaftung ist.[677]

Where there is an aspect of the treatment process that is under the full control of the doctor and the doctor commits a fault in this regard then there will be a reversal of proof. Two areas that this affects particularly are the areas of organisation and technical apparatus.[678] This is considered as a breach of a subsidiary obligation under § 280 I 2 BGB and is a breach of his subsidiary obligation to provide a safe treatment environment. The burden of proof and hence causation is then on the doctor to show that he is not responsible. For example then, it would be for the doctor to take such measures as were necessary to ensure the safety of a patient on the operating table.[679] This would include, for example, the provision of a properly working oxygen machine while a patient is under anaesthesia. The provision of secure medical equipment is a subsidiary obligation, which should be guaranteed.[680] Another example could be where a patient is placed in a bed in an ambulance. Here

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[675] B MARKESINIS and H UNBERATH, *The German Law of Torts*, p86

[676] ibid

[677] C KATZENMEIER, *Arzthaftung*, p167, my emphasis; Katzenmeier continues to criticise the theory saying that it has brought about almost a *Garantiepflichter* and by quoting J ESSER who says that this theory has effected an alarming distortion of fault principle and its norms. He says that it appears now that all possible social risks could now be caught under this theory and that there is an uncontrollable mixing (*Vermengung*) of "fault" and "danger" elements: J ESSER, JZ 1953, 129

[678] C KATZENMEIER, *Arzthaftung* , p482

[679] E DEUTSCH and A SPICKHOFF, *Medizinrecht*, p340

[680] NJW 1978 584 (584-5)

that patient may take advantage of the "fully-masterable risks" doctrine. It would, however, be otherwise where the damage can be ascribed to a particular corporeal anomaly or peculiarity in the patient.[681]

Geiß and Greiner state that the easing of the causal burden will be an exception to the general rule that it is for the plaintiff to prove his case and that this will only be seen with "groben Behandlungs – oder Organisationsfehlern."[682] They cite one case where there was an infection in a hospital nursery and the burden of proof was reversed. It was for the hospital to prove it was not negligent.[683] Spickoff gives a non-exclusive list of "voll beherrschbaren Risikos" that relate to the above case. These are

(a) hygiene standards;

(b) apparatus standards;

(c) standards of the medicine itself;[684]

(d) standard of personnel; and

(e) internal organisation according to various guidelines and directives.[685]

These "fully masterable" areas for the hospital essentially admits of few excuses, for example, showing that all relevant precautions had been taking further to the Robert-Koch Institute guidance. For example, the condition of a lens tube, the purity of disinfectant, the leaving of a swab in a patient's body in a simple operation, falling from a shower-chair or an examination couch or an error with the provision of medication can be seen as fully masterable risks.

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[681] OLG Köln VersR 1991, 695

[682] K GEIß and H-P GREINER, *Arzthaftpflichtrecht*, 240: "Die Ebene der haftunsbegründenden Kausalität wird nicht ohne weiteres umfaßt. Für den Kausalitätsbeweis greifen nur ganz ausnahmsweise Beweiserleichterungen ein, so etwa bei groben Behandlungs- oder Organisationsfehlern."

[683] BGH NJW 1971, 241

[684] BGH NJW, 1991, 1514

[685] A SPICKHOFF, *Medizinrecht* (Munich, Beck, 2011), p417

The most famous case in this area dates from 1977. It is mentioned by both Stauch and Katzenmeier.[686] In this case, a patient sustained damage to the brain while under general anaesthetic. There was a complication with the supply of oxygen. We see the court stating the ratio as

> Aus diesem Vertrag ergab sich für den Krankenhausträger u a die Pflicht, für die Operation ein funktionshähiges Narkosegerät zur Verfügung zu stellen. Diese Pflicht wurde objektiv verletzt, und das hat zu dem geltend gemachten Sachaden geführt....Dieser Grundsatz [that a doctor will not be held liable for a given outcome] kann jedoch auf die Erfüllung voll beherrschbarer Nebenpflichten, insbesondere die Gewährleistung technischer Voraussetzungen für eine sachgemäße und gefahrlose Behandlung, keine Anwendung finden.

The court pronounces here in clear terms that as far as ancillary obligations are concerned, such as the security of a patient in the hospital, then there is almost strict liability. From a causal point of view, this aids the patient significantly.

As far as any defence with regard to faulty apparatus is concerned, the doctor must show that the bad condition of the apparatus cannot be imputed to either him or to one of his staff. This is not an easy defence for the doctor to fulfil. He must show that he used the apparatus correctly, that he was up to date with the latest medical knowledge in that area, that he was trained, that he followed the operating instructions of the apparatus. He must also prove that he oversaw the proper functioning of the apparatus.[687] Yet, the doctor is not liable for guaranteeing the perfect functioning of a machine.[688] He is not an insurer for any construction defects. This lies with the manufacturer of the machine.[689]

This "fully-masterable risk" idea not only covers the actual organisation and planning of the hospital but also such things as the purity of the disinfectant that is being used, ensuring that intravenous drips are sterile and generally a guarantee of hygiene. What is interesting here is that there will be a presumption against the doctor or

[686] M STAUCH, *The Law of Medical Negligence*, p45 and C KATZENMEIER, *Arzthaftung,* p484

[687] C KATZENMEIER, *Arzthaftung*, p482

[688] ibid

[689] ibid

hospital in an operation if a patient contracts an infection if such an infection is typical when there is a lack of hygiene and that it was avoidable.[690] What happened in this case was that there was an allegation that following an operation on 1 September 1986 an infection was caused by substandard hygienic conditions in theatre. Furthermore it was alleged that the patient was not warned of such risks and damages were claimed from the hospital. Judgement for the plaintiff was denied at first instance. This was confirmed by the *Oberlandesgericht*, the State Appellate Court, on appeal. The BGH upheld the OLG's decision.

Going through this judgement, there are a number of points that are interesting from a causal point of view. First, the court recognised that all germs cannot be eliminated and that it was not necessary that a patient be informed of this as it is "geläufig" (*familiar*).

The BGH also referred to the reports on which it was basing its judgement. The words are pertinent for the theorist in assessing functionality. The medical treatment report stated (and the BGH referred to it) that the transmission of the infectious pathogen **clearly** came from human beings.[691] Further oral testimony showed such an infection was "**typisch** für eine operativ gesetzte"; the same doctor also testified that the spread of the infection from people was "die **naheliegendste**(*most obvious, self-evident*) Ursache" and it was noted that the mouth and nose of the operators are often the "**haufigste** *(most frequent)* Gefahrenquelle" and that "am **wahrscheinlichsten**" (*most probable*) the infection was breathed in. I have highlighted the words I thought important here as I think it shows what kinds of words scholars and lawyers should look for when considering a medical report and causation.[692] Adjectives of probability are fundamental to a legal understanding of the subject and they show how courts rely on them when coming to a decision. This is relevant for my comments on experts' reports later.

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[690] ibid, p485 and BGH NJW 1991, 1541

[691] "...einen menschlichen Keimträger als 'die naheliegende Erklärung' bezeichnet..."

[692] interestingly the court noted that the medical report could not establish whether the germ in question came from a particular member of the operation team but only that it came from one of them.

The BGH also commented that it was impossible to have complete sterilisation in theatre – the transmission of germs in this case was "nicht beherrschbaren". However, it is for the hospital to show

> ...daß alle organisatorischen und technischen Vorkehrungen gegen von dem Operationspersonal ausgehende vermeidbare Keimübertragungen getroffen waren.

Here we see then that the hospital has the burden of proof to show that it has discharged this duty. Why? Because "Sie ereignet sich gegebenfalls in der Sphäre des Krankenhausträgers." However, in this case, the hospital benefited from the uncertainty that existed. The court noted that the conclusion that there could still be an infection even if all hygiene standards were reached was not fully established. It left open the question whether or not this "germ transfer" was avoidable or not. In such cases, uncertainty benefitted the hospital.

Where an unruly patient has been placed in a wheelchair that is not stable then a doctor could further find himself subject to this doctrine.[693] Deutsch and Spickoff note that this doctrine

> ...greifen ferner dann, wenn einem Patienten aus nicht zu klärenden Gründen eine überhöhte Röntgendosis verabrecht wird.[694]

So where a duty can be classed as a fully-masterable risk or one that comes within a doctor's fully-masterable area then in the event the patient suffers damage, a doctor could be liable. This doctrine has no counterpart in the common law but, as mentioned, it does resemble somewhat the French *obligation de securité*. It is interesting in that German courts have increased the scope of doctor's duties here.[695] Many of the textbooks on the subject cite case law from newly qualified doctors, security (eg falls from stools), machinery, storage and hygiene. Of course, it always remains open for the defendant to show that the given the circumstances of the case, the risk does not lie with them.[696]

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[693] KG ArztR 2006, 153

[694] E DEUTSCH and A SPICKHOFF, *Medizinrecht*, p341

[695] K GEIß and H-P GEINER, *Arzthaftpflicht*, 240 et seqq

[696] ibid

Organisation is a broad term as case law above shows. What we can also note is that in expert reports, courts are evaluating causation by considering certain ideas of probability: what is to be expected in such a situation? What is the most common outcome? What is typical? This is the kernel of establishing causation. Yet this idea of probability was also mixed up with ideas of "sphere of risk". The germs, so to speak, in the above case, were in the sphere of the hospital. The courts recognised that not all germs can be eliminated and that people, in general, are aware of this. So does this mean that if an infection is contracted in a hospital in Germany (or even a certain number of days after a treatment in a hospital?) that there may be causation? The answer has to be no – but a qualified one. It must be remembered that although a plaintiff may have some procedural advantages (inasmuch as it might be for the hospital to prove that it conformed with all required health guidelines), courts will be mindful that perfection cannot be achieved – as was seen in the above case. Their attitude seems to be that everyone knows that some hygiene risks – in particular germs - are unavoidable. Hospitals do, however, have high standards to maintain. It will depend on the circumstances and on the quality of the report in any given case. It is submitted then that lawyers do a certain amount of research themselves and ask specific questions related to frequency, probability and possibility without leading too much an expert witness (where, of course, they have instructed their own experts). As I shall discuss later, this is why I think it is imperative that all reports must be questioned.

Finally in this area, and under the heading of fully masterable risks and organisation more generally, there is the question of newly qualified doctors. Newly qualified doctors are, of course, essential to the continuance of the profession. As is to be expected, however, newly qualified doctors, if not properly supervised, can easily make errors that can have severe consequences for patients. It is for this reason that more senior doctors must ensure the proper supervision of trainees. Katzenmeier notes

> Erleidet ein Patient bei der Behandlung durch einen (noch) nicht hinreichend qualifizierten Arzt Gesundheitsschäden, dann greifen Beweiserleichterungen für die Frage der Kausalität.[697]

[697] C KATZENMEIER, *Arzthaftung*, p487

In such a case, the hospital must show that the damage did not come about from a lack of supervision or experience. The BGH has already held that in such situations

> die Gefahr der Unaufklärbarkeit der Kausalität der vorwerfbar geschaffenen Risikoerhöhung für den eingetretetenen Schaden tragen.[698]

If fully controllable by the doctor then he has the burden of proof to show he did nothing wrong. However, if a patient displays an anatomical anomaly then the burden of proof goes back to the patient

> Das zeigt sich besonders deutlich an einem Ausnahmefall: tritt nähmlich bei operationsbedingter Lagerung dei Schädigung durch eine anatopmische Anomalie des Patienten ein, die zuvor nicht erkennbar war, greift wieder die Beweislast des Patienten ein.[699]

So where does the fully-masterable risk doctrine lead as far causation is concerned? It could be an argument in negligence itself but courts recognise it is a stand-alone doctrine. When we consider this theory, we must look to the doctors' or hospitals' organisational obligations and not to the curative obligations of a physician. Yet this idea of "organisation" as we have seen, is broad and extensive and it incorporates much more than the administrative. It puts responsibility on hospitals and doctors to ensure the hygiene of the hospital – surely a good thing. Doctors also have a responsibility generally to ensure that they leave no foreign bodies in a human post-operation[700] and there is also an obligation to ensure that newly qualified doctors are properly supervised. Yet the commonality between these scenarios is that the risks are not subject to the vagaries of the human body but rather they are fully-masterable by the doctors in question. There is nothing similar in the common law and a French approach is notably different.

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[698] BGHZ 88, 248

[699] BGH NJW 1995, 1618

[700] but as we have seen, the liability here is not strict

5.12 Missing Records

Doctors in Germany have a duty to keep proper medical records of their patients as set out in the Improvement of Patients Rights Act 2013.[701] Since 1978, it has been imperative that they be kept and they are not just an aide-memoire.[702]

The duty to keep records is part of the *Schutzzweck*.[703] From the diagnosis, medical directions on care, warnings that have been given to a patient before a procedure, and after treatment are but some of the areas that must be covered in good record keeping. Further analysis of the contents of the records is outside the scope of this work and reference is made to Katzenmeier.[704] What is interesting from a causal point of view is what inadequate record keeping actually means from a procedural point of view. If there is a breach of this duty, there is a procedural sanction.[705] As Janda states

> So wird vermutet, dass eine nicht dokumentierte Maßnahme vom Arzt nicht ergriffen worden ist. Ferner wird vermutet, dass sich ein nicht dokumentierte Umstand so ereignet hat, wie ihn der Patient glaubhaft schildert.[706]

Omitting to take proper records is a mistake in treatment. It is ancillary to the more general duty to provide proper treatment. If something is not documented, then it is assumed that a measure was not carried out unless the physician can prove that it was.[707] This does not give rise to a sui generis claim but only if there was some kind of serious mistake in treatment.[708] The test to be applied in ascertaining whether there has been a gap in treatment is whether the notes comprehensible to another doctor.[709]

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[701] §630(f)(1) BGB

[702] "Gedächtnisstuze", A SPICKHOFF, *Medizinrecht*, p471

[703] C KATZENMEIER, *Arzthaftung*, p473

[704] ibid et seqq

[705] ibid, pp476-477

[706] C JANDA, *Medizinrecht*, pp 332-333

[707] M STAUCH, *The Law of Medical Negligence*, p69; which may in fact not actually be so difficult

[708] BGH NJW 1983, 332 (332)

[709] BGH NJW 1996, 779

Causal problems arise when there have been omissions to keep proper records with regards to diagnostic tests.[710] This will be seen as a breach of a subsidiary duty of care (*Verletzung der Befundsicherungspflich*). The court must then enter into areas of hypotheses. What would such a test have shown and would any therapy have cured the patient?[711] In cases where a doctor has omitted to preserve proper records of a diagnostic, then German courts have been willing to relax proof by presuming that it appears "sufficiently likely" that misplaced test results would have revealed an ailment to which the doctor ought to have reacted.

Janda gives the following example. Patient P had to undergo an operation to take out a gallstone. During aftercare and further to an X-ray, it was noticed that some of the gallstone remained. This necessitated a further operation to have the remainder removed. Also the pancreas of the patient had become inflamed. During the trial, the X-rays were lost. It was not a matter of dispute that an X-ray was actually taken. In favour of the patient it will be presumed that the remainder of the gallstone was detectable.[712]

A problem that is encountered with the breach of this duty is that further questions with regard to causation may be difficult to establish. Situations arise both where there have been misplaced results and where there has been a total failure to carry out a test.

In 1987, a doctor omitted to perform a lung X-ray on a patient whom he had diagnosed as having bronchial-pneumonia but he actually had tuberculosis.[713] The court set itself two questions as far as causation was concerned:

i. if the doctor had taken the X-ray, would it **probably** have shown up something to which the doctor should have reacted?;
ii. would such reaction probably have helped the patient?

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[710] M STAUCH, *The Law of Medical Negligence*, p69

[711] ibid

[712] C JANDA, *Medizinrecht*, p333

[713] BGH NJW 1987, 1482, as also noted by M STAUCH, *The Law of Medical Negligence*, p86

Each case was to be judged on its merits.[714] Yet since 1996, the BGH has rejected this approach. The reason for this is that a patient who never had a test done or where test results were lost should not be in a worse position than a patient who does have the results but the physician then acted negligently. So now, there is just a presumption that the test would have shown something to which the doctor should have responded, not that such response would have helped the patient.[715] The burden of proof is then on the patient in accordance with §286 ZPO. However, the interesting exception to this is that where this failure to react to a test amounts to gross negligence then it will be for the doctor to show that a suitable response would not have helped the patient – a typical "he would have died anyway" scenario. This actually happened in one case where a doctor failed to carry out a blood test on a patient following a road traffic accident.[716] The patient then died of kidney failure. The doctor then had the burden of proof to show that such treatment would not have prevented the outcome. Stauch has translated this to English but I shall quote the original from the case report.[717] It reads

> Nach der neueren Rechtspruchung des *Senats* läßt ein Verstoß des Arztes gegen die Pflicht zur Erhebung und Sicherung medizinischer Befunde im Wege der Beweiserleichterung für den Patienten zwar zunächst nur auf ein reaktionspflichtiges positives Befundergebnis schließen, wenn ein solches hinreichend wahrscheinlich war. Ein solcher Verstoß kann aber darüber hinaus auch für die Kausalitätsfrage beweisleisgternd Bedeutung gewinnen, nämlich dann, wenn im Einzelfall zugleich auf einen groben Behandlungsfehler zu schließen ist, weil sich bei der unterlassenen Abklärung mit hinreichender Wahrscheinlichkeit ein so deutlicher und gravierender Befund ergeben hätte, daß sich dessen Verkennung als fundamental fehlerhaft darstellen müßte.

This is a curious state of affairs. What this means is that there is a basic presumption that any test would require a reaction on behalf of the doctor. This idea will then be mixed with the causal presumption of "gross treatment error" and if it can be

[714] ibid, M STAUCH

[715] BGH NJW, 1996, 1589

[716] BGH NJW 1999, 860

[717] BGH NJW 1999, 860 (861); M STAUCH, *The Law of Medical Negligence*, p87

regarded as such then the patient will benefit from a causal presumption. Yet what the case law is saying is that if the test would have shown a "deutlicher und gravierender Befund" then the doctor's failure to recognise this – ie his failure to react which has already been established – amounts in itself to a fundamental error! Is it fair then that from the mere omission of a test - being simply negligent in itself – that this can mushroom in the hypothetical to gross negligence? The alternative, it seems, is to let the patient bear the burden. I would submit that if a doctor has been negligent here then he must bear such consequences. The taking of proper notes and the maintaining of proper records are in the doctor's risk sphere and the burden of proof must lie with him where appropriate.

The codified answer now provided by the BGB at 630h (5) is

> [the provisions on gross malpractice] [are] also to apply if the treating party omitted to take or record a medically-necessary finding in good time where the finding would with sufficient certainty have led to a result which would have given rise to further measures, and if failure to carry out such measures would have constituted gross malpractice.

So again, failing to record accurately or omitting to record totally could ultimately result in a reversal of the burden of proof for the defendant doctor.

It can be seen then that the failure to take proper notes by a doctor in Germany has causal repercussions in procedure that do not exist in the other jurisdictions under consideration here.

5.13 Special Systems

Germany has a number of special systems in existence that help to show how, in certain circumstances, ideas of causation have been attenuated or modified. These laws necessarily reflect societal values and I shall consider two in Germany: the Pharmaceutical Products Act 1976 and the HIV-*Hilfgesetz*.

5.13.1 The Pharmaceutical Products Act 1976

The *Arzneimittelgesetz* 1976 (the "**Pharmaceutical Products Act 1976**") is the only special regime to exist in Europe existing before the Product Directive. It can therefore continue to exist. It is important for causation as I shall show below. The Act was passed following the 1960's thalidomide scandal. Section 84 of the Pharmaceutical Products Act is headed "Absolute Liability". It provides that

> (1) If, as a result of the administration of a medicinal product intended for human use, which was distributed to the consumer within the purview of the present Act and which is subject to compulsory marketing authorisation or is exempted by ordinance from the need for a marketing authorisation, a person is killed, or the body or the health of a person is substantially damaged, the pharmaceutical entrepreneur who placed the medicinal product on the market within the purview of the present Act shall be obliged to compensate the injured party for the damage caused. The liability to compensate shall only exist if
>
> 1. when used in accordance with its intended purpose, the medicinal product has harmful effects which exceed the limits considered tolerable in the light of current medical knowledge, or
>
> 2. the damage has occurred as a result of labelling, expert information or instructions for use which do not comply with current medical knowledge.

So here there is reference to the "pharmaceutical enterprise" which places the product on the market. We also see here the adoption of a risk / benefit analysis in the circumstances. It is not sufficient that doctors warn the patient of the risks. They must be indicated on the medicinal product.[718] Lenze notes that it is problematic for the patient to show that he would not have taken the drugs if the warnings had been

[718] S LENZE "German Product Liability Law: between European Directives, American Restatements and Common Sense" at p 120 in D FAIRGRIEVE (ed) *Product Liability in Comparative Perspective*, (Cambridge University Press, 2005)

there if the prescribing doctor knew about the risks.[719] So again there is the problem of proof by virtue of the counterfactual. Even if the patient knew of the risks, how would he establish he would not have taken the drugs? I imagine this would have to be judged on a case-by-case basis considering inter alia how far it was necessary for that patient to take the medication and the availability and efficacy of other treatments in a similar way to operation risk.

The Pharmaceutical Products Act 1976 is also interesting for the criteria it provides on causation in Article 84(2). The Act presumes causation if the drug in question is capable of causing the injury. It reads

> The capability [of the drug causing the damage] in the individual case will be determined according to the composition and the dosage of the administered medicinal product, the manner and duration of its administration when used as intended, the temporal relationship to the occurrence of the damage, the damage symptoms and the person's state of health at the time of the administration as well as all other circumstances which, in the individual case, speak for or against the causation of damage. The presumption shall not apply if, in the light of the circumstances pertaining to the individual case, another fact is capable of causing the damage. However, the administration of additional medicinal products which, in the circumstances pertaining to the individual case, are capable of causing the damage shall not be considered as another fact unless, owing to the administration of these medicinal products, claims for reasons other than the lack of causality for the damage, do not exist under this provision.

This is interesting in that it sets out criteria which determine "capability" and thus causation. These are interesting in that criteria similar to those in the multiple sclerosis / hepatitis B cases in France seem to be adopted. It appears here that generalizing scientific proof is relegated to second place. Reference is made to "the individual case" here. So, for example, if a patient takes an anti-psychotic for depression, which has a potential side effect of causing seizures in certain patients, then a court could hold the manufacturer of that drug liable if such seizures are deemed to exceed a tolerable level given the illness for which the patient is being treated. There would also be a presumption that the particular anti-psychotic caused

[719] ibid

the seizure. If, however, the patient decided to go out partying late into the night, imbibing lots of alcohol and having very little sleep before starting work the next day, then this would certainly be another fact in the individual case capable of causing any damage resulting from the seizure.

In another case under this Act, the plaintiff had certain pains dating from 1993 that were treated with painkillers.[720] From February 2001, the plaintiff began taking painkiller VIOXX. In the middle of January 2002, the 73-year old suffered from a heart attack but he still continued to take VIOXX. Two years later, in May 2004, the plaintiff was admitted to hospital with angina pectoris. The plaintiff claimed from the defendant that the VIOXX caused his damage from 2002. The plaintiff failed in his claim. I shall concentrate on the causal reasons here only. The plaintiff was not afforded any *Anscheinbeweis* or reversal of the burden of proof, as this would only be allowed

> ...wenn das Schadenereignis nach allgemeiner Lebenserfahrung eine typische Folde der Pflichtverlezung darstelle.

and this was not the case here. Such damage would be typical, for example, where a patient became infected with HIV following a blood transfusion and such patient did not belong to the HIV risk groups. In such a case, there would be a presumption or a lightening of the burden of proof in his favour. In the case at hand, however, the plaintiff also had "signifikante Risikofaktoren" which had to be taken into account. The risk factors could also have caused, or contributed to, the heart attack. They were his age, his blood pressure and the fact that he had been ski-ing. What I think can be gleaned from this case then is that it is particularly difficult to go from the general to the individual and more and more medical law cases show this.

I find this Pharmaceutical Products Act unique in that it sets out, in legislation, factors to be taken into account when considering causation. It is suitable for a particular area where causation may prove difficult: drugs. Notwithstanding all the factors that it lists, it remains particularly vague. As well as the factors to be taken into account that are listed, what also must be considered are "other circumstances

[720] BGH 6 Zivilsenat, judgement from 16 March 2010 – VI ZR 64/09

which, in the individual case, speak for or against the causation of damage". I question therefore in reality whether this clause on causation was necessary. Perhaps it was to act as a gently reminder to the judiciary as to what they must take into account. What does seem necessary is the causal provision that "the administration of additional medicinal products which, in the circumstances pertaining to the individual case, are capable of causing the damage shall not be considered as another fact unless…", Germany has adopted this policy approach and it is suitable for that jurisdiction. Yet it would be foolhardy to divorce consideration of such criteria more globally from the standard of proof and it is this which I shall consider in the comparative chapter.

5.13.2 HIV-*Hilfgesetz*

The HIV-*Hilfgesetz* was passed in 1995 to allow patients who had been infected by HIV following a blood transfusion to be compensated. This sets up an endowment whereby those who were infected with HIV, or with AIDS following on HIV from contaminated blood, can receive no-fault compensation.[721] It must be shown, however, by medical evidence that the HIV / AIDS has arisen as a result of a blood transfusion. Causality would seem to speak only to the possibility of infection

> Zum Nachweis der Ursächlichkeit genügt es, daß im Verlauf einer Behandlung ein Blutprodukt verwendet worden ist, das eine HIV-Infektion verursacht haben kann.[722]

Those who are not haemophiliacs must bring evidence of when the transfusion took place.[723] Where a spouse or partner seeks to recover, more guidance on the causal requirement is given. The law states

> Im Falle des Absatzes 2 ist durch ärztliche Bescheinigung nachzuweisen, daß eine HIV-Infektion oder AIDS-Erkrankung vorliegt und die Infektion mit großer Wahrscheinlichkeit durch den Ehepartner, Verlobten oder Lebenspartner übertragen worden ist.

So at least here we have the indication of "great probability" – another adjective in causal description.

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[721] §15(1)

[722] §15(5)

[723] ibid; "Im Falle des Absatzes 1 sind die Voraussetzungen nach Satz 1 durch ärztliche Bescheinigung nachzuweisen, aus der die Ursächlichkeit des verabreichten Blutproduktes für die vorliegende HIV-Infektion oder die dadurch bedingte AIDS-Erkrankung hervorgehen muß. Zum Nachweis der Ursächlichkeit genügt es, daß im Verlauf einer Behandlung ein Blutprodukt verwendet worden ist, das eine HIV-Infektion verursacht haben kann. Antragstellende Personen, die nicht Bluter sind, müssen darüber hinaus durch eine Bescheinigung der mit dem Blutprodukt behandelnden Einrichtung nachweisen, wann diese ihnen das Blutprodukt verabreicht hat. Anfallende Kosten für die Ausstellung der Bescheinigungen werden nicht erstattet."

5.15 Conclusions

Stauch suggests that the chances of obtaining redress in general for a patient in Germany are higher than in England.[724] He cites however, in footnote, that there is no data on the subject but it may well follow as a result of the favourable substantive and procedural law rules in Germany notwithstanding a prima facie higher burden of proof. Perhaps this is because in judges' minds the direct link between costs and resources is less explicit. In Germany, it is insurers who bear the cost. In the United Kingdom, it is justified by direct taxation and although ultimately the cost will fall on the insured in Germany, it may take longer so to do.

What I noticed in Germany first of all was how much the substantive law was actually affected by procedural devices. Procedural law inherently shaped substantive law. As a consequence, this naturally had an influence on causation. The study of procedural law in Germany is therefore imperative if a true understanding of the intricacies of causation in medical liability is required. It is true also that the level or the standard of proof is higher in Germany than in the United Kingdom. This would make one think intuitively that cases would be more difficult to prove in Germany than in the United Kingdom. However, such are the German plaintiff-friendly procedures that a plaintiff's lawyer should assess the case to ascertain whether the plaintiff could take advantage of a reversal of a burden of proof, a lightening of the burden of proof, or whether the situation involves certain risks of which the care-provider was the "full master" or whether there has been malpractice with regard to the keeping of proper documentation.

In Germany then, causal analysis very much starts from what it considers to be first principles. This is similar to other jurisdictions concerned. Case law has admitted the conditio sine qua non test and then a further test of adequate causation is applied. Such tests, however, have not totally satisfied the court and, as we have seen, even when causation is an issue, sometimes the courts do not mention these tests at all. This leads me to believe then that, as far as medical negligence is concerned, these traditional theories are not sufficient. Indeed, when justice is required, resort is had to the *Schutzzweck* rule and no mention is made of the traditional causal analyses.

[724] M STAUCH, *The Law of Medical Negligence*, p158

What should be made of the reversals or the lightening of the burden of proof in Germany with regard to causation? Undoubtedly such rules help the plaintiff but their justification or otherwise is not for consideration in this paper. What is to be considered here is how they differ from the other jurisdictions. Just to consider again briefly the case with the dentist; it may be considered that to leave the burden of proof on the patient when a dentist should know that working with chapped hands could create a risk is not fair or just. Germany would then apply either a lightening of the burden of proof or a total reversal of it. This is a solution that would not necessarily be followed in the United Kingdom.

Perhaps the one area where German law is causally distinctive is with regard to the disclosable risks inherent in a given procedure. There is certainly, as we have seen, basic information that has to be provided; but even here it is subject to certain conditions. What we have in Germany is the situation that the doctor must inform the patient of even the minutest risk if its eventuation could have a serious effect on the patient's life: and the case law suggests how far a doctor should go in this regard. Even risks of one in 20,000 have had to be disclosed. A doctor would also do well then to record that he has done this. This area of risk also relates to hypothetical causation. The question arises would the patient have gone ahead with the procedure even if he knew about the risk. There is no loss of chance recovery permissible as in France. Again the law favours the patient here in that even if there has been a mistake in the treatment given or not, the law will hold a doctor liable for all injuries following from any damage.

I also considered the German Pharmaceutical Products Act 1976. Compensation can be obtained here if an injury generally exceeds an accepted tolerable limit resulting from a defect in production or administration of a drug.[725] Giesen and Stauch would appear to disagree on whether liability under the act is strict or not. Giesen says that it is[726] and Stauch that it is not strictly in that there is a cost-benefit analysis to be

[725] §84

[726] D GIESEN, *International Medical Malpractice Law*, 1124 (Tübingen, Mohr, 1988)

made first.[727] I would agree with Stauch in that it must first be ascertained what an acceptably tolerable limit is and this surely must be the result of epidemiological evidence to be presented in court.

Given Stauch has said that a plaintiff would more likely (in general) be successful in a claim in Germany than in England, I suggest, goes someway to establishing my argument that it is pointless to attempt to deduce causal generalities. To contrast with France, there is no loss of chance and a patient cannot generally recover for a "medical accident". As I shall mention in the comparative chapter, all jurisdictions are particularly different, especially when it comes to causal approaches, risk disclosure, criteria for liability with drugs and procedure. This necessarily affects how legal causation is understood and applied.

[727] M STAUCH, *The Law of Medical Negligence*, p145

Chapter 6: Comparative Chapter

6.1 Introduction

This paper has sought thusfar to introduce the reader to the essential elements of causation in medical responsibility in the United Kingdom, Germany, France and Luxembourg. The purpose of doing this is to show through research that there is no common idea of causation that can be gleaned from either case law or academic writing. Even in "easy cases" causation can be said to be an issue. I believe it is in analysing these cases from a functionalist comparative lawyer's viewpoint that I can come to the conclusion that there is no common concept of causation and this can be shown with regard to research done here in the medical sphere. I have attempted to show this through an analysis of academic writing and of case law in this regard. I considered in Chapter 1 causation as a philosophical and a logical concept; what we mean when we talk about legal causation and how that differs from other notions of causation, be it in science or in life more generally. I also considered ideas of conditions and common sense. I later developed in the same chapter certain essential causal approaches as equivalence theory, adequacy theory and purpose-of-the-rule violated theory. While some people might eschew discussing philosophy, logic or set theory in tort law, this is not my approach. I find it essential that to have a full understanding of a subject as vast as causation, a certain overview of these areas is crucial. It would have been remiss if I had discussed equivalence or adequacy theory without at least touching on the philosophy from which it comes. Further, in the area of logic, we have seen such problems as a disease following on from a certain act. "I had a vaccination for hepatitis B and then I developed multiple sclerosis" could be a logically accurate statement but it tells us absolutely nothing of causality. We need to know more about inter alia the time-reference. We need to know as much as we can while excluding conditions. Also, counterfactuals are the lifeblood of philosophical causal problems. They are not just annoyances irrelevant to the practice of tort in the courts. As I showed in the case of *Chester v Afshar*, courts embark on a philosophical counterfactual enquiry to establish what a patient would have done had she known of the risks. The courts in all of the jurisdictions may not frame it in this way but counterfactuals are the essence of the sine qua non theory. I also had to discuss probability and statistics as probability is central to adequacy theory Statistics are central to a court case where they can often form evidence for or against

the plaintiff. Statistics can also affect the burden of proof. I also made it clear in this Chapter that causation is not just a matter of agreeing on rules, principles or guidelines and then applying them. Procedure in each jurisdiction is also important. The standards of proof must be considered, as well as how courts deal with expert evidence. This shows that proving causation in the law is inherently entwined with local procedure. I then considered what I found the most important themes in medical causation in the United Kingdom, Germany and France in order to show how widely the systems differ in their methodologies.

In the United Kingdom chapter, as in all the chapters, I gave the briefest of overviews of the tort system in question. In the United Kingdom, there must be a causal link between the fault alleged and the damage caused to find liability. There is no codification in the United Kingdom and reference must be made to the common law. I then introduced the legal dichotomy of conditio sine qua non diluted for legal causation (*causa causans*). I also showed in some cases how legal policy could show causation. This was done in the most part by an exposé of case law showing how these ideas had developed. I presented also how procedure plays an important role in the United Kingdom which, has resulted in part, to the rejection of the loss of chance doctrine in medical tort cases. It is this "balance of probabilities" test which led me in this chapter in particular to consider the use of statistics in courts and how they play a part in establishing a causal link.

By considering Germany, my wish was to show its more philosophical approach to causation, at least in its foundation, and how it has influenced the other jurisdictions considered here. I examined how its basic approach was similar to the United Kingdom in that it used equivalence theory tempered with adequacy theory. From time to time, however, public policy would dominate. Yet it is in procedure perhaps that one notices the contrast with the United Kingdom. I then studied disclosure malpractice in Germany where the doctor has a heavy duty on him to show that even the smallest risks be disclosed. Recent legislation, in particular with regard to the Improvement of Patients' Rights Act 2013 (and its amendment of the BGB) was also considered.

With France and Luxembourg, I wanted to demonstrate how much more practical these two countries seem to be when tackling their cases on medical liability where cause is an issue. The last two countries do not seem to become tied up with the dogmatic pursuit of one particular road as opposed to another. Unlike the other two jurisdictions in question in this paper, France does not "start out" with equivalence or adequacy theory in principle. It has not as yet made a choice as to which one it prefers and I doubt the courts are in any hurry to choose. Indeed why should they? I also deduced through my research that France appears to be much more victim-friendly than perhaps Germany or the United Kingdom, in large measure no doubt, to its recognition of loss of chance in medical negligence cases. I considered loss of chance and this was also examined along side French procedural law. I then wrote about nosocomial infections and medical hazards, recovery for the latter being in particular a very French idea. I briefly looked also at the disclosure obligation incumbent upon a doctor in France. One disadvantage of French case law, however, was its brevity.

Even with a consideration of these four jurisdictions, what is interesting is that ideas of causation always change to suit the particular case. This is clear from the case law I have exposed. Therefore I wanted to be able to show that, at least within the framework of medical liability, due to the mercurial nature of causation, that it is impossible to derive any workable notions of causation that can be relied on again and again by those who seek to harmonise tort law in Europe in any meaningful way. As we have seen, problems in medical causation are often the same across the jurisdictions. This has resulted in one jurisdiction's allowing recovery in certain areas where another jurisdiction would not – loss of chance being the example that perhaps stands out the most. There are also questions of proof which divide the jurisdictions: perhaps most significantly we see in the United Kingdom that the plaintiff must prove his case on the balance of probabilities whereas in France and Luxembourg, there is a high level of proof in that the judge must intimately believe the plaintiff's case. In Germany, the standard of proof is also prima facie higher than in the United Kingdom.

My plan in this final chapter is as follows. I wish first to consider the essential similarities and differences among each of the jurisdictions that I have expounded

herein – the classic comparative lawyer approach. I do not wish to consider which is the "best" law but rather simply to arrive at an understanding of how the jurisdictions differ. From this accounting of differences, I wish then to show that there can be no common understanding of causation. I believe this should be a most stimulating task from an equivalence functionalist viewpoint. I shall do this in three stages focussing on France/United Kingdom, Germany/United Kingdom and then France/Germany.

Then, to underline my argument in this paper, I shall show that there can be no understanding of what factual causation or legal causation actually is. There can therefore be no one concept of causation. There is no need then to attempt to elucidate, clarify or define it as some do in draft projects of harmonisation of European tort law.

I shall then reflect on the PETL and the DCFR, and in particular their references to causation. I do this to show that given the decisions and academic writing that we have that it is impossible to extract any workable principles as far as causation is concerned that could be applied consistently. It follows therefore that the PETL and the DCFR as projects must change their present understanding of causation. If there cannot be any agreement on causation (as the approaches in the jurisdictions differ so widely) and causation is an inherent and central part of liability in tort law, then it is my contention that both these projects must change.

Whether we like it or not, however, it appears that causation in the law at a European level is here to stay. The ECJ has been asked to pronounce on non-contractual obligations. Causation is necessarily part of this. I must consider causation in this regard. I suggest how the ECJ might wish or might develop causation. What is different at the level of the TFEU, however, is that causation is nowhere defined. It is left to ECJ case law to interpret it. This is more realistic than attempting to define it in draft documents that purport to harmonise European tort law. I imagine, however, that the situations arising concerning medical causation at this level may be few and far between. It would be remiss of me, however, not to consider the application of causal notions in the highest court in Europe. As part of my consideration of European causation more generally, I shall consider the Product

Directive, the Environmental Liability Directive and how these ideas of cause might be implemented given our understanding of how courts in three major legal systems have come to interpret the idea.

6.2 France and the United Kingdom

6.2.1 Overview

Both France and the United Kingdom are essentially fault-based systems in tort. For the United Kingdom, finding causation is part of the deductive reasoning that any student follows when assessing whether there has been a breach of a duty of care (evidencing negligence) and whether damages should be awarded in any given case. In France, the notion of fault is based on the simple recitation of Article 1382 Civil Code stating that anyone who causes damage through his fault has an obligation to make it good.[728] No duty of care need be shown and it is not necessary that the damage need be reasonably foreseeable, although the latter is sometimes referred to. Khoury notes here that courts sometimes rely on the *prévision raisonnable des consequences* (reasonable foreseeability).[729] Damages are what have been caused as a direct consequence in France and there is much case law. In neither jurisdiction is the idea of causation defined.

As far as causation itself is concerned, there is an immediate difference as soon as we are confronted with the notion in both jurisdictions. Quézel-Ambrunaz notes

> Le droit français ne connaît pas formellement l'opposition entre la cause in fact et la cause in law…comme cela semble être le cas dans nombre d'autres systèmes juridiques.[730]

He is right. In the United Kingdom, a theoretical dichotomy is made between cause-in-fact and a cause-in-law. This is not to say that the French do not use the term conditio sine qua non; on the contrary, its academic writing is full of its use,[731] by contrast, however, systematic reasoning, as we like to think we have in the United Kingdom, is not followed. Sometimes I thought the French had cast off any attempt to discover the most dominant theory in their law in preference for pithy comments

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[728] as noted, the doctor / patient relationship in France is usually in contract. Causal notions, however, are often made to tort in French law even in this area.

[729] L KHOURY, *Uncertain Causation*, p28; G VINEY and P JOURDAIN, J GHESTIN (dir) *Traité de droit civil : Les conditions de la responsabilité*, (2nd edn, Paris, LGDJ, 1998), 346

[730] C QUEZEL-AMBRUNAZ in "Definition de la causalité en droit français" in *Le droit français de la responsabilité civile confronté aux projets européens d'harmonisation*, p355

[731] though I have not come across "cause légale" yet

that causation is a "redoubtable mystère"[732] or simply that it was "toujours irritante".[733] Some French authors, as Quézel-Ambrunaz notes, have even suggested that judges abstain from analysing causation, that causation be replaced by an idea of remoteness or that it be absorbed in the idea of damage.[734] We even see some similar ideas such as common sense and equity appear in both the French and common law traditions.[735] What I did not see in the common law tradition was any reference that causal problems could be solved by "feeling" or *sentiment*.[736]

6.2.2 Starting Points

I think it would be wrong to say that the starting points for any given causal problem in France and the United Kingdom are the same. There may well ultimately be a rejection of causal theories in France. That said all of them, with the exceptions of the *causa proxima* and the *Schutzzweck der Norm*, have been used in decision-making. In solving a causal problem, a court could rely on equivalence of conditions or the adequacy theory. France has used both and has relied also on counterfactual analyses. I noted that French writers and cases often referred to the following

> La cause est une condition qui était objectivement de nature à produire le type de dommage qui est survenu·.[737]

In British jurisprudence, I have seen no outright mention of adequate cause though I think notions such as reasonable foreseeability in damages come close to it (though perhaps not to the German understanding of adequacy). In France, as I mentioned, there is direct causation – where the plaintiff necessarily recovers – and then there is indirect causation – where the plaintiff will necessarily not recover. Adequate causation seeks to eliminate the mere circumstances of the damage and isolate its

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[732] G VINEY, *Le déclin de la responsabilité individuelle* (thèse, Paris, LGDL, 1965, n°2)

[733] G DURRY, obs sur CC 2 12 Dec 1968, *Revue trimestrielle de droit civil* 1969, p570

[734] C QUEZEL-AMBRUNAZ in "Definition de la causalité en droit français" in *Le Droit français de la responsabilité civile confronté aux projets européen d'harmonisation*, p345

[735] ibid

[736] ibid

[737] C QUEZEL-AMBRUNAZ, *Essai*, 80

immediate cause(s), namely those event(s) of a nature to have caused the damage in a normal state of affairs (*dans le cours habituel des choses*).[738]

6.2.3 Conditio sine qua non

Every law student in the United Kingdom is introduced to the case of *Barnett v Chelsea and Kensington Hospital*[739] when studying causation from first principles. It will be remembered that this case concerned a doctor who did not treat a man who had previously been poisoned by arsenic. He was doomed to die in any case. The doctor may have breached his duty of care towards his patient by not treating him but causation could not be shown and the plaintiff's claim was rejected. This is seen as one of the "easy" cases when introducing conditio sine qua non theory. Yet I am not certain it would have been decided the same way in France. France is more victim-friendly and I believe France might have considered the fault (breach of duty of care) and allowed causation for public policy reasons. I cannot be certain, of course. Similarly in *Bolitho*, I am not certain whether it would have been decided in the United Kingdom and in France in the same way. This was the case where a doctor had decided not to intubate a child and this was held to be acceptable as long as there was medical opinion to back this up. As Lord Browne-Wilkinson opined

In all cases the primary question is one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consists of an omission to do an act which ought to be done (eg the failure by a doctor to attend) that factual inquiry is by definition in the realms of hypothesis.[740]

He continued

> However in the present case the answer to the question "what would have happened?" is not determinative of the issue of causation.[741]

The defendants admitted that if the professional standard of care required any doctor who attended to intubate the plaintiff then his claim must succeed. Yet

[738] L KHOURY, *Uncertain Causation*, p27

[739] [1968] 2 WLR 422

[740] *Bolitho v City and Hackney Health Authority* [1997] UKHL 46; Bailli, p5/9

[741] ibid

Lord Browne-Wilkinson goes further in analysing why this is the case. He adopted the analysis of another judge. I have quoted it before but I quote it here for ease of reference

> '…a plaintiff can discharge the burden of proof on causation by satisfying the court *either* that the relevant person would in fact have taken the requisite action (although she would not have been at fault if she had not) *or* that the proper discharge of the relevant person's duty towards the plaintiff required that she take that action. The former alternative calls for no explanation since it is simply the factual proof of the causative effect of the original fault. The latter is slightly more sophisticated: it involves the factual situation that the original fault did not itself cause the injury but that this was because there would have been some further fault on the part of the defendants; the plaintiff proves his case by proving that his injuries would have been avoided if proper care had continued to be taken.'[742]

This is interesting for a number of reasons. First, we have the admission that a counterfactual analysis is not always determinative of the answer sine qua non – notably in the case of omissions. What kind of behaviour do we supplant? As Quézel-Ambrunaz notes

> La jurisprudence tend à toujours exiger que soit demontrée la violation d'une obligation[743]

and therefore some "legitimate alternative" would be sought in France.[744] So I suggest therefore that if there had been a breach of a similar obligation as there was here in *Bolitho*, and a French judge had two sets of experts' reports, then I suggest on balance, it would come down in favour of the plaintiff who had created the risk. Yet the problem here is exactly this: expert opinion differed. One expert said there was a duty to intubate, one that there was not. Again procedure is mixed with substantive law. In France, the scenario may not have arisen in that there would probably only have been one expert report and the judge would have followed this.

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[742] ibid

[743] C QUEZEL-AMBRUNAZ in "Definition de la causalité en droit français" in *Le Droit français de la responsabilité civile confronté aux projets européen d'harmonisation*, p363

[744] ibid

Yet I cannot say which experts' report. If there had been two experts' reports, one saying there was negligence and one saying there was not then it is unclear to me how France would have resolved this difficulty – probably in favour of the victim given that the doctor had created the risk, but I cannot be sure. Certainly the judge could not make any scientific pronouncements and he would have to take other societal values into account. It is a question of law and a judge cannot supplant his lay medical expertise, or at least, he would be courageous so to do. In the United Kingdom, the position is different. If there is one body of medical opinion which finds there to be no negligence then there will have been no negligence save as has now been modified in *Montgomery*. So even just by considering this case in detail shows how causation would be treated differently in this case.

So it is my assertion that even where we seem to have "easy" cases (*Barnett*) and a case where similar outcomes might be expected, I would be hesitant to rush to such a conclusion. How jurisdictions treat procedure, evidence and expert reports must be considered.

6.2.3.1 Difficulties in using the conditio sine qua non approach in France and the United Kingdom

Using the conditio sine qua non test itself alone can often result in unfairness. Alternatives to the sine qua non test have often become necessary when it has become clear that to leave the plaintiff with nothing would result in injustice. As we have seen in *Wardlaw* and *McGhee*, the ratios of "material contribution to the injury" and "material increase in the risk of injury" were introduced as it could not be shown that but for the defendants' negligence, the plaintiffs would not have suffered the injury that they did. In France, I am certain that the result, though perhaps not necessarily the reasoning would have been the same, ie recovery would have been allowed for the plaintiff. Cause-in-fact would be jettisoned perhaps for causal adequacy. With *McGhee*, perhaps a deeper analysis of probability would have been gone into before finding for the plaintiff. The idea of increase of risk or creation of a danger could also be used in France save that

> The conceptual objection to the effect that increase of risk is an element of fault, not causation, applies equally to…France…the notions of danger and risk are usually

> part of the assessment of the fault requirement have been of use to the courts mainly in the assessment of the objective potential of damage arising from an activity.[745]

That said, France did hold *Bouygues Telecom* liable on the basis of the precautionary principle though this was not a medical liability case.[746]

6.2.3.1.2 Different Agents

One example where French and British law could well differ, however, is in the area where there are different agents which contribute to or cause a loss. *Fairchild* established this doctrine.

With *Fairchild v Glenhaven Funeral Services*,[747] where the plaintiff had developed mesothelioma as a result of over-exposure to asbestos, it was not certain which of his employers was responsible. One of the judges[748]in this case even noted that France would provide a remedy but based on different legal principles. Citing van Gerven, Lever and Larouche's *Cases, Materials and Text on National, Supranational and International Tort law*[749]he noted that

> Furthermore, it must be noted that some French legal writers are advocating that French law moves away from *perte d'une chance* towards a reversal of the burden of proof on the basis of the negligent creation of risk.

I admit the solution would be the same here. I highlight simply how difficult the theory is to identify and this makes codification, in my opinion, without much value. The United Kingdom has had in the past its opportunities to introduce reversals of the burden of proof but has rejected them. The balance of probabilities requirement remains engrained in British civil law. Whether or not France would actually reverse the burden of proof, I am not certain. I have not seen this in case law. *Fairchild* is certainly the kind of case, if it came to be litigated in France, which might

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[745] L KHOURY, *Uncertain Causation*, p220

[746] see supra

[747] [2002] UKHL 22

[748] Lord Bingham

[749] [2002] UKHL 22, at para 24

well result in the raising of presumptions provided that they are *certaine*, *précises* and *concordantes*.

By contrast, if we remember the case of *Wilsher v Essex Health Authority*[750] where the defendant hospital inserted a catheter negligently into the heart instead of the aorta resulting in the provision of excess oxygen. There were, however, five other agents here which could have caused the retrolental fibroplasia (RLF) as suffered by the plaintiff. Oxygen was just one of them. Although Jourdain notes that

> Le droit français traite les situations de causalité multiple en envisageant chaque cause isolément. S'il apparaît que plusieurs faits peuvent se voir attribuer la qualité de cause juridique du dommage, tous seront considérés comme ayant cause l'intégralité de celui-ci, peu importe que ces faits soient concomitants ou successifs.[751]

No-one could say whether the excess oxygen did or did not cause or contribute to the RLF suffered by the plaintiff. It was not proven. It was admitted that this was a hard case but a right one. Yet in the United Kingdom there was interplay between what seemed to be burden of proof and causation. Lord Bridge expressed sympathy with victim and the fact that British system offered only an "all or nothing" recovery so we must remember that burden of proof is important in the United Kingdom. Again I am near certain that recovery would have been allowed for this case in France. Conditio sine qua non could not have been used as the counterfactual question would not make sense in this context. Causal adequacy may have been used. I think simply that France would have followed Jourdain perhaps not as quoted above but rather as there was no proof that oxygen caused the damage, it may have used its "creation of a danger" doctrine to establish causation. There was a fault and there was a creation of a danger.[752] French law would focus on fault, moving the balance towards probable causation. This could also be combined with negligently created causal uncertainty. This is not a stand-alone doctrine in causation in medical law but rather could be adjoined to a useable causal theory. As Khoury notes

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[750] [1988] AC 1074

[751] P JOURDAIN, "La causalité" http://grerca.univrennes1.fr/digitalAssets/288/288515_pjourdain2.pdf at 7

[752] L KHOURY, *Uncertain Causation*, p219

> In France, the doctrine has argued that the law should take into account the inequalities of the parties *vis-à-vis* the evidence and the fact that one party has the best ability to adduce evidence. But the French writings also make no claim that this factor should be an autonomous and sufficient criterion.[753]

So then, another area where there would be causal divergence is this sub-category of conditio sine qua non theory where there are different agents causing the damage. I suggest France would be more victim-friendly by, for example, allowing recovery in cases like *Wilsher*, where the United Kingdom did not, although there was one dissenting judge in this case at the Court of Appeal.[754] He argued that if tortious behaviour adds materially to the creation of a risk then the defendant is assumed to have caused the injury even though the existence and the contribution of the breach of duty cannot be determined.[755]

6.2.4 Loss of Chance

As noted by Lord Bingham above in *Fairchild*, the United Kingdom does not allow recovery for loss of chance in medical negligence whereas France does.[756] French courts have tried to be careful to award this as a separate head of damages when there are serious, precise and concordant presumptions that show the fault is directly related to the damage.[757] However, if loss of chance is to be recognised as a separate head of damage, then an equation involving the full damages is not necessarily appropriate.[758] Yet as noted above, courts do not believe that they are partially compensating the plaintiff's damage.[759]

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[753] L KHOURY, *Uncertain Causation*, p221

[754] Mustill CJ

[755] [1986] 3 All ER 801 at 829

[756] British courts have allowed loss of chance in cases not involving medical negligence, see *Allied Maples Group v Simmons and Simmons* [1995] 1 WLR 1602

[757] CC 14 Dec 1965, Bull n°541, para 707; also cited by L KHOURY, *Uncertain Causation*, p110

[758] see the supra and the equation used for calculating loss of chance

[759] L KHOURY, *Uncertain Causation*, p111

Since 1965, French courts have been ready to award damages for loss of chance.[760] In this case, analogous to *Hotson*, the Cour de cassation found that there were serious, précises and concordant presumptions that linked the boy's damage to the defendant's fault. It also held that the defendant had caused the boy a loss of chance for recovery. The court valued this and awarded the plaintiff damages.

The French case already referred to of 17 November 1982, I think can be compared readily with *Wilsher*.[761] If we remember in *Wilsher*, there were five possible causes that could have resulted in the child's RLF but it was never proven whether in fact oxygen could actually have caused the RLF. Similarly in the French case, the air in the blood could have been caused either by air in the syringe or air already existing in the sinus. The Cour de cassation overturned the Cour d'appel by denying compensation for the plaintiff on the basis of lost chance of avoiding the embolism stating that lost chance could only be used to assess damages. As Khoury concludes by saying, loss of chance cannot be used when there are alternative causes of the damage. Yet notwithstanding this French courts still make use of loss of chance even where there is doubt between the fault and the final damage.[762]

Another further case where I think we can see a different approach and outcome would be in that of *Gregg v Scott*.[763] Here we saw recovery being denied when the plaintiff who visited his doctor complaining about a lump was told it was nothing to worry about. After nine months, the lump was still there and eventually he was referred to a specialist. Statistics showed that out of 100 people, 17 could be cured if they had had prompt treatment but not if treatment was delayed for one year; 25 people would be cured if delayed by one year and 58 people would not be cured at all. The claimant argued that he had originally had a 42% chance of recovery (adding the 17 and the 25 together) and that by delaying his treatment the first doctor had caused him to lose a chance. The House of Lords held that this could not form the basis of a claim in medical negligence. In France, however, there is no notion of

[760] CC 1 14 December 1965, JCP 1966.G.II.14753

[761] CC 1 17 Nov 1982, Bull n° 333; JCP 1983.II.20056

[762] L KHOURY, *Uncertain Causation*, p112-3

[763] [2005] UKHL 2

balance of probabilities. Recovery, I am near certain, would have been allowed. The courts there would have not sent a claimant away without a remedy in what would otherwise be such a hard case. They would have allowed loss of chance.

So again, I believe that such great differences with regard to approach and solution do exist. I do not believe they can be glossed over by saying that in essence the result is the same. We see in the "easy" and the "hard" cases that — the result would probably not be the same. This differing approach in the area of loss of chance I believe strengthens my case to show that the gleaning of common principles in medical causation is a fruitless task.

6.2.5 Burden of Proof

In both jurisdictions, there is a standard of proof to be met by the claimant. In the United Kingdom, this is on the balance of probabilities. In France it is the *intime conviction* of the judge. The former is traditionally described and understood as the judge's accepting one version of events as more likely than another version of events. This is not calculated mathematically but based on preponderance of evidence. If we use quantitative probability within 0 and 1, then for the plaintiff to win her case, she would have to prove it to a value of 0.51. There are also evidential rules in the United Kingdom. In contrast, in France, as Taruffo notes

> The principle of *intime conviction*…[does] not by [itself] entail the adoption of any specific standard of proof, let alone the standard of proof beyond reasonable doubt.[764]

He writes that this standard also has a negative aspect in that there is no application of legal proof. To give us an idea of what "intimate" actually means, he goes on

> Roughly speaking, it does not matter whether the judge has especially strong rational and evidentiary bases (in terms of probability) to believe what she believes. Her deep individual conviction has to be well-rooted in her feelings, in order to produce a "moral certainty" or *prevue morale* about the facts of the case. This does not mean

[764] M TARUFFO, "Rethinking the Standards of Proof", (Summer 2003) 51 *The American Journal of Comparative Law*, 666

> reliance upon a clear standard of proof: it means to rely just upon the personal conscience of the judge.[765]

Khoury says that in practice, a very high probability will suffice.[766] There is no law of evidence in France as such and unfortunately a detailed appreciation of epidemiological reports and statistical evidence is lacking compared to those decisions in the United Kingdom. French decisions are much shorter compared to the minutiae considered by the British justiciary. Taruffo's description above is perhaps to be expected, however, from a system that does not place too much reliance on precedent.

Another contrast between the two systems is that there is less room afforded to the plaintiff in the British system for the burden of proof to change. So, for example, while in the French system the plaintiff must prove fault, causation and harm, the burden of proof can shift to the defendant on causation, where for example, the defendant was responsible generally as a *gardien de la chose* or in medical liability, where defective equipment was involved in the tort.[767] Causal presumptions will also be raised in France when the evidence is certain, precise and concordant. Although in the United Kingdom, there is not as much doctrine on the subject of presumptions, it is typical of British courts to refer to this as rather a "robust, common sense approach" rather than necessarily referring to presumptions. Lord Toulson LJ held in *Drake v Harbour* that

> …when a man who has not previously suffered from a disease contracts that diseases after being subjected to conditions likely to cause it, and when he shows that it starts in a way typical of disease caused by such conditions, he establishes a prima facie presumption that his disease was caused by those conditions…That presumption could be displaced in many ways. The respondents sought to show, first, that it is negative by the subsequent course of the disease and, secondly, by suggesting

[765] ibid, p667

[766] L KHOURY, *Uncertain Causation*, p38

[767] KM CLERMONT and E SHERWIN, "A Comparative View of the Standards of Proof", (Spring 2002) 50 *The American Journal of Comparative Law* 249

[another condition] as an equally probable cause of its origins.[768]

Presumptions then are much like the doctrine of *res ipsa loquitur* . I am rather fond of Lord Denning's language when he says "While I was in your hands something has been done to me which has wrecked my life. Please explain how it came to pass…"[769] Yet I would not argue that this shows the similarity of the French and the British systems. Where the doctrine of "British presumption" or *res* might apply is where a patient enters a hospital to have the left leg amputated and exits with the right leg amputated – this would be something which has "wrecked the patient's life". Yet I submit British courts would shy away from the use of a presumption for (say) nosocomial infections and the burden of proof remains firmly on the plaintiff to show the hospital's negligence by not conforming to certain standards.

In addition to the standard of proof level in itself, I have also cited a case where, I submit, the outcome would not necessarily have been the same because it was based on a judge's acceptance of one expert witness's report as opposed to another.[770] The principle in France is one expert's report suffices though two are possible.[771] Certainly more than one expert's report could be demanded in France[772] but then the judge would have to choose one over the other and how would he do this? Penneau is right to warn a judge not to supplant "...sa pseudo-connaissance livresque".[773] I suggest later that only a cross-examination of reports and witnesses can focus minds. It is therefore my contention that procedural law here could result in a different outcome for a plaintiff in France.

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[768] (2008) EWCA Civ 25 at 27 and 28; also cited at J POWERS, N HARRIS and A BARTON, *Clinical Negligence*, para 25.10

[769] *Roe v Minister of Health* (1954) 2 All ER 131 at para 83

[770] *Wilsher*; French Code of Civil Procedure, article 264: "Only one person will be appointed as an expert, unless the judge deems it proper to appoint more than one expert."

[771] ibid

[772] ibid

[773] see supra, J PENNEAU, *Faute et erreur* 99

6.2.6 Conclusion

It can be seen then that many of the causal problems in medical causation that are found in France are found also in the United Kingdom. I submit, however, that France does take a particularly victim-friendly attitude to resolving causal quandaries especially when their approach is compared to the United Kingdom. This can most particularly be seen with the use of loss of chance where there is only one potential cause of damage. Here the court is simply allowing a head of damages that is just not recognised as yet in the other jurisdictions. It is not a get-out or a fiction to help the victim but a discrete and definite head of damages. What is more is that a causal link must still be proven between the loss of chance and the final fault. Khoury supports Viney and Jourdain's theory that it might be more appropriate to allow for presumptions of causation when there has been fault and this is a matter that might be developed in France in the future.

I have tried to highlight above some of the important differences between the British approach to causation and the French approach. I have attempted to show how some of the cases in Britain would probably be decided differently in France and vice-versa. What is important here, from a functionalist point of view, are not only the methods adopted by the two jurisdictions, but also the final result.

At first sight, the methodologies of both jurisdictions might lead one to suspect that outcomes would differ. The initial approach to causation diverges somewhat. In France, philosophy, especially German, has influenced doctrine and how causation should be tackled. There, problems are usually confronted using one of either the equivalence theory or the adequacy theory. Writers differ as to which one is the more used. In the United Kingdom, there is the conditio sine qua non tempered with policy: the factual causation and legal causation dichotomy. Adequacy theory so-called has not been received in the United Kingdom. Yet, although at times, France and the United Kingdom may reach the same result on the same facts, there exist deep chasms between the two jurisdictions' approaches as I have shown in this comparative section which takes from the research in the main body of this paper. Perhaps most significantly, the United Kingdom does not accept loss of chance in medical causation. This would lead to different result in highly significant cases like *Wilsher* and *Gregg*. There is also no special recovery allowed in the United Kingdom

for medical hazards (*aléas thérapeutiques*): a patient must take his chances. Policy in the United Kingdom is different in this regard. There is also no private / public hospital dichotomy as such in the United Kingdom. When courts are faced with hard cases, resort will often be had to "policy" or "common sense" and as I hope to show, I do not believe that common sense exists for causation in medical negligence. Such ideas must depend on the particular preferences of the judge or judges in question.

Procedure also differs. On the one hand, we have one jurisdiction that requires proof to the balance of probabilities and on the other, we have a jurisdiction that requires an *intime conviction* of the judge. We have seen above that this can depend on the "personal conscience" of the judge and be subject to a very high degree of probability. On the point of causal presumptions, I think France does a great service to victims when allowing these. It does not simply allow them to prefer victims to defendants but it is suggested because this France has decided where the risk should fall. In cases of blood transfusions, for example, it would be extremely difficult for a plaintiff to prove (absent these presumptions) that his contamination came from one of the blood samples. Defendants are in a better position to examine and trace the samples and contact the donors if necessary. This should encourage better record keeping and administration within such institutions. The institutions also can advance facts about the plaintiff's lifestyle such that he is a drug-taker, is at risk from HIV or underwent acupuncture. So the defendant rightly can suggest that the infection need not necessarily have come from their blood samples. As we have seen, however, one of these risk factors is not sufficient. Temporal considerations are also important. Similarly, in cases of nosocomial infections, the plaintiff has a great advantage that a plaintiff in the United Kingdom would not have. This is part of the justification of policy.

I have also shown how cases on causation might be decided differently because of procedural rules. There is generally one witness's report in France whereas in the United Kingdom there are usually at least two. There is not, in France, the cut-and-thrust of examination-in-chief, cross-examination and re-examination, which would allow plaintiff and defendant to test each other's reports. If science conflicts in the United Kingdom then it is now for the judge to choose the report he prefers

but his reasoning should be set out. In French courts, it may not even be known if there is a scientific conflict on the subject if only one expert is chosen.

As we have seen, France's use of *obligation de résultat* and *de moyens* also plays an important role in establishing causation. This is of particular note in the area of nosocomial infections as defined. Here where a patient enters a hospital there is an accessory *obligation de securité* on the doctors to ensure that he succumbs to no extraneous or exogenous infection. This is also protected under legislation, the CPS. No similar *obligation de securité* exists in the United Kingdom and there is no specific legislation protecting patients from nosocomial infections.

As mentioned, there is protection from medical hazards or *aléa thérapeutique* at *droit commun* and also in the CSP if a particular degree of incapacity is met. If this degree of incapacity is not met, then *droit commun* applies and we have a public / private dichotomy.

As can be seen then from certain uses of burden of proof and procedure, be they *obligations de résultat*, *moyens* or for allowing certain presumptions, France does favour the victim when there is causal uncertainty in cases of medical negligence. This can be seen clearly from the cases cited and from my suggestion of the outcome of inter alia *Wilsher* in this chapter. The difference with the United Kingdom is that France might have gone too far in allowing recovery for the eventuation of risks that we must expect as human beings. Clean hospitals can be encouraged in other ways and not necessarily by allowing plaintiffs to sue. The solidarity fund is a policy decision. Causation has been supplanted in statute by *imputabilité* and it is suggested recovery is made easier in such cases.

So given these significant differences between France and the United Kingdom in the area of medical causation, loss of chance in particular, medical hazards and other special systems for recovery, I submit that no common thread of causation exists between these two jurisdictions. Consequently, if there is no commonality, then there can be no purpose in trying to set out a framework in tort for causation that could be used Europe-wide, in particular with the PETL or the DCFR.

6.3 Germany and the United Kingdom

6.3.1 Overview

Tort law exists in Germany just as it does in the United Kingdom and in France. Causation between the damage and the fault is similarly required to show liability. I have described the basics of tort law in Germany and the United Kingdom in the body of this paper above. In German law, in contrast to the English and Scots law of tort and delict respectively, there are certain subjective rights that are protected. These are set out in delict at §823 BGB. Strictly the relationship between a doctor and his patient is governed by contract, however, notions of causation are readily taken from delict. Further, damages are now allowed for non-pecuniary loss in medical negligence for breach of contract. Although not recognised in a code in the United Kingdom, these same invasions to the person are also recognised in British law[774]as have been developed under the common law.

However, to consider this only and deduce an unreal commonality would be hasty. It is impossible to consider only this without an appreciation for procedure. Burdens of proof in both jurisdictions are appreciably different. There are numerous ways in Germany for attenuating the high standard of proof for a plaintiff, it is true, which are not found in the United Kingdom. These range from *Anscheinbewewis* to a full reversal of the burden of proof. Procedure is inseparably linked with causation.

6.3.2 Starting Points

At first glance then, it would seem that Germany and the United Kingdom have more in common with one another at the outset as far as causation is concerned than would say Germany or the United Kingdom when compared to France. This perhaps as there is a theoretical division between causation-in-fact and then causation-in-law. Germany, being quite logical in its approach, insists that a cause-in-fact test is used to attribute the harm to the wrongful act using *hinwegdenken* in the first instance tempered with adequacy theory. In the United Kingdom, as I have suggested, I think these matters just become quite confused and everything is piled onto a muddled legal heap and called "causation" as and when it suits but perhaps to a lesser extent than in France. In Germany, whether the conduct was indeed one of

[774] and even between Scotland and England there are differences in tort law though these need not detain us here.

the necessary conditions at work is perceived, apparently, as a neutral issue of fact.[775] The answer is either yes or no. I do not think such neutrality exists. In *The German Law of Torts*, Markesinis and Unberath, I think, sets out the problematic for comparisist.[776] In some textbooks, remoteness of damage is treated as part of the duty of care, in others it is treated as part of causation, in others as part of reasonable foreseeability. I think that all these ideas run into each other and

> The comparisist will have to learn to jump over these artificial hurdles of classification and, in so doing, reflect once again on how policy and not concepts or theories determine the ultimate result.[777] [

Again this is a problem of classification. How jurisdictions categorise their problems is important as we can then see how they analyse aspects that might limit damages. Causation (not "factual"), remoteness of damages, duty of care are all ideas that do this and yet they can all be put in the Venn diagram of "legal causation".

I find that the process of causal analysis at this stage is essentially the same prima facie in both the United Kingdom and in Germany. The process of *hinwegdenken* is found also in the United Kingdom (though not so called) and can be assimilated to the conditio sine qua non thought-process. It is in the second stage of the process where approaches differ. In the United Kingdom, reference is often made to the legal cause or the *causa causans*, which is generally understood to have more implications with policy. Other factors such as the protective purpose of the rule violated, fairness and reasonableness, and proximity are also to be found in English case law.[778] I appreciate Spier and Haazen's comment when they write with regard to England that

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[775] M STAUCH, *The Law of Medical Negligence*, p47

[776] B MARKESINIS and H UNBERATH, *The German Law of Torts*, p113

[777] ibid

[778] As per J SPIER and O HAAZEN's comparative conclusions on causation from J SPEIR (ed) *Unification of Tort law: Causation*, p31

> …this multi-factor approach bears considerable resemblance to that of the theory of adequacy, as well as the openly flexible approach of reasonable imputation chosen for these principles of causation.[779]

Adequacy, which is in my opinion, wholly connected with probability in the second-stage test of German causal theory, is essential in any German causal enquiry. Spier and Haazen expand on the notion of adequacy in the below quote which is more German in its interpretation. There is no causation only if the plaintiff's act results in a very unexpected, unforeseeable consequence that nobody ever had to reason to deal with before. As Spier and Haazen cite

> The observer knows, for example, that a vaccination damage can happen even if the statistical probability lies under 0.01 per cent. Only very rarely does he not foresee that damage could occur.[780]

This is quite a different approach from that in the United Kingdom. An optimal observer in German law knows (nearly) everything and such a standard would not be placed on a British doctor. In Germany, it would be virtually impossible for a doctor to escape liability. Even in cases where statistics are used, following the case of *McTear*, courts insist on having the subject – in this case epidemiology – literally "taught" to them. The plaintiff's lawyers must explain epidemiology and all its relative reports, formulae and statistics to judges. I am not surprised it is not within judicial knowledge! Again, to highlight the dissimilarity between the United Kingdom and Germany, the burden of proof in the United Kingdom is never reversed. If a doctor has caused a patient to lose 42% chance of survival by mis-diagnosis, this patient must still prove negligence. First, it is essential that the "chance" or the "probability" be 51% or more **and** that the statistics, I submit, can be applied to the plaintiff in a particular, individual and meaningful way. Loss of chance would be closed to a plaintiff in both jurisdictions in such a case. If, however, it can be proved that the physician made a "gross treatment error" then in Germany, the burden of proof could be reversed. This is where, for example, a German *Gregg v Scott* plaintiff could potentially recover whereas in the United Kingdom, he did not.

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[779] ibid

[780] ibid

Another area where causation is important is where the victim has acted in a particular way. In Germany, unwanted children following a failed sterilisation are not seen as a "blessing" as they are in the United Kingdom. Essentially then in Germany , failed sterilisations do cause unwanted children legally and the United Kingdom they do not. Here is a difference. No-one is right. It is just societal mores.[781]

What is "unreasonable" or not in Germany and in the United Kingdom intertwines with policy considerations. It can be difficult to pull them apart – even if one wanted to. Policy considerations are a recognised "third step" of causation in Germany. In the United Kingdom, policy considerations are more like part of causation – they sit parallel perhaps with conditio sine qua non and *causa causans*.[782] In Germany, this, as we have seen, has been expressed as the "protective purpose" of the rule so that Germany also has an effectively flexible approach where account can be taken of foreseeability, proximity, adequacy, policy and the protective purpose.[783] I refer again to the above "kidney" case where the mother was able to recover for her economic loss and suffering. Britain too, I suggest, has quite openly used policy to allow plaintiffs to recover where a doctor has been at fault as, where not allowing them to do so, would be unjust.[784]

So then it can be seen that the starting points of causation in both countries are quite similar. There are legal principles of causation which are applied and then these are diluted when the result would be unfair. However, it is also notable that in Germany, there is a greater onus on doctors to show that they have disclosed certain risks that need not be disclosed in the United Kingdom. If a doctor does not do this (and the burden of proof is on him to show that he has) then it could lead to a finding of battery against him. I refer again to the statistics with regard to the risks inherent in vaccination procedures. As I already mentioned above, to

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[781] see supra BGH NJW 2000, 1782; BGH NJW 1980, 1450 and *MacFarlane v Tayside Health Board (Scotland)* [1999] UKHL 50

[782] *Chester v Afshar* (2004) UKHL 41

[783] J SPIER and O HAAZEN, *Unification of Tort Law: Causation*, p134

[784] *Chester v Afshar* [2004] UKHL 41

consider this without an examination of how this works in practice by way of procedure would be remiss.

6.3.3 Procedure

In Germany, the burden of proof is without any subjective or "intimate" standard in theory. The court has the freedom to evaluate proofs.[785] The court has to be "freely convinced" of a particular matter before it takes it as true or not. This truth that is required has been defined as a "high probability".[786] These comparisons are important as they can show how, in theory at least, a plaintiff might have a harder time proving a case in Germany than in the United Kingdom. It would seem then that it is correct that the standard of proof in Germany can be quite exacting for a plaintiff at times. There are, however, as we have seen, a number of relaxations of proof in Germany that can come to the aid of a victim in Germany.

Haftungsbegründende causation is subject to the higher standard of proof than *haftungsausfüllende* causation which can be proven using §287 ZPO on the basis of the "balance of probabilities".[787] We have seen already the case law here with regard to a case in 1962.[788] As a reminder, a patient here suffered an allergic reaction when she applied skin cream that was negligently prescribed. She then contracted a bone marrow disorder, which resulted in her death. The court found that causation between the application of the skin cream and the bone marrow disorder was a "secondary harm" which fell to be proved according to the lower standard of proof. So in Germany, even in the same civil case, the burdens of proof can vary. In the United Kingdom, the same burden of proof applies throughout the case.

As I mentioned above, there are a number of proof relaxations in Germany that can come to a patient's aid. I have already considered *Anscheinbeweis*. It is not a reversal of proof but rather something untoward has occurred. Something has happened that does not usually happen in the normal course of events. It calls for explanation. This

[785] §286 ZPO, see supra; M TARUFFO "Rethinking the Standards of Proof", (Summer 2003) 51 *The American Journal of Comparative Law* 659 at 667.

[786] ibid, "hohe Wahrscheinlichkeit"

[787] M STAUCH, *The Law of Medical Negligence*, p84

[788] BGH VersR 1963, 67

is similar to *res ipsa loquitur* in the United Kingdom. It is like a presumption of causation for both jurisdictions. So in this respect, we can see a similarity in procedure with regard to the changing of the evidential burden of proof if these devices are taken in isolation.

Another area where the burden of proof is inescapably linked to causation is the law with regard to gross malpractice (*grobe Behandlungsfehler*). This is now codified in the Improvement of Patients' Rights Act 2013.[789] Where there has been gross malpractice then there is a presumption that this has caused the patient's injury. This helps the patient enormously as far as causal difficulties are concerned. Perhaps if loss of chance were brought in, then I imagine, plaintiffs who now recover 100% taking advantage of this reversal of the burden of proof would then only be able to claim a percentage thereof.

In the United Kingdom, the burden of proof in all civil cases remains the balance of probabilities. The plaintiff must convince the decision-maker that his story is more likely than the defendant's. If a plaintiff can convince a judge that his story is 51% likely, then he must win. There exist few tactical devices in British law for shifting the burden of proof. Even if there has been what might be determined as "gross" negligence in Europe, it is still for the plaintiff to prove causation from that act of gross negligence to the damage. It can be seen then that compared to the United Kingdom then, one would expect fewer cases to be successful in Germany given the quite high level of proof in Germany. I have shown, however, that this is not always the case. There is a "secondary harm" level of proof. There is *Anscheinbeweis* and there is reversal of the burden of proof totally. Only one of these I would suggest has a parallel in the United Kingdom, namely *Anscheinbeweis*. My conclusion here is that the burden of proof is higher in Germany and this must necessarily affect results in cases where causation is in issue.

As far as expert witnesses are concerned, the European inquisitorial approach is followed. It is the court which selects the experts to be appointed.[790] It is, of

[789] §630h (5) BGB

[790] §404 ZPO: **Section 404 Selection of the expert** (1) The court hearing the case shall select the experts to be involved and shall determine their number. It may limit itself to appointing a

course, up to the court to appoint more than one but it is the court (ie the judge(s)) that shall determine his mission.[791] Lawyers do have a right to question witnesses but this is generally perfunctory. Objections to questions can be made by the opposing lawyer.[792] There is no cut-and-thrust of common law cross-examination.

6.3.4 Comparative Conclusion

This comparison of English / German law has set out the fundamental differences of methodology and approach when courts in respective jurisdictions are faced with similar problems of medical causation. The principles used in German law are those set out in §823 BGB are delictual notwithstanding the contractual nature of the physician / patient relationship.

Even if we could say that the starting points of both jurisdictions are quite similar theoretically, I think it must be admitted that in practice, results could differ quite significantly. In Britain, the "but for" test exists at the first stage. In Germany, it is called the equivalence theory. In Germany, even equivalence theory is divided into two, each having a different standard of proof. In Britain the courts then look to legal causation as a limitation. In Germany, there is adequacy theory based on probability and with observers who are deemed omniscient but it acts as a filter to

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single expert. It may appoint other experts to take the stead of the expert first appointed; (2) Should experts have been publicly appointed for certain types of reports, other persons shall be selected only if particular circumstances so require; (3) The court may ask the parties to the dispute to designate persons who are suited to be examined as experts; (4) Should the parties to the dispute agree on certain persons to be appointed as experts, the court is to comply with what they have agreed; however, the court may limit the selection made by the parties to a certain number.

[791] §404a(1) ZPO: **Section 404a Directions by the court as regards the expert's activities** (1) The court is to direct the expert in terms of his activities and may issue instructions as concerns their nature and scope; (2) Insofar as the special aspects of the case require, the court is to hear the expert prior to wording the question regarding which evidence is to be taken; it is to familiarise the expert with his tasks; and is to explain to the expert the task it has allocated to him should he so request; (3) Where the facts of a case are at issue, the court shall determine the facts on which the expert is to base his report; (4) To the extent required, the court shall determine the scope in which the expert shall be authorised to elucidate the question regarding which evidence is to be taken, and it shall also determine whether or not he may contact the parties, and at which point he is to permit them to participate in his investigations; (5) Any instructions given to the expert shall be communicated to the parties. If a separate hearing is held at which the expert is familiarised with his tasks, the parties are to be allowed to attend.

[792] N FOSTER and S SULE, *German Legal System and Laws* (2003, Oxford, Oxford University Press), p132

adequacy. Even then, if the courts are still presented with a result that insults justice and fairness, both jurisdictions have devices that enable (or should enable) the court to reach a reasoned result, in as much as policy can be reasoned. For example, if a doctor was negligent (or even grossly negligent in Germany) by not attending on a patient, and that doctor can show that the patient would have died anyway because a poison had been added to his cup of tea, then the defendant doctor I submit may not be able to escape liability as easily as he would do in the United Kingdom.[793] There is a presumption now under the Improvement of Patients' Rights Act 2013 that this gross negligence had caused the patient's death.[794] It was admitted in this British case that the doctor was negligent in sending the patient away in the first instance. He would have to show that the poisoning would have caused his death anyway, which of course, he may well be able to provided the misdiagnosis could be regarded as grossly negligent. Germany may invoke policy in this case to obtain a satisfactory result but then again, so may the United Kingdom if the case were to come before a court there now. I submit that *Gregg v Scott* could have been decided otherwise in Germany. I suggest that the a mis-diagnosis resulting in the loss of a 42% chance would be seen as grossly negligent. In Germany therefore, it would be the defendant who would have to trouble himself with interpreting the court's expert report that the plaintiff would have fallen into that category of people who would die notwithstanding the mis-diagnosis. Another completely contrasting decision we have seen is that of a child born as a result of a failed sterilisation. In Germany, it is not seen as a "blessing" (recovery allowed) and in the United Kingdom, it is (recovery disallowed). Policy is making causation with two totally differing results.[795]

The Improvement of Patients' Rights Act 2013 has codified much in the BGB now with regard to where the burden of proof lies in the event of a treatment error. I would suggest it is helpful but it certainly does not mean that solutions would be the same in both countries. First, we see that where treatment was "fully manageable" (*voll beherrschbar*) for the doctor then an error is presumed to be committed by him if a

[793] see *Barnett v Chelsea and Kensington Hospital* [1968] 1 All ER 1068

[794] §630h (5) BGB

[795] NJW 1980, 1450 and *MacFarlane v Tayside Health Board (Scotland)* [1999] UKHL 50

risk has eventuated which caused the patient damage.[796] This is the kind of injury that occurs not because of the medical treatment itself but rather because of the treatment environment.[797] This is almost approaching a kind of strict liability. Nothing of the sort exists in the United Kingdom and the burden of proof remains always on the patient to show that the hospital or physician breached his duty of care with regard to the treatment environment. This does not exclude a plea of *res ipsa loquitur* but nonetheless, the burden of proof always remains with the plaintiff.

Similarly, even where "gross" negligence[798] has been committed in the United Kingdom, there will be no reversal of the burden of proof. This, again, is in contrast to the situation in Germany. In Germany if there has been gross malpractice (*grober Behandlungsfehler*) causing damage to the patient then this is presumed to be the cause of the injury.[799] Similarly where a doctor omits to take or record a finding where the finding would have with sufficient certainty have led to a result which would have given rise to further measures and the failure to carry out such measures constitutes gross negligence then there is the presumption that the malpractice also caused the injury.[800] If the doctor cannot rebut the presumption then it becomes a case of misdiagnosis mixed with questions of hypothetical causation as to what the test would have revealed and what the doctor would have done.[801] Again the United Kingdom knows of no such possibility to reverse the burden of proof.

With regard to medical records, there is a presumption of causation in Germany that if it is not recorded, then it has not been carried out.[802] Contrast that with the United Kingdom where there is no such presumption and the doctor will probably go into the witness stand and speak to procedure carried out. In this regard, he can refer to

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[796] §630h(1) BGB

[797] for example, the provision of a defective oxygen machine

[798] however that can be imagined in the United Kingdom as the United Kingdom has tended to shy away from differentiating between negligence and gross negligence, see *Wilson v Brett* (1843) 11 M&W 113

[799] §630h(5) BGB

[800] §630h (5) BGB

[801] M STAUCH, *The Law of Medical Negligence*, p69

[802] §630h (3) BGB

his usual procedure and the courts will reach a conclusion. It may be thought that this amounts to the same thing. I suggest not. A court will consider the doctor's creditability, his comportment in the witness stand and whether his evidence is corroborated and by whom. It will depend on the case. There is no codified procedural measure in the United Kingdom to help the victim.

Ensuring that a patient has sufficient information on which to base her decision on whether or not to progress with a medical intervention is of crucial importance in a causal inquiry. As I have pointed out, if this consent is vitiated, then the treatment is unlawful.[803]

There is now a doctrine of "informed consent" in the United Kingdom following the decision of *Montgomery v Lanarkshire Health Board*.[804] The patient's consent can no longer be trumped by a responsible body of medical opinion. However, a court is unlikely just to believe any story advanced by the plaintiff that even if she had been told of all the risks then she would not have gone ahead with the procedure. Similar to Germany, I think a court would be wary of a patient manipulating her evidence in order to recover damages, especially where there was no other alternative or where the intervention was urgent. Even where the patient does not know what she would have done, recovery can still be allowed in the United Kingdom.[805] This is policy trumping causation *sensu stricto*. Following *Montgomery v Lanarkshire Health Board,*[806] however, patients must now be informed of all material risks and any reasonable alternative or variant treatments which are available.[807] Importantly, it was held that materiality of risk "cannot be reduced to percentages"; that a doctor should always engage in dialogue to "make an informed decision"; and finally that the therapeutic exception should not be abused.[808] In Germany, courts are looking for a doctor to explain in "general terms" (*im Großen und Ganzen*) each particular risk in a given

[803] having potentially criminal implications for the physician in Germany

[804] [2015] UKSC 11

[805] *Chester v Afshar* [2004] UKHL 41

[806] [2015] UKSC 11

[807] ibid, Lords Kerr and Reed at para 87

[808] ibid, at paras 89-91

treatment but he need not go so far if he thought this might confuse the patient. A patient can, of course, ask for more details where necessary. Under the Improvement of Patients' Rights Act 2013, the patient must be advised of inter alia risks, necessity, urgency and suitability of the measure. Alternatives to the measure must also be suggested to the patient where this is appropriate.[809] It is for the doctor in Germany to prove that the patient consented.[810] If, however, it is shown that the information provided to the patient was not adequate, then all is not lost for the physician. If he can prove that the patient would have consented to the measure had proper information been provided then he will not be found liable.[811] Of course, this raises the question of how German courts would treat a situation where a patient says she does not know what she would do but that she would take further advice and think about it.[812] This was a hard case in England where the Law Lords were divided 3:2. Perhaps in Germany they might use a *Schutzzweck* protection to allow recovery on the same basis as recovery was allowed in the United Kingdom. German courts have decided that only a hesitation need be shown yet this is not what has been codified and Germany does not have stare decisis. In *Chester*, there was no "hesitation" as such. In my opinion, the German courts would probably find for a patient who had not been informed properly and in accordance with the 2013 Act even if a precise counterfactual could not be established. I think this not just from how the courts have developed their law in this area but also the more "victim friendly" approach in Germany generally and also, and it cannot be forgotten, Germany's history with medical experimentation under National Socialism.[813] If British law lords can be divided 3:2 on issues of causation then it would not surprise me if Germany decided also differently. Again I believe that causation should not be codified and that this is the essence of my thesis.

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[809] §630e (1) BGB

[810] §630h (2) BGB

[811] ibid

[812] *Chester v Afshar* [2004] UKHL 41

[813] see J SHAW, "Informed Consent: A German Lesson", (1986) 35 *International and Comparative Law Quarterly* 864 at 870; noting that Germany's history led to the drafting of the Nuremberg Code on permissible medical experiments further to the War Crimes Tribunal's judgements

In general then, and to conclude this part of the paper with regard to Germany and the United Kingdom, I am not so convinced as Stauch when he writes

> Thus, it seems clear that the outcome of a claim based on the same underlying facts would often be the same in both countries. It is only comparatively rarely, say, an injured patient would obtain damages in Germany, where in identical circumstances, he would fail in England. [814]

While I agree that where a case is a simple "but for" then of course, outcomes in Germany and in Britain are more likely to be the same. The problem arises when the situation becomes a little more complicated. Even more difficult cases like *McGhee* and *Fairchild* are likely to have the same result as in the United Kingdom. There is, after all, provision for joint tortfeasors in Germany.[815] Yet what about cases like *Wilsher* where recovery was not permitted in the United Kingdom because it could not be said with certainty that oxygen caused or had materially contributed to the child's blindness on the balance of probabilities? A fortiori one might suppose the same result in Germany with its higher standard of proof. Yet this could be a chance for a German court to invoke "gross malpractice" and reverse the burden of proof, leaving it for the defendant to exculpate himself in some way. Again there is no reversal of the burden of proof in Britain regardless of how negligent a physician has been. As just considered, what about cases where a doctor has not disclosed the risks of a procedure adequately? In Germany, there is the approach that "risks" should be made known to the patient even those to hundredeths of a percentage point. This is codified even. In the United Kingdom, "informed consent" now exists as per *Montgomery*.

There is a two-stage test in both jurisdictions as a matter of principle and both also reject recovery for loss of chance in medical causation.[816] It is, however, not ruled out totally in the United Kingdom for the future. The starting theory in both countries might be similar but from then on, I believe that there are significant differences between the two countries. I will not deny that there are common elements in both

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[814] M STAUCH, *The Law of Medical Negligence*, p161

[815] §830 BGB

[816] Germany rejects totally loss of chance

jurisdictions with regard to causation. However, I believe the differences to be significant enough that any kind of purported harmonisation between the two systems or together with the two systems must be unworkable. Again this is not to say that Britain cannot learn from different arguments or approaches from Germany or vice-versa. British courts have indeed started to do this and I commend this. What I attempt to argue rather, is that projects that seek to harmonise European Tort Law must adapt their wording with regard to causation.

6.4 Germany and France

6.4.1 Overview

I think it is quite clear by now how the two jurisdictions of France and Germany treat causation in their case law. Both their civil codes insist on a defendant's having "caused" harm but, this is not defined anywhere. I do not think it necessary to consider or examine again the fundamentals of causation in both jurisdictions as these are set out in the main body of this paper and then recapitulated in the overviews above and I make reference thereto.

I think the clearest difference between France and Germany is where the causal enquiry begins. Germany quite clearly, unequivocally and unambiguously starts from a conditio sine qua non analysis. It starts with equivalence theory, or *hinwegdenken*, and then applies adequacy if it considers appropriate. It applies its reasoning and different stage tests to the problem in hand. Germany then goes on to use policy filtration where necessary. France, on the other hand, starts sometimes from equivalency and sometimes from adequacy. France is not really sure yet of its causal starting point. There are disputes about which theory is the more used this but no count has been made and "…le bilan n'est pas decisif".[817] France applies various theories and often it comes down to the policy of not sending a victim away empty-handed. Even where science is not certain of a causal link, often France will allow a causal link as a court is there not just for scientists but also to protect morals and society generally – and courts readily admit this. This does not, however, mean that same problems would result in the same outcomes in both France and Germany. Sometimes they would, sometimes they would not. Even in the jurisdictions themselves, the law can be divided.[818] Perhaps the biggest divergence comes with Germany's not accepting loss of chance. Other differences can be seen in the special systems for recovery of medical hazards that exist in France and not in Germany and in areas of the reversal of the burden of proof. It is the last of these that I shall consider first.

[817] G VINEY and P JOURDAIN, *Traité de droit civil*, 342, even if "les points ont étés comptés", ibid

[818] see the rather greater protection given to those in a public hospital and are subject to administrative law in France than those who would be subject to the Cour de cassation's jurisdiction as far as medical hazards of less than 25% AIPP are concerned.

6.4.2 Burden of Proof

Both France and Germany have high standards of proof. There is free proof in Germany and *intime conviction* in France. It is up to the judges to determine whether the case has been proved or not. This is a high test in both jurisdictions[819] but there are devices that come to the aid of a plaintiff who finds himself in evidential difficulty.

In France, if a patient can show certain facts, provided such facts are precise, consistent and serious and are linked with the damage, then this could lead the judge to form a causal presumption, allowing the plaintiff a clear evidential advantage. There are similarities in a parallel procedural device in Germany.

One way to consider this is to take an example (not from case law) and consider how it might be resolved in both jurisdictions. A patient must undergo a procedure to have an occluder fixed to close an atrial septal defect – a hole in the heart. As is quite common in such situations (especially among young patients), the patient is asymptomatic. However, after the operation, the patient begins to have palpitations and even notices a tachycardia from time to time. During these spells of cardiac arrhythmia, the patient feels dizzy and sometimes has a little difficulty breathing. Damages may be framed in terms of fear or loss of enjoyment of life. In France, there exists the possibility of a causal presumption if these three adjectives above could describe the factual situation if the judge sees so fit. There might be no proof of negligence at this stage but from a tactical point of view, the presumption (and in my opinion, more or less, the burden of proof) may shift from the plaintiff to the defendant. The judge may think happened shortly after the patient has come out hospital. However, it should be remembered that these adjectives of "graves, précises and concordantes" are imperative. A judge cannot just assume a *présomption de fait* unless these adjectives fit with the facts.

In Germany, the idea of *Anscheinbeweis* exists. Here the plaintiff must show that something needs explaining rather than showing a link from a certain of circumstances, *a*, to a result, *b*. *Anscheinbeweis* is generally not accepted to be a

[819] nominally higher than in the United Kingdom

reversal of the burden of proof. However, these are certain presumptions that raise a prima facie case. The tactical burden of proof shifts from the plaintiff to the defendant. Palpitations and tachycardia generally do not occur after such operations so the question may arise what did the surgeon do that has resulted in this, if anything. Of course, it may well be the case that the patient has an abnormal anatomy and the surgeon can lead proof to this effect but what is interesting here it would be for the surgeon to lead this proof if *Anscheinbeweis* is accepted. In Germany, a court will not use *Anscheinsbeweis* simply where a treatment has failed to obtain a desired outcome. This has been held to be the case even where a second surgeon has performed an operation that a first surgeon unsuccessfully performed.[820] The court will generally look to the merits of the plaintiff's case to decide whether it is strong enough to deserve the strategical advantage of *Anscheinsbeweis*. In truth, I find this example difficult. It is doubtful that the surgeon acted negligently in this case simply from palpitations and occasional tachycardia. Further there is the question whether palpitations or tachycardia is to be classed as an "injury"? They might well be annoying for the patient but injurious…? Yet if the patient was asymptomatic beforehand and now the patient has these symptoms, which (potentially) could have an effect on his quality of life, this is certainly something that calls for explanation – even perhaps valuation. Even where the patient is not able to bring the loss he has suffered, or will suffer, under any kind of "fault", in France, he may still be able to recover for an *aléa thérapeutique*. Does not the advancement of cardiology, medicine in general and therefore society benefit from knowing about these post-operative consequences? The patient should not be left without reparation; such would be the French policy, in any case; not so the German.

The question of disclosable risks is also relevant here. Were such "risks" (are they risks, in fact?) disclosed to the patient? I suggest that they ought to have been, if there were known, especially if they have an effect on the patient's life. So we can see here then how the different jurisdictions might treat such an eventuality. There are different kinds of presumptions from which the plaintiff can profit.

[820] M STAUCH, *The Law of Medical Negligence*, p73

In the event that the patient is unable to prove either causal presumptions in France based on certain facts being "graves, précises et concordantes", or the patient's being unable to show an *Anscheinsbeweis* in Germany, then all is not lost. I find similarity with the French secondary *obligation de securité* and the German *voll beherrschbare Risiken*. These risks fall within the doctor's "sphere" rather than that of the patient. With the former, from the moment the patient enters the hospital, then the hospital in a way has a duty to protect the patient from harm, whether it be disease, infections or defective equipment. Similarly, in Germany: this obligation, also classed as an ancillary obligation, is almost strict.[821] So in both jurisdictions, there would be reversals of the burden of proof with regard to ancillary obligations in contract. However, in Germany, this cannot be used where the injury is related to the state of the patient.

Much of the *droit commun* in France is now codified in the CPS. If indeed the symptoms complained of above are an iatrogenic[822]complaint (*affection iatrogène*) then recovery could be permitted from the national solidarity fund. If it is a medical hazard (*accident medical*) then the same statutory scheme applies. However, if the required 25% injury is not attained then the *droit commun* applies and I have set this out already. My submission is that recovery would depend first whether the patient was in a public or private hospital. If he were in a public hospital then the patient would have more chance to recover based on *Bianchi* and the idea that *aléa* are more linked to a kind of *obligation de securité*. He must of course show that (a) the risk was known; (b) there was no reason to think that the patient was exposed to such a risk; (c) that the condition of the patient has no relation with the initial state of the patient; and (d) that the character of the hazard is extremely serious. If he is in a private hospital then generally the Cour de cassation has shied away from allowing recovery simply on the basis of *aléa*. It has taken the view more or less that medicine involves risk. It is not risk-free while maintaining a distinction with *obligation de securité*. What can be deduced from this, I submit, is that it can be seen, even within one jurisdiction itself that causal solutions are uncertain and tentative. I submit then that a common sense solution or "obvious" solution is impossible. How then can we use causation as

[821] ibid, p46

[822] Art L1142-1 – I CPS

a notion and apply it to a greater European harmonisation project? I suggest that we cannot.

There is no equivalent in Germany of medical hazards à la CSP or à la *Bianchi*. However, a canny plaintiff will usually try to make her facts fall under "fully masterable risks" to allow the total reversal of the burden of proof to operate. For example, in the event of a post-operative infection, if it can be shown that the infection was indeed "masterable", only then will the burden of proof move to the defendant to show that he could have taken further precautions.[823] The BGH has recognised that where a hospital has taken all hygienic measures then there must be some risk that still lies with the patient.[824]

I submit therefore that there are not similarities in approach with France and Germany. What is similar is a high level of proof, at least in theory. What is also similar is that there exist ways, approaches and techniques to attenuate this high burden of proof. There is prima facie case in Germany, not so in France. There are *présomptions de faits* in France but not so in Germany as such. There is "fully masterable risks" in Germany and there is a kind of similar *obligation de securité* together with *aléa thérapeutique* in France combined with the CPS. The latter do not exist in Germany. I have found that courts seem to be the most adaptable in France, not sticking rigidly to any particular causal dogma, and even saying that the seriousness of the fault is a *lien de rattachment*.[825] Yet it is not clear, however, when this would be used. So the garden of causal case law in France does need some pruning and tidying-up round the edges in order to make the paths through it more inviting. French case law is not as logical as German law and perhaps even less predicable. That said, I believe there is generally one over-arching principle – not to send a deserving victim away empty-handed. Who is a deserving victim in France? I submit one where there was a 70 per cent chance according to expert reports that the doctor had caused damage due to a non-diagnosis – disallowed in Germany.[826] Here loss of

[823] BGH NJW 1991, 1541

[824] ibid

[825] H MAZEAZD, L MAZEAUD and A TUNC, *Traité*, 1435

[826] BGH NJW 1999, 860

chance would have come to the victim's aid in France. In Germany there is no loss of chance but I suggest more generally counsel for the plaintiff could have pleaded "gross malpractice" to reverse the burden of proof. Yet not all losses of chance constitute "gross" malpractice. A misdiagnosis does not necessarily constitute "gross" malpractice so the reversal of the burden of proof may not always come to a victim's aid in Germany. So in conclusion, I suggest that given principles of causation are based on factors external to the law itself – ie whether the victim was in a private or public hospital – in France then the law is not coherent there. I hope I have shown with the comparison with Germany, that no common principles can be extracted from these two major legal systems in this important area in tort law. Therefore if no common principles can be extracted then no principles common to the two systems exist. I suggest therefore there is no need to expand on how people should understand causation in the law.

6.4.3 Comparative Overview

So much then for the comparative overviews between the jurisdictions themselves. I hope I have shown above that there are important differences between the jurisdictions when it comes to tackling causal issues. I would just like here to marshal my findings with an "overview of the overviews", standing back somewhat from the research and trying really to ascertain what makes causation in medicine so different in the jurisdictions under consideration here. It is my contention overall that given the substantial as well as procedural differences in civil law in this area that ideas of possible harmonisation in causation should be abandoned.

In *European Tort Law*, Cees van Dam states that

> Generally, a distinction is made between establishing causation and limiting causation. The first issue refers to the question of whether a causal connection can be established between the negligent conduct or the strict cause on the one hand, and the loss on the other. In order to establish causation all jurisdictions apply the conditio sine qua non test.[827]

I think this paragraph unnecessarily confuses. It is confusing to use the words "establishing" and "limiting". The courts have "established" causation once they make a final judgement on the matter. What he means to say, I think, is that there are generally two tests to establish causation: one is the conditio sine qua non test and one is legal causation where policy comes in. Also, to say that "all jurisdictions apply the conditio sine qua non test" in his sense of "establishing causation" is also wrong. We have seen that France does only sometimes.

In all jurisdictions, however, it is true to say that they have accepted the conditio sine qua non test as one test of **a number** of tests in establishing causation. It can be the first test the jurisdictions apply before complementing it with a filter, be it adequacy, policy or limitation using a procedural device. France, however, sometimes goes directly for adequacy theory. In Germany, policy is important as we have seen and it has even been noted by the BGH that adequacy theory and the scope of the rule theory are "in fact not real causation theories but tools to establish the consequences

[827] at p268

for which the defendant has to answer."[828] In the end, policy choices play a decisive role, particularly in borderline cases. I have to agree.

In the United Kingdom, there are a number of ways that can limit, what is ultimately a question of causation. The British courts use such controlling devices as duty of care, foreseeability, remoteness and causation. I find it more and more difficult to separate causation from these.

France, for its part, insists that causation be certain and direct before it will permit a causal connection. As we have seen, France uses both equivalence and the adequacy theory without really favouring one over the other. This notion of probability inherent in the adequacy theory is, for me, akin to that of reasonable foreseeability. So here we do have two similar notions that can be compared and their function in both jurisdictions is to determine causation. There is, in France, a reception of an "objective probability". But again, the difficulty lies really in separating ideas of probability, foreseeability and so on from causation in itself.

In Germany also, notions of foreseeability are used with regard to the causal *haftungsausfüllende Kausalität*. It could perhaps be argued that a "significant increased probability" test is one that is less vague than that of reasonable foreseeability but then again we have to remember that the adequacy theory itself proved inadequate, perhaps ironically, and a new scope of the rule theory developed.[829]

Another notion that I also think confuses causation is that of contributory negligence. This is where the court is saying that the victim either in part or in whole contributed to his own injury.[830] Contributory negligence is dealt with in the United Kingdom under the Law Reform (Contributory Negligence) Act 1945 Act. In France, it is categorized as *faute de la victime*. In Germany, contributory negligence is dealt with under §254 II BGB and like in the United Kingdom, it is similarly weighed by the

[828] C van DAM, *European Tort Law*, p316 referring to BGHZ 3 261 (267) VersR 152, 128 DOUBLE CHECK

[829] BS MARKESINIS and U UNBERATH, *The German Law of Torts*, p108

[830] I think it would be easy to justify abolition of this doctrine and simply frame judgements in causal terms but that is for another day

judge.[831] Lord Atkin stated in *Caswell v Powell Duffryn Associated Collieries Ltd* that he found it impossible to "divorce any theory of contributory negligence from the concept of causation."[832] I have sympathy with this.

The burden of proof is a procedural matter yet it is tied up unquestionably with causation. To what extent must the plaintiff show that there was a causal link between the defendant's act and the plaintiff's injury? If the plaintiff need only show that his version of events is possible, then he need not work very hard. If he has to show that his version of events is likely, then he might have to work a bit harder. If, on the other hand, the plaintiff has to show that his version of events is probable to 51%, 60% or even 80% then he has to do a lot more. How a jurisdiction treats its plaintiffs in this respect is important for the plaintiff's chances of success. As we have seen, however, even though a jurisdiction's requirements in this matter might be quite high, it may provide for other procedural devices that allow the plaintiff to overcome what might seem initially insurmountable hurdles.

In all the jurisdictions concerned, the starting principle is that it is for the plaintiff to prove his case. In the United Kingdom, the plaintiff must prove his case on the balance of probabilities. He must prove his case to 51%. As we have seen this is never reduced. I would like to underline that there are no presumptions and no reversals of proof from which the plaintiff can benefit. That said, however, there are the ideas of prima facie proof and *res ipsa loquitur* which put the defendant in the position of having to explain a situation. There is no dichotomy in causation between proof for an infringement of a right and ultimate damage as there is in Germany, where, for its part, it looks for effective certainty ("full judicial conviction") for the causal link between the defendant's act and the infringement of the claimant's right under the BGB, on the one hand, and has a lower standard of proof for the ultimate damage on the other ("balance of probabilities"). In Germany, there is *Anscheinbeweis* akin to prima facie proof or even the presumptions that exist in French

[831] In Germany, the causal potency of a victim's conduct in producing his damage will be important but not the unique factor to be taken into account; see BS MARKESINIS, *The German Law of Torts*, p104. One example would be a victim's failure to obtain medical treatment after an injury (RGZ 139, 131, 136)

[832] [1940] AC 152, 165

law. I have shown the situations in which this can occur. *Anscheinbeweis* has played an important role with infections as we have seen. Reversal of the burden of proof never occurs in either British or French law with regard to "gross negligence" – nor for that natter, at all. Now the plaintiff must still prove that there was "gross fault" but once proven in Germany, it is then for the physician to prove that the plaintiff's damage did not occur from his gross fault. Importantly, and even more to the plaintiff's advantage, the gross fault could perhaps come from simply not attending on a patient and then whatever the agent that caused the patient's injury or death was, it would be for the defendant to show the fault is not attributable to him. Although Britain and France might treat such cases with *res ipsa loquitur* or causal presumptions, there is no reversal of the burden of proof as such. If the defendants cannot offer an explanation, then this might well amount to the same thing in causation **in certain situations** but it is an important boundary in the law of causation between German law and the other jurisdictions.

French courts generally require the *intime conviction* of the judges before they are persuaded of the plaintiff's case. This, as we have seen, submits to various presumptions provided that they are *précises*, *serieuses* and *concordantes*. These can significantly help the plaintiff. Although these do not have to be justified by science, they cannot just exist in the air. We have seen that cases in France do not have to be justified by science (and I think particularly here of the hepatitis B vaccination / multiple sclerosis cases). This allows France to stand out when it comes to proof of causation. I doubt that such decisions would be followed in Germany or in the United Kingdom. There would at least need to be some hard science behind such a decision before a causal link were admitted. I have already cited a case in Germany where causation was established to 70% yet the plaintiff failed to recover.[833] As was stated in the hepatitis B decisions, there were policy reasons which allow for such a causal link to be determined. Similarly, the same can be seen with the subsidiary "obligations of security" in contract that appear in France and Germany when one is staying in hospital. In France and Germany, there can be a presumption against a hospital for the malfunctioning of machines and even for nosocomial infections but a doctor is not to be regarded as the insurer of such machines. In the United

[833] BGH NJW 1999, 860

Kingdom, this is not known. In Britain, however, there is special statutory liability for mesothelioma that is not to be found on the Continent. In Scotland there is statutory liability for pleural plaques.[834] I have referred also to the special liability systems extant in each jurisdiction. It is not the purpose of this paper to determine which law is better but rather to highlight such aspects of causation with respect to the jurisdictions under consideration and how it is impossible to group them together or even to extract principles from case law as some would have with regard to causation.

[834] see infra

6.5 Conclusion

I have not found with delictual liability from a comparative perspective, unlike Lando with contract that "…although the rules were different, the courts had or would have reached the same results."[835] What is more, with regard to causation, the differences even within jurisdictions are striking. In the United Kingdom, we see that Law Lords in the Supreme Court differ in their own understanding and application of causation. France still has not really decided whether it favours an equivalence or adequate approach to causation and Germany is generally more inclined to a British approach (or vice-versa) from a different starting point but with significant procedural differences. While I do not necessarily believe as per Legrand that one should

> Purposely privilege the identification of differences across the laws [compared] lest [I] fail to address singularity with authenticity.[836]

, I do believe it is important to focus on these differences when faced with projects that, while not deliberately disregard them, perhaps pay less attention to them than is required when there may be the higher aim of codification in tort. I am understanding of Legrand's view that any attempt at codification is "violence"[837] and we must be honest about causation in medical law. It is not a subject that is fit for any kind of codification. Therefore we must be wary when we are presented with attempts to codify causation in general and, for our purposes, I cite the DCFR and PETL. I have shown here the differences in theoretical and practical approaches in the jurisdictions under consideration. They differ intra- and inter-jurisdictionally. That does not exclude, however, that we can learn from other jurisdictions' approaches to causation – far from it. The House of Lords has referred to both Germany and France in *Chester v Afshar* and I think that Luxembourg was certainly inspired in its recent decision on nosocomial infections by French case law on the

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[835] O LANDO, "Optional or Mandatory Europeanisation of Contract Law" in S FEIDER and CU SCHMID (eds), *Evolutionary Perspectives and Projects on Harmonisation of Private Law in the EU*, EUI Working Paper LAW 99/7 (Florence, European University Institute)

[836] P LEGRAND, "The Return of the Repressed: Moving Comparative Legal Studies Beyond Pleasure", 75 *Tulane Law Review* 1033

[837] P LEGRAND, "Paradoxically, Derrida: For a Comparative Legal Studies" 27 *Cardozo Law Review* 631

subject.[838] Learning from each other is something quite discrete from claiming that laws resemble in each other in areas where, I hope to have shown, they do not at all.

[838] CC Grand Duché de Luxembourg, No 8/13 du 31 January 2013

6.6 Problems with Causation

Given this classic method of comparison of jurisdictions above, it is my submission that my research and my conclusions show that there can be no functionalist comparative solutions across the jurisdictions in question here. I believe *a fortiori* also that difficulties will also be encountered within jurisdictions. This is because thankfully philosophers and thinkers have struggled with the question of causation for millennia. Disagreement is especially noticeable in the United Kingdom where judges are permitted to give dissenting opinions. This makes the United Kingdom a choice jurisdiction for further research in this regard. So lawyers and jurists cannot agree what causation is, what its limits should be and whether and to what extent, it actually is something distinct from damages. It is this which I wish now to examine in this final chapter. If there can be no common notion of causation on even a national level, then it is pointless to attempt to define it on an international level. This is not a bad thing, rather, just what is.

It is not the purpose of this paper to go over the metaphysics of causation or even of causation in the law. No consensus has been reached either among philosophers or among lawyers or academics as to what each is. Simply, I think it serves this paper to show the disagreement that could arise among one of the fundamental linchpins of causation and, moreover, the one that is forwarded by the PETL: the conditio sine qua non.

In his though-provoking article, "'Factual Causation' and 'scope of liability': What's the difference?" David Hamer, argues that there is in all reality a false dichotomy between factual causation and legal causation: a dichotomy that is used primarily in the United Kingdom and common law countries and to a lesser extent in Germany and France.[839] This is relevant for the purposes of this paper as it shows that one of the fundamental ideas in causal legal thought – the conditio sine qua non – in itself is not about fact. It involves, as I seek to argue, a value judgement. This further strengthens my argument that it is impossible to construct a European idea of causation (or an idea of causation more generally) and hence European concepts of tort law as not only are the jurisdictions at odds

[839] D HAMER, "'Factual Causation' and 'scope of liability': What's the difference?" (2014) 77 *Modern Law Review* 155

with each other, but also philosophy. There is no agreement on what factual causation is.

6.6.1 Factual and Legal Causation

The dichotomy between factual causation (the conditio sine qua non) and legal causation (*causa causans*), as I have shown, is a staple of most European jurisprudence in some form or another. The United Kingdom employs it as a starting point on any causal problem, Germany in as much it uses *hinwegdenken* and policy and France uses when it suits the courts. Hamer, in his article, presents a scenario that can be seen as highlighting problems with regard to factual causation. What is the behaviour to be substituted in a hypothetical world? The example is the following

> Peter is hit by Dan's car while Peter is walking across the road at an intersection. According to Peter, he was struck when Dan drove through a red light. Peter claims to have suffered a broken leg in the accident, and to have subsequently suffered burns when the ambulance that was rushing Peter to hospital was hit by lightning. In hospital Peter goes into anaphylactic shock in an allergic reaction to antibiotics, suffering permanent brain damage; the treating doctor had failed to check Peter's records.[840]

Our instinctive reaction is probably that Dan should not have driven through the red light. Yet what if he had a justification so to do, for example, he was driving his wife in labour to hospital? Do we really say that Dan is a legal cause of the anaphylactic shock because of the doctor's negligence? Probably not, though he is surely the "factual" cause. Would we all agree even that Dan is the "factual" cause of Peter's burns when the ambulance was struck by lightning? I suggest not.

In *Chester v Afshar* the plaintiff honestly said that she would not have known what to do in the event she had been told of the risk of the operation. Her claim was successful. In such case, factual causation is mixed with legal causation. Recovery and causation were allowed simply on the grounds of policy. Hart and Honoré's comments in this regard (from 1985) are prescient

[840] ibid

> If in such cases the courts wish to do justice, and yet not openly to flout the authority of rules stated in bald causal terms, one expedient is to take such matters into account under the heading of causation and to extend this term to cover the limitations of policy thought desirable.[841]

This is exactly what was done in *Chester*. Although the causal rule was not framed in statute, the Law Lords clearly had some hesitation (and some dissent) about allowing causation in this case. The conditio sine qua non would not have produced a fair result as they saw it and the plaintiff's right to bodily integrity was taken as fundamental. Justice had to be done.

Statute can often set out the possible hypothetical world. In the famous case of *Gorris v Scott*[842]the plaintiff and defendant had contracted to transport sheep by ship. The plaintiff's sheep had not been penned in as was required by the Contagious Diseases (Animals) Act 1869. The sheep were washed overboard in a storm. The court more or less accepted that if the sheep had been penned that they would not have been washed into the sea. However, Kelly CB opined

> There was no purpose direct or indirect to protect against such damage…the Act is directed against the possibility of sheep or cattle being exposed to disease.[843]

As Hart and Honoré, write such problems are difficult and will often involve questions of judicial legislation. In Germany and the United Kingdom especially, the judges must find the mischief.

Another controversy tackled in Hamer's article is whether there is a fundamental difference between past events and future hypothetical events. Although I shall not take a deterministic view of reality unless and until all the mysteries of quantum mechanics are solved,[844] I think it would be well near impossible to constitute factual possible worlds for medical negligence cases. It is here, and I agree with Hamer in

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[841] HLA HART and T HONORE, *Causation in the Law*, p94

[842] (1874) 9 LR Ex 125

[843] ibid, at 130

[844] BBC Radio 4, *In Our Time: The Physics of Reality*, 2 May 2002 : http://www.bbc.co.United Kingdom/programmes/p00548dl

this, that issues of burdens and standards of proof are relevant. We talk about legal fictions. In my opinion, this can be seen clearest with perhaps the biggest difference among the jurisdictions – recovery for loss of chance and in the special regimes that exist in each of the jurisdictions.

Consideration of the conditio sine qua non here was designed just to show that all is not as it may seem and it is not as simple as asking the question "but for the defendant's conduct…?". The question "but for?" is a relative one. The counterfactual can often be difficult to determine. What behaviour indeed must be substituted? This can be a puzzling question and sometimes statute may provide an answer. Yet more often than not, a value judgement has to be made as to where to stop the "cone" of causation. All causes are equivalent after all. So lawyers must stop somewhere. This is what "factual causation" really is. Let us not pretend that it is not a value judgement.

The second branch of causation that is often considered after "factual" causation is some kind of causal filter and for our purposes, we shall just call it legal cause. I do not believe that they are readily separable from each other. I hope the below shall highlight this. I hope this shows also that legal causation is not only about the scope of liability as may be thought.

6.6.2 Legal Cause

Hamer further develops his article by suggesting that legal causation in itself is not just about the scope of liability.[845] In the Dan/Peter example above, Hamer holds that Stapleton would have considered Dan's parents and even events such as Caesar's crossing the Rubicon, the Cretaceous-Palaeogene extinction event and the Big Bang as causes.[846] He says that even to refer to such things as "causes" is to deny how people understand the word in everyday life.[847] People in every day life, Hamer suggests, would negate the suggestion that the Big Bang is actually one of the causes of Dan's liability above. Stapleton and Wright would certainly disagree, holding them to be causal, and any other selection to be purely normative. He states, quoting Wright,

> …the defendant's tortious act was a *necessary* condition for the occurrence of an injury, it is unnatural to deny that the act was, as a matter of *fact*…a factor in producing the injury…To state otherwise is to make a noncausal, nonfactual policy judgement about responsibility for injury.[848]

I would agree with this. I am not insisting that any other opinion is wrong but I think it underlines the importance between causation in the law and causation in any other discipline. People will understand causation…simply how they understand it. I do not see how it can be denied that these remoter causes – Big Bang, Caesar's crossing the Rubicon – can be repudiated as causes in the factual, historical and even scientific - sense. Even using the "but for" test, there is a value judgement made in excluding them – even from the conditio sine qua non! Essentially, the test is (i) "legal" factual causation and (ii) legal causation. Adjectives like "proximate" and "potent" cause can then be employed when cutting the causal "cone" for given purposes. Yet it is where we cut the cone of causation that we want to know this answer. It does not admit of a right or wrong answer. In Dan's example, if asked, I might not answer that the cause of Peter's injury was Caesar's crossing the Rubicon,

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[845] D HAMER, "'Factual Causation' and 'scope of liability': What's the difference ?" (2014) 77 *Modern Law Review* 155 at 177

[846] D HAMER, ibid, 129 referring to J STAPLETON, "Legal Cause: Cause-in-Fact and the Scope of Liability for Consequences" (2001) 54 *Vanderbilt Law Review* 941, at 1000-1001

[847] D HAMER, ibid at 179

[848] R WRIGHT, "Causation in Tort Law", (1985) 73 *California Law Review*, 1735 at 1783

but if cross-examined on the question, I certainly would not deny it. In fact, I do not understand how anyone could deny the fact; it might simply not be our initial, intuitive response. It might necessitate a change in one's understanding of factual causation but nonetheless, there it is. Hamer writes

> In law and in everyday life people purport to discriminate between stronger and weaker causes, and Wright and Stapleton fail to demonstrate that these judgements are other than what they seem.[849]

I do not believe this is true. I think Wright adequately shows what these judgements are. They are non-causal, nonfactual policy judgements about responsibility for injury.

Where Hamer is correct, however, is in his assertion that many people do not understand causation in this way. I tend to agree.[850] They would simply point to lightning as Peter's cause of the Peter's burns without necessarily mentioning the Big Bang or perhaps even Dan's passing through a red light. I would accept this. Lighting is a freakish occurrence. For some people, it may render inefficient anything that came before it. Causation can be legitimately understood in this way. What I think is of most relevance to this paper, is that it can be understood in this way – and in many other ways! As I have suggested, there can be no "common sense" with causation in difficult cases. I think the case law presented in this paper shows this without doubt. I hope further to add to the disagreement in understanding causation by highlighting these examples also.

What Hamer does show in this paper is that notions of factual causation and "legal" or normative causation are fluid. Their concepts may not be as rigid as it may seem. Determining what is a conditio sine qua non requires, in my opinion, a *causa causans* judgement in the first instance. This ensures that we deal with legal causation. I wish to underline again and again that what a court is looking for is not causation scientific, it is not causation historical, it is not causation economic, but legal causation. These other disciplines may be helpful, informative and

[849] D HAMER, "'Factual Causation' and 'scope of liability': What's the difference ?" (2014) 77 *Modern Law Review* 155 at 179

[850] I have, however, no data on this.

valuable when coming to our legal conclusion but they remain separate disciplines. They may be subject to experts' opinions but a court is only looking for causation in the law. I have already shown this in case law. I refer to the hepatitis B vaccine / multiple sclerosis cases in France as the epitome of this. Given then that the causal question can often be so impenetrable and unyielding, loaded with unknowns and uncertain variables, the extraction of what the causal question is itself can often be demanding and challening. Even when we think we have the question, as I have shown above, there is not necessarily one way to confront it. There can be dispute over the substitution of counterfactual behaviour or by de-limiting the *causa causans* somewhere. People do understand causation differently. I would suggest that the Big Bang is a cause of my birth. There are many various causes. Other people may deny this. How relevant the Big Bang becomes in a causal problem, depends, of course on, the causal problem. Bearing all this in mind then, I suggest that it is going to be well near impossible to try to define causation or to try to hone in on any "one theory above all" in principle for European law. Any pretensions in that direction are misguided.

Not only is there no agreement among the jurisdictions in question here, but moreover there is no agreement within the jurisdictions – as best represented by the United Kingdom Law Lord decisions – and among what people generally using "common sense" may regard as causation. Yet this is not a bad thing. It is not to be criticised. Let us admit that we cannot define causation, and just live with the word "causation". It will be interpreted according to the judge and there are many causal doctrines from which judges can pick to attain the result they desire.

6.7 Projects in Europe towards the Drafting of a European Civil Code

Notwithstanding what I hope to have shown above, there exists nonetheless a desire to harmonise European tort law. The European Parliament called for a European civil code in 1989,[851]1994,[852]and then in 2000.[853] Attempts have centred primarily on contract law.[854] However, tort law has followed suit with the inclusion of tort law in Book VI of the DCFR[855] on non-contractual liability arising out of damage caused to another and the drafting in 2005 of the Principles of European Tort Law.[856] There have also been other "Knowledge-Building" research groups[857]such as the Pan European Organisation of Personal Injury Lawyers, the *Ius Commmune Casebooks for the Common Law of Europe* project and the Common Core for European Private Law Project. The last three scour the texts of European case law reporting on solutions offered in the jurisdictions in question and present them. Infantino writes

> …any attempt to codify or harmonise tort law should be undertaken with the understanding that the enforcement of top-down rules also requires the collateral support of a bottom-up harmonisation.[858]

[851] OJ, 1989, C 158/400

[852] OJ 1994 C 205, 518

[853] OJ 2000, C 323, 377 where the European Parliament stated that "greater harmonisation of civil law has become essential in the internal market" and called on the European Commission to draw up a study in this area.

[854] Following on from the European Commission's Action Plan 2003 (COM (2003) 68) and the development of European contract law together with revision of the *acquis communautaire* (COM(2004) 651); for an interesting critique on the deficiencies of the provisions of the DCFR and the PETL see P GILIKER, "Can 27 + 'Wrongs' Make a Right? The European Tort Law Project: Some Sceptical Reflections" (2009) 20 *Kings Law Journal* 257

[855] funded by the European Commission

[856] The DCFR can be found with commentaries in *Principles, Definitions and Model Rules of European Private Law* ("**Principles and Models**") (prepared by the Study Group on a European Civil Code and the Research Group on EC Private Law (Acquis Group), 2009, Sellier, Dissen, Germany), consultable on-line at http://ec.europa.eu/justice/policies/civil/docs/dcfr_outline_edition_en.pdf ; the PETL were published in *Principles of European Tort Law* by the European Group on Tort Law (Vienna, Springer, 2005)

[857] to use the terminology of M INFANTINO in her article "Making European Tort Law : The Game and Its Players" (2010) *Journal of International Comparative Law* 46 at 78

[858]ibid, at 84

The bottom-up harmonisation involves a collection and understanding of the common law of European jurisdictions. It is not the purpose of this paper to rehash the arguments for or against the creation of a European Civil Code but rather to consider and assess the propositions from the DCFR and PETL with regard to their provisions on causation with special focus on the legal systems of France, the United Kingdom and Germany as representative of the main legal families.[859] The DCFR even invites such criticism. It is with this spirit that I approach this paper. It notes

> The DCFR is an academic text. It sets out the results of a large European research project and invites evaluation from that perspective. The breadth of that scholarly endeavour will be apparent when the full edition is published. Independently of the fate of the CFR, it is hoped that the DCFR will promote knowledge of private law in the jurisdictions of the European Union. In particular it will help to show how much national private laws resemble one another…[860]

Of course, it is necessary to understand what is meant by causal language in PETL or DCFR. As Wester-Ouisse has pointed out, each jurist will bring his own understanding of causal language to the table.[861] This is an additional problem for codification, in my opinion. Not only do the jurisdictions differ significantly in their solutions in the area of medical causation but causation itself is a concept fraught with value judgements. It would be an achievement in itself to codify what is meant by it in any one of the jurisdictions never mind in all European jurisdictions!

I hope that my research does to some extent evaluate the DCFR and the PETL. I hope it shows that national private laws do differ, at least with regard to causation in tort, to a significant extent and certainly that they do not "resemble one another" to the extent that could facilitate or suggest codification. I wish to refute this proposition by advancing the findings of my research. I am nonetheless a fervent supporter of systems learning from each other – in my research I have shown how this has been done. The French took from the Germans in causation and more

[859] as per the Ius Commune Casebooks for the Common Law of Europe Project

[860] *Principles and Models*, p8

[861] V WESTER-OUISSE, "Définition de la causalité dans les projets européens sur le droit de la responsabilité", in *Le droit français de la responsabilité civile confronté aux projets européens d'harmonisation* (Recueil des travaux du Groupe de Recherche Européen sur la Responsabilité Civile et l'Assurance (GRERCA), Paris, 2012), p391 et seqq

recently I showed how the House of Lords has been willing, on occasion, to refer to the Continent to consider how a solution in medical causation might be formulated. This is something quite separate from what is attempted by certain scholars in their enthusiasm for codification. What instead I want to demonstrate is rather that common principles in causation in tort law are unworkable at the European level as shown by the dissimilar approaches in causation. It is for others to research on other aspects of these projects. Causation is, however, a pillar on which these projects are built. If confidence is to had in them, then it is necessary that we have an honest debate about their interpretations of causation. I invite reflection and consideration on how the articles with regard to causation are both currently drafted. I hope this paper may go some way to advancing that debate.

My main propositions therefore are in this European part of the paper are primarily two. Firstly that there can be no common European idea of what constitutes causation. This can be seen especially in the domain of medicine. Second, there can be no understanding of causation that can be reduced to principles.

The third and accessory part of this paper is to acknowledge, however, that causation is a concept that is here to stay in a hard law form at the European level. The ECJ has considered causation to some extent and I shall look at this case law. There is also, for example, the Product Directive which still requires that the defect caused damage and the Environmental Liability Directive which sets out certain principles with regard to causation. Although there has been no case law at the ECJ level with regard to the Product Directive at the time of writing, this does not mean that there will be no references to it for interpretation in the future. I will examine the little case law in in the ECJ which deals directly with causation. It may or may not come as a surprise that I shall suggest no principles with regard to causation as I find causation impossible to define and is ultimately determined by "feeling", policy or whatever the judge determines himself to be common sense.

6.7.1 Contract or Tort

I showed above that in Germany, France and Luxembourg, a patient's relationship with his doctor is based on contract. Any remedy therefore is usually, strictly speaking, governed by rules governing damages in contract. However, I also showed that many of the ideas and notions of causation were borrowed from delict in all three jurisdictions. It is only the United Kingdom that treats the patient/doctor relationship as purely a non-contractual one.[862] I consider therefore that the principles of DCFR on non-contractual liability and PETL with regard to causation would apply in the event causation were a matter of dispute in a patient/doctor relationship as it is here where we can see the most discussion on causation and it is this that is important. The Principles of European Contract Law do not even mention the word "causation" nor do they deal with remoteness of damages.[863] They do, however, deal with foreseeability.[864]

The fruit of those two groups of scholars favouring codification can be seen in the DCFR and in the PETL. Both favour codification. I shall consider first the DCFR.

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[862] save in the case of private hospitals, which are the exception. Most people in the United Kingdom use the free National Health Service

[863] cf article 1151 of the Luxembourg Civil Code which states that damages in contract can be obtained where they are "…une suite immediate et directe de l'inexécution de la convention."

[864] see the Principles on Contract Law: **Article 9:502: General Measure of Damages** The general measure of damages is such sum as will put the aggrieved party as nearly as possible into the position in which it would have been if the contract had been duly performed. Such damages cover the loss which the aggrieved party has suffered and the gain of which it has been deprived.

Article 9:503: Foreseeability The non-performing party is liable only for loss which it foresaw or could reasonably have foreseen at the time of conclusion of the contract as a likely result of its non-performance, unless the non-performance was intentional or grossly negligent.

6.7.2 Draft Common Frame of Reference (DCFR)

Before I consider causation in the DCFR, a word needs to be said about first principles.[865] The fundamental rule of liability in delict is to be found in Book IV 1:101. It sets out a "basic rule". It states

> A person who suffers legally relevant damage has a right to reparation from a person who caused the damage intentionally or negligently or is otherwise accountable for the causation of the damage.

Where a person has not caused legally relevant damage intentionally or negligently that person is accountable for the causation of legally relevant damage only if Chapter 3 so provides.

The first thing to note about first principles is that it is framed in terms of the victim of the damage. If the victim suffers relevant damage *x*, then he is entitled to some kind of reparation from person *y* who caused the damage. This is in contrast to PETL and how the jurisdictions under consideration here frame their articles on delict.

The next question is what is a legally relevant damage? This is set out at 2:101. It provides that

Loss, whether economic or non-economic, or injury is legally relevant damage if

- one of the following rules of this Chapter so provides;
- the loss or injury results from a violation of a rights otherwise conferred by the law; or
- the loss or injury results from a violation of an interest worthy of legal protection.

Loss caused to a natural person as a result of injury to his body or health and the injury as such are considered as legally relevant damage;[866] loss suffered by third

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[865] The co-operation of both the Study Group on European Civil Code and the Research Group on Existing EC Private Law presented the DCFR as principles to be commented on and discussed. Commentaries on the DCFR state that it is to serve as a "possible model" for a common frame of reference, for legal science, research and education and as a "possible source of inspiration". The common frame of reference itself, however, will be more concentrated on contract law.

[866] Art VI 2: 201, DCFR

persons as a result of another's personal injury or death is also protected[867]as is infringement of dignity, liberty and privacy.[868] These are the most relevant sections for the purposes of this paper. [869] The same interests are protected in DCFR as are in PETL. There would then appear to be some agreement and harmony that the protection of life and bodily integrity are protected interests: so far, so good.

6.7.2.1 Causation in the DCFR

The provisions of causal requirements between damage and a tortious act are to be found in Chapter 4 of the DCFR. It provides for a general rule and then particular rules on collaboration and alternative causes. Collaboration shall not detain me unduly here. I shall be more concerned with the general rule and with alternative causes. In addition to these specific provisions on causation, it would be remiss of me not to consider some of the defences as provided for in Chapter 5 DCFR as defences in themselves either deny completely or limit causation. I consider these relevant in the context of medical causation. Defences include consent and acting at one's own risk, contributory fault and accountability. As I shall show, PETL is broader in its causal chapter in that it expounds more potential causal scenarios. Again it is not for me to pronounce on which of the PETL or DCFR is "better" but rather to suggest that there can be no common understanding of causation in these European codes. The general rule for causation then in the DCFR is

> A person causes legally relevant damage to another if the damage is to be regarded as a consequence of:
>
> - that person's conduct; or
> - a source of danger for which that person is responsible.

[867] Art VI- 2: 202, DCFR

[868] Art VI 2: 203, DCFR

[869] Art VI 2: 204, DCFR protects loss upon communication of incorrect information about another; VI 2: 205 protects loss upon a breach of confidence; Art VI 2: 206 protects loss upon infringement of property or lawful possession; Art VI Art 2: 207 protects loss upon reliance on incorrect advice or information

In cases of personal injury or death the injured person's predisposition with respect to the type or extent of the injury sustained is to be disregarded.[870]

The DCFR approaches first principles differently from either the BGB or the French Civil Code.[871] The last two do not try to define causation. Yet here in the DCFR there is an attempt to define causation consequentially. This is the first mistake. I think I have shown with an overview of a causal analysis in medical causation at least for the jurisdictions of the United Kingdom, France and Germany that to define causation is to err. This will also be my criticism of the PETL. Causation is such mercurial and ever-changing concept that to attempt to demarcate its limits is not wise. I quote

> La notion de causalité est une redoubtable sirène: elle égare volontiers ceux que subtilité séduit et qui cherchent à la pénétrer jusque dans ses mystères intimes.[872]

I find the quote quite amusing and metaphorically French but it has some truth to it. By trying to create some kind of European code, I think it natural that drafters will want to, and try to, define as much as they can for the sake of standardization. Standardization itself can be "seductive", it is true. To continue the metaphor, I believe my research above has shown, that any attempt of definition will only lead to a great crashing on a legal Lorelei. Yet I even ponder the reason for setting sail…

It could be argued that not much can really be given to this definition as set out in the DCFR shown above. I might agree with this but then why attempt to define it at all? It would be better just to stick to the almost taciturn Civil Code and BGB. There nothing is given away with regard to causation and doctrine and case law interpret it. This could be criticised in itself – perhaps especially with regard to French law – in that doctrine has not come to any decision and the law remains unclear – but I suggest that is the nature of causation more generally and especially with regard to medical causation. Moreover, there is no desire to adhere to any rigid precedent in France and judges decide the facts more or less as they come before them.

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[870] Art VI 4 :101, DCFR

[871] I do not compare here the British common law as this by definition is not codified

[872] CC 2 1 Feb 1973, JCP 1974 II n 17882, note by N DEJEAN DE LA BÂTIE

Although there is no admission of a wholesale adoption of adequacy theory in the commentary to this chapter, I propose that that is what is hinted at here. The use of the word "consequence" suggests to me first of all a definition by exclusion: a determination of that of which it is not: it is not conditio sine qua non. This is supported by the commentary thereon. Second, the use of the word "consequence" makes me think of first a philosophical problem and of adequate causation in that what would happen "in the natural course of things".

Unfortunately, as Hart and Honoré have shown, the use of the word "consequence" is fraught with difficulty.[873] I shall adapt their first example to medicine.

Example

A, as a result of his negligent driving, causes B injury as a result of which B must spend two weeks in hospital where he acquires measles as a result of bacteria that were brought through the window by a breeze. There is no question the hospital was negligent. If we use the DCFR, is B's contracting measles a "consequence" of A's negligent driving? They note simply

> No short account can be given of the limits thus placed on "consequences" because these limits vary, intelligibly, with the variety of causal connection asserted.[874]

It could be argued that a breeze and bacteria are just part of the environment and simply a condition or the circumstances in which the cause operates.[875] I agree with Hart and Honoré in that it is easy for us to be misled by the use of certain metaphors which are used when we describe causation. "Breaking the chain of causation" is often used when in fact, what is meant is that what such intervening events do are *complete* the *explanation* of harm.[876] They note

> In truth in any causal process we have at each phase not single events but complex sets of conditions, and among these conditions are some which are not only

[873] HLA HART and T HONORE, *Causation in the Law*, p71 et seqq

[874] HLA HART and T HONORE, *Causation in the Law*, p70

[875] *Minister of Pensions v Chennell* [1947] KB 250, 256

[876] HLA HART and T HONORE, *Causation in the Law*, p73

> subsequent to, but independent of the initiating action or event. Some of these independent conditions, such as the evening breeze in the example chosen, we classify as mere conditions in or on which the cause operates; others we speak of as "interventions" or "causes."[877]

What I want to show here is that it can be a difficult question as to whether an event is a cause or a condition and how can we limit, as Hart and Honoré question, the "consequences". The usual limited factors of foreseeability, proximity, and policy all come into question.

Second, it is necessary to consider the generalisations of consequences. What is meant here, and this is why philosophy and theory are important, is the description of the consequence. In a case like *McTear*, for example, it is necessary to describe the death as "death by smoking", not just "death" or even "death by lung cancer" – and this is where Mrs McTear's case failed. Mrs McTear failed to be more precise in showing that lung cancer was caused by (or even a consequence of) her husband's smoking cigarettes. It could have been caused by a number of factors – it could have been caused by conditions![878]

Another way of testing whether something is a consequence is to hypothetically eliminate the act. Yet this reminds us simply of the conditio sine qua non test which is specifically what the DCFR has avoided. If Mrs McTear's husband had not smoked, it could not be said that he would not have contracted lung cancer and died. A more difficult case arises with omissions: in *Chester v Afshar*, it was not clear what Miss Chester would have done had the surgeon informed her of the risks inherent in the operation. This is what provoked the disagreement among the Law Lords: should the court stick to principle to allow for consistency or should equity prevail on the basis of public policy? It is not apparent to me that any clearer notion of "consequence" would be forthcoming were European jurisdictions to adopt the DCFR.

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[877] ibid, p72

[878] ie the environment

Third, the use of the term "consequence" suggests adequacy theory to me. The notion of "consequence" is undoubtedly tied up with that of the adequacy theory. As Hart and Honoré note

> The adequacy theory is concerned with the relation of probability between the condition and the ultimate **consequence**….[879]

They go on

> But the probability of the occurrence of the third factor can be made indirectly relevant to the adequacy of the condition by incorporating…the description of the ultimate consequence.[880]

The authors of the DCFR admit that there is no reduction to a conditio sine qua non formula[881]in what I understand to be some implied criticism of PETL (where the first principle is conditio sine qua non) as this would "merely have put a 'factual' or 'scientific' concept of causation into words."[882] There is indeed quite a fierce rejection of equivalence theory in the DCFR comments.

They continue that

> Numerous exceptions and expansions would have been necessary, even at this level, without there being any real prospect of exhaustively covering the subject-matter.[883]

This seems to imply that numerous exceptions and expansions will not be necessary by adopting some kind of "consequence" as a general rule. As I hope to have shown above, philosophy does not permit of such simplicity. I could not disagree more with Lord Salmon's now famous passage when he opines with regard to fine distinctions with causation in the law that it can

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[879] HLA HART and T HONORE, *Causation in the Law*, p479; my emphasis

[880] ibid

[881] *Principles and Models*, p3425

[882] ibid

[883] ibid

> no doubt be a fruitful source of interesting academic discussion between students of philosophy. Such a distinction is, however, far too unreal to be recognised by the common law.[884]

I believe the contrary to be true. When codes antagonise or challenge philosophy in considering that they can use the word "consequence"[885] without thinking of the consequences [sic], then they must answer such criticism.

Even when using the "consequence" test as opposed to a "but for" test exceptions and expansions will also be necessary if a code is proposed in this way. The DCFR authors do recognise the fact that factors to be taken into account do not lend themselves to listing and that "Each individual case can make a new calibration necessary."[886] I agree with this and even more, I would say that there is no point even to set out a first principle of "consequence". There can be no jurisdictional agreement on what a "consequence" is. I am also near certain that any consequential notion will be jettisoned where it does not produce a fair result. The following commentary is telling in that what can influence this are such factors as the protective policy aim of the norm of social behaviour, general policy considerations, remoteness and probability. This would appear to be in contradiction with the authors' affirmation earlier on that

> This branch of the law does not impose liability for damages simply for moral or general political reasons. It is not the "duty defaulter", the "rich person", or the insured party who is made liable, but rather a person to whose sphere of control the subsequent mishap may be traced back.[887]

Therefore what the DCFR is prima facie proposing is, in my opinion, some kind of formulation of adequacy theory (though not admitted as such) as a general principle. Yet, and in the authors' commentary to the DCFR, this comes with the blessing of its filtering by legal devices and norms such as policy, remoteness and probability. It

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[884] ibid, at 62

[885] or indeed formulations of the conditio sine qua non theory

[886] *Principles and Models*, p3426

[887] ibid, p3422

also excludes some kind of imposing of liability for general "political reasons" (whatever that means) and further we must consider the "sphere of control". To be honest, I am confused as to what they mean by "consequence". They use the word once and then comment much on it but their commentary seems to be somewhat contradictory. They allow for policy but would not impose liability simply for "general political reasons" if I equate that to policy. They also refer to probability. As shown above, and in my chapters outlining the nature of adequacy, many of the formulations of adequacy theory include ideas of probability in them in the first place. To comment that causation can be interpreted using probability is simply inviting comparison to adequacy.[888] I am certain that the authors were aware of adequacy theory when drafting this text.

A third theory that I have exercised herein is that of breach of a particular purpose of norm. It is perhaps used more in Germany than in any other country here. It is not defined in the BGB but that is often what is considered in practice. If a third party is to be held liable for breaching a norm, then this should be stated clearly rather than having to fumble about with legal reasoning that is surrounded by adequacy theory in commentary to a proposed European code. It would not have cost the authors of the DCFR much to add in a rule about protective purpose given that they have sanctioned its use. I am not saying that I would advocate it but they seem to over-egg the commentary and they only have one first causal principle, namely "consequence".

The DCFR has refused to discriminate cause-in-fact and cause-in-law. The authors openly state that

> It is not the function of paragraph (1) of this Article to attach itself firmly to a defined theoretical position within the broad spectrum of opinion. The width and complexity of the subject do not speak in favour of a precise rule on causation.[889]

As we shall see below, this is in total contrast to PETL. DCFR and PETL are at odds. It is curious therefore, in my opinion, why the framers of the DCFR decided to

[888] though whether it is right to use ideas of probability in these theories has been the object of criticism G VINEY and P JOURDAIN, *Traité de droit civil*, 344c

[889] *Principles and Models*, p3425

define causation, even if one does not accept my comparison to adequacy theory, in terms of "consequence" or a "source of danger". They peculiarly reject conditio sine qua non theory while at the same time noting that the article on causation does not firmly attach itself to a "theoretical position within the broad spectrum of opinion" – maybe, but it certainly rejects a theoretical position within the broad spectrum of opinion.

With regard to loss of chance, the authors comment that

> The question of liability for loss of a chance would be a question concerning legally relevant damage, not causation; of course the differences of opinion on this issue confirm that these two elements of liability (legally relevant damage and causation) partially intersect.[890]

While I ultimately believe that causation in the law cannot be divorced from questions of remoteness of damage, foreseeability and legally relevant damage, I think they are being somewhat disingenuous when they say that loss of chance relates only to legally relevant damage and not causation. It is often loss of chance that is used in France when full causation to (legally relevant) damage cannot be established. I take the example of *Wilsher* (oxygen was inserted to the heart instead of the aorta and there were six different agents at play) where, if it had been decided in France, then loss of chance would clearly have been used. I suggest that any argument with regard to legally relevant damage would be just that – namely, that the *damnum* is not an *iniuria*. As we have seen, legally relevant damage includes loss incurred as a result of injury to a person's health. No doubt defendant health providers would first argue that loss of (say) a chance to recover from 42% to 25%[891]is not a legally relevant damage. The defendants have not caused a *damnum iniruia datum*. It is not a real "asset" in the way the loss of an arm or a leg through a tortfeasor's negligence would be. Yet had the figures been suitable for the burden of proof in the United Kingdom, then the plaintiff may have recovered. The United Kingdom and France have both recognised that compensation for the loss of chance can be recovered. In the United Kingdom, however, recovery for a lost chance in the domain of medical negligence

[890] idem, p3425

[891] as in *Gregg v Scott* [2005] UKHL 2; and after all, the plaintiff was still alive in this case.

has not been permitted to date.[892] Second, I would note that – to use the terminology of the DCFR – it could well be a **consequence** of a health provider's negligence that a patient lose a chance to recover scientifically or statistically. How the act, *a*, having the consequence of *b*, where *b* is a (legally) relevant damage, is to be categorised is something for the courts in question. I think therefore it was somewhat unnecessary to mention the fact that causation and legally relevant damage intersect – I think this goes without saying. The commentators were wise not to expand further on this point given its controversy in Europe.

Another criticism I make of the DCFR is that they evade the issue of burden of proof. They opine

> …the decisive element is the determination that the legally relevant damage suffered is to be deemed a consequence of a person's conduct or the realization of a source of risk, for which the person bears responsibility. Therefore, under paragraph (1) there is no room for specific provisions on the burden of proof, and particularly no room for the reversal of the burden of proof in special situations.[893]

The drafters have really concentrated on the substantial here. It seems to me that they really want to concentrate on the words "person's conduct" or "source of danger". I do not understand why there is no room for the provision on the burden of proof. PETL provides for it.[894] Yet bizarrely, the drafters then go on to say that if the matter comes to court, then the judge is afforded a certain amount of discretion which "may and must be exercised".[895] They then write

> Whether the existence of a cause-and-effect relationship between the wrongdoing and damage can be drawn from [the facts], is not something which seems amenable to the allocation of the burden of proof.[896]

I find this statement quite shocking and it leads me to wonder to what extent they have accurately considered research from case law in Europe. Cause is inextricably

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[892] ibid

[893] *Principles and Models*, p3428

[894] Art 4: 201 – entitled "Reversal of the Burden of Proving Fault"

[895] ibid

[896] ibid

linked to the burden of proof. It is precisely **facts** that lead to the shifting of the burden of proof, especially in France and in Germany. I have shown how if a judge in France is convinced of certain precise, serious and concordant facts then this will lead to a presumption that the defendant did indeed cause the damage – if not a de iure reversal of the burden of proof then a de facto one.[897] Similarly, in Germany, there is actual and theoretical reversal of the burden of proof where there has been a *grobe Behandlung*, not to mention the doctrine of *Anscheinbeweis*. I am not advocating that there should be a reversal of the burden of proof in one case or another but two of the jurisdictions more or less reverse the burden of proof. Would not that have been a special situation? At least PETL more or less leaves it up to national jurisdictions[898]but as I hope I have shown, there is no agreement among the jurisdictions under consideration here as to when the burden of proof should be reversed, if at all. The United Kingdom never admits of reversal of the burden of proof; Germany does. The United Kingdom does not allow for the presumptions. France does.

6.7.2.1.1 Article 4:101(1)(b) *"a source of danger"*

On the second prong of paragraph (1), what exactly a "source of danger" would be is not clear. I wonder whether a faulty medical prosthesis would be regarded as a "source of danger". The question as to whether a doctor herself should be liable for a prosthesis is controversial. The Product Directive only affords an action against the manufacturer in the event a "product" is defective. In France, it was left to the Cour de cassation to decide the matter.[899] The PIP breast implant scandal where 47,000 British women were affected shows how "dangerous" some prostheses can be.[900] I can easily imagine other medical equipment being regarded as a source of danger. What is interesting here is that PETL does not

[897] L KHOURY, *Uncertain Causation*, p45

[898] Art 4: 201, PETL

[899] CC 1 12 July 2012, Bull n° 165

[900] Interestingly in the United Kingdom, where women have paid by credit card, then their credit card company would also be liable under s75 of the Consumer Credit Act 1974. Women in France can have the procedure to remove the breasts for free but in the United Kingdom this can only be done if clinically necessary, see http://www.bbc.co.United Kingdom/blogs/watchdog/2012/04/pip_implants.html

provide for a "source of danger" causal responsibility in such a way.[901] It is certainly an interesting approach to causation in the medical field but I am not sure what it achieves that either an equivalence or adequate cause analysis does not especially given where commentators have allowed for Article 4:101(1)(a) to be interpreted according to policy.[902]

6.7.2.2 Article 4:103 Alternative Causes

Article 4:103[903] of Book VI of DCFR provides that

> Where legally relevant damage may have been caused by any one or more of a number of occurrences for which different persons are accountable and it is established that the damage was caused by one of these occurrences but not which one, each person who is accountable for any of the occurrences is rebuttably presumed to have caused that damage.

This is a particularly significant provision as it holds that someone who did not actually cause damage could be held responsible for it. Here defendant A can be liable for damage B that he maybe did not cause. The British case of *Fairchild* come immediately to mind here. Such a provision is in particular to deal with the circumstances of the latter case. Just to remind ourselves, in *Fairchild* the plaintiff was employed by employers E1 and E2 who were in a breach of a duty of care by allowing P to breathe in asbestos dust. P contracted mesothelioma. It could not be shown when the cancer was contracted but either E1 or E2 was responsible. So *Fairchild* would have been ripe for application of this article. This article goes further and allows for the situation where there would be different agents that had potentially caused the damage – this being one of the limitations on *Fairchild* at the moment.

This article seems not to produce a solution in *Wilsher*. It will be remembered that here although noxious agent (a) materially increased the risk of the child's being harmed by noxious agent (a), evidentially, there was not a sufficient causative link to

[901] indeed PETL in a way provides for the reverse of this by suggesting that the victim has to bear loss for activities caused with his "own sphere".

[902] it is perhaps more relevant for nuclear power stations

[903] Article 4:102 DCFR provides that "A Person who participates with, instigates or materially assists another in causing legally relevant damage is to be regarded as causing that damage."

the harm as noxious agents (b), (c), (d) or (e) could have also caused the harm. It could not be shown that oxygen was more likely [sic] to cause the harm than any of the other agents. The DCFR insist on different persons' being accountable.[904]

The authors do make clear, however, that recovery under this paragraph would not be possible where one particular person is fully responsible for the damage but that person is not financially capable of making full reparation. In such a case, "there is no reason why the victim should have the windfall benefit of other persons to sue."[905] So in *Fairchild*, if it can be shown that the "guilty" fibre which caused the mesothelioma actually came from E2 as opposed to E1 then E2 would be totally liable. Science, however, was not at that stage yet.

6.7.2.2.1 Article 4:103 Medication on the Market

The authors make clear that Article 4:103 is not to be used for pro rata market liability.[906] This is seen in their illustration here.

> The claimants' mothers had during their pregnancy taken medication, which was marketed in the same chemical formula under different brand names by competing companies. This medication caused the claimants to suffer from cancer of the uterus years later. They cannot say, however, which brand of medication the mothers bought at the time, nor even whether the medication taken came from any one of the companies which they now seek to hold liable; the medication may well have come from a company which no longer exists. VI.–4:103 does not help the claimants' with either of these difficulties. An "occurrence" within the meaning of VI.–4:103 is lacking. This is because even if all of the companies were active and present in the market, the claimants could not prove that each had unleashed a danger on their mothers. In other words, it is not even ascertained that any one of the mothers took medication from *different* companies. The people involved simply cannot remember who brought about the cause of damage. This does not suffice for VI.– 4:103.

[904] *Principles and Models*, p3453

[905] *Principles and Models*, p3454

[906] ibid, p3454

Neither has such a solution revealed itself in the case law. This paper concentrates on Europe but I exceptionally refer to the United States of America where the idea of market-share liability was first advocated. I found the solution quite novel and, potentially, a solution but moreover another way of thinking about legal causation. The case was *Sindell v Abbott Laboratories*.[907] What happened here was that the plaintiff's mother had taken the drug diethylstilbestrol (DES) when she was pregnant. As a result of the drug, the plaintiff developed cancer. There were many manufacturers of the drug and it was impossible to say which manufacturer had made the pills that the plaintiff's mother had taken. Importantly the drugs were fungible. The defendants together produced about 90% of the drug. The court held that the defendants were liable in accordance with their market share. Justice Richardson, however, dissented and held that such judicial activism should be left to the legislature. The principal elements of the model are the following:

- the defendants must actually be potential tortfeasors;
- the product must be fungible;
- the plaintiff cannot identify which defendant produced the fungible product which harmed that particular defendant; and
- a substantial share of the manufacturers who produced the product during the relevant time period are named as defendants in the action.

For the purposes of this article, the commentary to the DCFR states that two occurrences would be lacking for the purposes of Art 4:103.[908] This is because, they say, that even if all the companies were active and present on the market, the claimants could not prove that each had unleashed a danger on their mothers.[909] Arguably, this is an overly restrictive interpretation of Art 4:103 and I am not convinced why market-share liability could not be introduced via this article provided we are talking about a generic drug. I believe this is possible as the article says, "where legally relevant damage **may** have been caused by any one or more of a number of occurrences for which different persons are accountable…".[910] I suggest

[907] 26 Cal 3d 588

[908] *Principles and Models*, p3454

[909] ibid

[910] my emphasis

here that in a case such as *Sindell*, damage may well have been caused by one of the pharmaceutical companies. Typically, in such a case, the causal link (accountability) could be established using market-share liability. It could be an interpretation not shut off from national jurisdictions. The authors' insistence that market-share liability is not brought in by this article may well have been their intention but their intention does not occlude the possibility of lawyers' using it in their writs and other submissions.[911] What is important here is not so much that market-share liability **could** be introduced by this article, rather that there could be different interpretations according to national jurisdictions' proclivities. The solution adopted in Europe thusfar (in the Netherlands) with regard to DES is that where manufacturer unlawfully put the drug into circulation then the manufacturers were jointly and severally liable.[912] By contrast, PETL advocates the market-share solution.[913]

The authors also give an illustration of defences for this article. They cite one illustration of asbestos.

> The injured person, X, was consecutively employed by several employers and was exposed to asbestos dust at the workplace. The severe lung disease that X contracted can be caused by even a single inhalation of particular asbestos particles. It is consequently unclear whether the disease was contracted when X worked for employer A or employer B; it is clear only that both acted negligently. A and B are solidarily liable. If contributory fault is attributed to X because of a failure to wear the necessary protective clothing, X's claim is to be correspondingly reduced, and this holds true whether the contributory fault occurred during the period of employment with A or with B. In contrast, if X had occasionally pursued the same occupation in a self-employed capacity, so that the cause of the illness could have been due to that independent exposure during the same time period, VI.–4:103 does

[911] notwithstanding, of course, the fact that certain jurisdictions may use commentaries as a guide to interpretation

[912] see decision cited by C van DAM in *European Tort Law*, p333 of HR 9 October 1992, NJ, 1994, 535 ; another justification was that it was acceptable to hold the summoned parties jointly and severally liable from a reasonableness point of view

[913] Art 3: 103(2), PETL

> not apply. In such a case it cannot even be established that either A or B caused the damage.[914]

Their result in the above illustration seems quite harsh. Just because the plaintiff might have been self-employed for a certain period (a week? a month? a year?) precludes his recovery. This is quite astonishing and does not appear to be in line with any of the European case law. Another option open to the authors would have been to follow *Barker v Corus* to its conclusion and only allow recovery for those periods where the causal connection could be proven. They appear not even to have allowed for this. They have categorically said that

> In contrast, if X had occasionally pursued the same occupation in a self-employed capacity, so that the cause of the illness could have been due to that independent exposure during the same time period, VI.–4:103 does not apply. In such a case it cannot even be established that either A or B caused the damage.[915]

This is an extremely punitive result and no jurisdiction in Europe, I submit, would follow it. Totally to deny causation simply because of a period where the plaintiff was self-employed is unnecessarily punitive. The authors say that their illustration was taken from *Barker v Corus* but they have not followed it fully in their commentary. Here, it may be remembered, a number of the employers had become insolvent and so the question was whether the other employers were responsible for the whole. It was held that employers should only be liable for proportionately – ie for the percentage of the whole based on the number of years the plaintiff worked for that particular employer. This decision was highly criticised and there was a great political backlash resulting in the Compensation Act 2006 but this applying only to mesothelioma – more of this later.

It would appear then that given the commentary that their illustration does not accurately reflect *Barker v Corus* as they suggest. Causation was not totally denied in *Barker*.

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[914] *Principles and Models*, p3454

[915] ibid

6.7.2.3 Chapter 5: Defences under the DCFR

Understanding the purpose of a defence necessarily affects our understanding of causation. Where a defendant is able to use a defence, and he is successful, then the court is ultimately holding that the defendant's conduct did not cause the plaintiff's harm or that he caused it but the plaintiff himself is in part responsible for his own harm. Causation is stymied to a certain extent. There are a number of defences set out in the DCFR under "Defences". The ones on which I shall comment are consent and acting at own risk, contributory fault and accountability, necessity and ultimately the obligation not to treat without consent.

6.7.2.3.1 Consent and acting at own risk

Article 5:101 provides the following

> (1) A person has a defence if the person suffering the damage validly consented to the legally relevant damage and was aware or could reasonably be expected to have been aware of the consequences of that consent.
>
> (2) The same applies if the person suffering the damage, knowing the risk of damage of the type caused, voluntarily takes that risk and is to be regarded as accepting it.

It is a general principle of all the jurisdictions here covered that *volenti non fit iniuria*. The essence of this doctrine is that where the plaintiff assumes the risk of harm, the "chain of causation" is broken providing the defendant with a complete defence to the action. The plaintiff's voluntary action breaks the chain of causation and this is, of course, relevant, for the purposes of this paper. This as the commentators of the DCFR rightly note, is only "rarely codified".[916] It is interesting to note that "consent" to iatrogenic interventions was codified in Germany in 2013 in the Improvement of Patients' Rights Act 2013.

The authors also note that it is only "valid consent" that precludes liability.[917] For our purposes, one important ground of invalidity is lack of sufficient information[918]and this idea of informed consent, for it is the notion of informed

[916] *Principles and Models*, p3460

[917] ibid, p3462

[918] the other grounds given are lack of capacity of the injured person, and illegality or immorality

consent that is expressly provided for in the DCFR that is introduced here in Article 8:108.

6.7.2.3.2 Patient's Consent

Article 8:108 DCFR deals specifically with patient consent. It provides that

> (1) The treatment provider must not carry out treatment unless the patient has given prior informed consent to it.
>
> (2) The patient may revoke consent at any time.
>
> (3) In so far as the patient is incapable of giving consent, the treatment provider must not carry out treatment unless:
>
> (a) informed consent has been obtained from a person or institution legally entitled to take decisions regarding the treatment on behalf of the patient; or
>
> (b) any rules or procedures enabling treatment to be lawfully given without such consent have been complied with; or
>
> (c) the treatment must be provided in an emergency.
>
> …
>
> (6) In the situation described in paragraph (2) of IV.C.–8:106 (Obligation to inform in case of unnecessary or experimental treatment), consent must be given in an express and specific way.
>
> (7) The parties may not, to the detriment of the patient, exclude the application of this Article or derogate from or vary its effects.

As I have shown in my research with regard to the various jurisdictions, the question as to whether a patient has actually consented to a medical intervention remains a central one in matters of causation. If a patient has not adequately given his consent in a way recognised in that jurisdiction then we have either a breach of contract or tortious liability. Even criminal liability is possible.[919] In the DCFR, there is provision for treatment without consent in contract. In the United Kingdom, the doctor / patient relationship is governed by tort. Article 8:108 specifically introduces the notion of "informed consent". This is a particularly American doctrine and it was explicitly rejected in the United Kingdom until recently.[920] In the United Kingdom, it was the law that physician would not be held liable in tort if a

[919] as in Germany, though of course, still possible in France and the United Kingdom, but only in rather extreme cases

[920] *Sidaway v Governors of the Bethlem Royal Hospital* [1985] AC 871

responsible body of medical professionals found that the physician's conduct was reasonable. Now, with the case of *Montgomery v Lanarkshire Health Board*,[921] the doctrine of "informed consent" applies to risks. In France, the rule is that the consent must be "loyale, claire et approprié" and all risks, that, if they were to eventuate, would have a significant effect on the patient's life, must be advised. Often in France, breach of this duty often gives rise to a claim as loss of chance.[922] In Germany, now under the Improvement of Patients' Rights Act 2013, the treating party is obliged to explain to the patient in a "comprehensible manner" any and all circumstances relevant to the treatment, the therapy and measures to be taken. The Act, as we have seen, later goes into greater detail about the obligations to provide information and the burden of proof. "Informed consent" is the doctrine whereby a patient's consent is vitiated if he is not given the information that a reasonable patient would require in the circumstances.

The typical causal problem that is encountered in cases of patient consent is that a patient has not informed of a particular risk, the risk materialises and the patient suffers damage. The causal question posed is, would the patient have gone ahead with the intervention in any case had she known of the risk? This is a value judgement and is dealt with in different ways in the jurisdictions under question. Germany, for its part, insists on the disclosure of even minimal risks; France insists on the disclosure of risks, that if they were to materialise would have a serious effect on the patient's way of life and the United Kingdom insists on "informed consent". To recover, a patient need only say that he would not have gone through the procedure. Of course, a witness's credibility is something that would ultimately be assessed by a court. However, as we have seen, in Germany, courts are often very reluctant to believe a patient who states that he would not have gone through a procedure where the risk was minimal. Indeed the whole situation

[921] [2015] UKSC 11

[922] CC 1 17 Oct 1998, JCP 1998.II.10179, note P SARGOS; in Luxembourg the doctor must give the patient "adequate information"; Art 40, loi du 28 August 1998 sur les établissements hospitaliers

must be taken into account. So if, having a particular procedure was the only way of saving a patient's life, and a non-disclosed risk eventuated, then, depending of course on its severity, courts would be reluctant to believe a patient who stated he would not have gone through the procedure had he known about the risk. There is always a fine balance to be made between which behaviour should be taken into account. If we follow a strict equivalence of conditions application then we would only take into account that patient's behaviour; yet that patient's behaviour must not be allowed to trump reasonable expectations of the health care professional. There are issues of policy at stake when causation is considered in such situations. So again here, what the patient would have or should have done depends entirely how the jurisdiction in question interprets the conditio sine qua non. Do we apply *hinwegdenken* completely subjectively or do we apply an objective reasonable person test? The question is not necessarily one of strict factual causation. I need only cite *Chester* again to show how divided the House of Lords was on this issue. These are value and policy judgements reflecting causation in the law.

6.7.2.3.3 Article 5-102 – Contributory Fault and Accountability

The framers of the DCFR also consider contributory fault and accountability of the plaintiff. This is an important defence in that it limits causation. Often courts speak of the plaintiff being (say) 20% responsible and he therefore has his damages reduced by that amount. I suggest what the court is really saying is that the defendant only caused the damages requested by the plaintiff to 80% - it may amount to the same thing but I think my theoretical formulation is more honest. Article 5:102 DCFR provides that

(1) Where the fault of the person suffering the damage contributed to the occurrence or extent of legally relevant damage, reparation is to be reduced according to the degree of such fault.

(2) However, no regard is to be had to:

a. an insubstantial fault of the person suffering the damage;

b. fault or accountability whose contribution to the causation of the damage was insubstantial….

(3) Compensation is to be reduced likewise if and in so far as any other source of danger for which the person suffering the damage is responsible under Chapter 3 (Accountability) contributed to the occurrence of the damage.

As examples, the framers state that where injured person X contracts lung cancer either when X worked for A or for B but it is not clear exactly when and that both A and B were negligent then A and B would be solidary liable.[923] They mention that if X had been provided with protective clothing and X had refused to wear this clothing then his claim would be correspondingly reduced.[924] They then opine

> In contrast, if X had occasionally pursued the same occupation in a self-employed capacity, so that the cause of the illness could have been due to that independent exposure during the same time period, VI-4:103 does not apply. In such a case it cannot even be established that either A or B caused the damage. [925]

I have already commented on this above at "Alternative Causes". The last sentence quoted above is harsh. The court is not looking for a scientific proof in these cases but rather, where there has been exposure to asbestos fibres, and X contracts mesothelioma, is it fair to say that it was caused either when X was working for A or B, or indeed when X was working for himself? The answer now is not clearly yes, as it is in the United Kingdom. The period for when X was working for himself can be dealt with under "contributory negligence and accountability". As I showed above, this was the solution favoured in *Barker v Corus*. In this case, the defendants were found to be severally but not jointly liable at common law. This was reversed by the Compensation Act 2006 in so far as cases relating to mesothelioma are concerned. *Barker* still, surprisingly, remains the law for all non-mesothelioma cases. Germany, France and Luxembourg do not need to adopt a special rule for mesothelioma cases as such situations are dealt with under their interpretations of causation.

So then, as can be seen by the framers of the DCFR, there would seem to be no one understanding of what contributory negligence or accountability is. Even in the United Kingdom, legislation was necessary to overturn the case of *Barker v Corus* and this legislation applies only to mesothelioma cases. Where other diseases and causal agents are at play, to suggest that solutions even in this area might be uniform across Germany, United Kingdom and France is foolhardy. The

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[923] *Principles and Models*, p3454; as would be the case in all the jurisdictions considered here

[924] ibid

[925] ibid

Supreme Court may well again decide as it did in *Barker* that defendants be severally but not jointly liable. In France and in Germany, I suggest that solutions immediately favouring joint and several liability would be found.[926]

6.7.2.5 Medical Records

The DCFR deals specifically with a doctor's obligation to keep medical records. This can be relevant as it can go someway towards a plaintiff's proof in establishing whether a measure was taken or not. If nothing is provided for then causal inferences may be made. The PETL do not deal specifically with medical records and it is only Germany where the issue comes up at all in doctrine and case law as being an issue of causal concern. It is also codified there. In the United Kingdom and France and Luxembourg, it is just part and parcel of negligence or fault. Records are important because they provide prima facie evidence that a measure was taken or was not taken. As far as causation is concerned, questions arise when diagnostics are lost or misplaced. So, for example, X-Rays become lost but it is not a matter of dispute that the X-Ray was taken. Should there be a presumption in favour of the patient that a further procedure should have been carried out as appears to be the case in Germany?[927] We also had the situation where a doctor failed to carry out an X-Ray on a patient whom he diagnosed as having bronchial-pneumonia but in reality he had tuberculosis.[928] This turns into a question of faulty diagnosis. The question arise then whether our causal enquiry, as in Germany, should read something like: "If the physician had carried out an X-Ray, would it have shown something to which (a) the doctor would have responded; and (b) would have helped the patient?"[929]

Yet the DCFR introduces a completely new basis for causation that is to be found neither in France nor in the United Kingdom and not, at least as far as I can see, as an *Anscheinbeweis* in Germany. It is what is spelled out in Articles 8:109(2)-(3). Here a

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[926] see the respective chapters for France and Germany on problems posed in *Unification of Tort Law : Causation*

[927] C JANDA, *Medizinrecht* (Konstanz, UVK, 2010), p333

[928] BGH NJW 1987, 1482

[929] M STAUCH, *The Law of Medical Negligence*, p69

health provider has a duty to afford a patient access to his medical records and answer questions with regard to the same. The DCFR provides at Article 8:109 that

> (1) The treatment provider must create adequate records of the treatment. Such records must include, in particular, information collected in any preliminary interviews, examinations or consultations, information regarding the consent of the patient and information regarding the treatment performed.
>
> (2) The treatment provider must, on reasonable request:
>
> (a) give the patient, or if the patient is incapable of giving consent, the person or institution legally entitled to take decisions on behalf of the patient, access to the records; and (b) answer, in so far as reasonable, questions regarding the interpretation of the records.
>
> (3) If the patient has suffered injury and claims that it is a result of non-performance by the treatment provider of the obligation of skill and care and the treatment provider fails to comply with paragraph (2), non-performance of the obligation of skill and care and a **causal link between such non-performance and the injury are presumed**.[930]

So it can be seen here then that where the treatment provider does not provide the patient with access to his records and the patient claims lack of due skill and care by the treatment provider causing the patient's injury, then a causal link between such non-performance of the obligation to provide due skill and care and the injury is presumed. The drafters provide quite little commentary on this article although it seems quite innovative. This is not so much a presumption of causation in the case of missing records but rather with regard to the "access" and "interpretation" of the records. Where the access right is denied then there is a presumption of causation. So for example, a neurologist decreases the dosage of anti-epileptic medication for a patient who had one epileptic seizure in her life after a period of (say) being 15 years seizure-free. It is reduced from (say) 1000mg per day to 600mg per day. This is noted on the records. An electroencephalograph (EEG) is taken to ensure that this is the right course of action and it displays nothing unusual yet the specialist fails to note it in the records. The patient then has an epileptic episode to his injury after he is on the lower dosage. A patient might then seek to argue that the drop from 1000mg to 600mg was too much in the first instance. A doctor might be reticent to

[930] my emphasis

give his patient access to his records as he knows that he did not note the conclusions of the EEG. It would, of course, be open to the specialist to rebut this but it might be difficult where the EEG was not taken in a hospital with witnesses, say at his private clinic.

It is important to note here that there is no mention of causal presumptions in the event that there has not been adequate record-keeping. The health provider must simply give access thereto. It can perhaps be seen as somewhat of a missed opportunity here. The authors do deal with this concern, however, in their commentaries. They state that

> If no records, or only incomplete records, are produced it may be argued that non-performance of the obligation should be presumed. This provides a powerful sanction for the keeping of adequate records. The lack or incompleteness of the medical record may be said to justify the reversal of the burden of proof in a liability claim.[931]

They continue, however, that it may be unrealistic to expect the treatment provider to act in such a way as it would be against his interests.[932] I am not sure what this means. However, the DCFR is exactly the opposite of the case in Germany.[933] There, if a measure is not noted, then there is a presumption that it has not been carried out at all. In the United Kingdom and France, it seems to be the case that if it has not been noted then it will probably be some evidence that it has not been carried out but doctors, witnesses and others who can speak to the fact that it has will be permitted to: there is no presumption as such in these jurisdictions.

Also important for purposes of causation is the detail of the records. The authors provide an example of poor record keeping

> A patient is diagnosed as having a severe insufficiency of the renal function; her left kidney needs to be removed. The surgeon operating on the patient removes the right kidney owing to lack of clarity of the record created by the physician

[931] *Principles and Models*, p2023

[932] ibid

[933] §630h(3) BGB

> responsible for the diagnosis. In this case, the poor quality of the records contributed to the non-performance of the contractual obligation.[934]

They continue that, although record-keep is important, it can be a "difficult task or time-management, organisational and budgetary reasons, whereas the possible gain for the patient may not always very clear".[935] I find this quite astonishing. A doctor is trained to keep appropriate records in accordance with the job he does. Of course, if a toothache treatment takes 15 minutes and writing up notes thereafter takes 30 minutes if "every wad of cotton used in the administering of treatment is accounted for" [sic].[936] I remain astounded by the example. No-one is asking for such minutiae of notes. All professional jobs require record-keeping and generally, it must be reasonable. In all of the jurisdictions in question, the lack of adequate record keeping resulting in so grave an error as the kidney example given above would contribute towards establishing fault. In the United Kingdom, the negligence would clearly be at the diagnosis stage as it would be in France. In Germany, it is likely that the burden of proof itself would be reversed and this would be treated as gross treatment error.

This proposal by the DCFR is quite radical with regard to the United Kingdom and France. We have seen already in Germany that there is some codification at statute with regard to medical records. In France there is no case law or legislative act on the subject but failure to keep proper records is a breach of a contractual obligation.[937] Any direct damage resulting from the doctor's fault will result in the defendant's being condemned and having to pay damages. In the United Kingdom, the General Medical Council issues guidance about keeping records

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[934] *Principles and Models*, p2023

[935] *Principles and Models*, p2023

[936] ibid

[937] Art L 1111-8 CSP, al 1: Les professionnels de santé ou les établissements de santé ou la personne concernée peuvent déposer des données de santé à caractère personnel, recueillies ou produites à l'occasion desactivités de prévention, de diagnostic ou de soins, auprès de personnes physiques ou morales agréées à cet effet. Cet hébergement de données, quel qu'en soit le support, papier ou informatique, ne peut avoir lieu qu'avec le consentement exprès de la personne concernée.

and any non-compliance with this advice would be admissible in any proceedings as evidence against a defendant to establish negligence.[938]

6.7.2.6 Summary: DCFR

In the DCFR a patient has a right to his bodily integrity. A patient will then enter into a "contract for treatment" with his physician. There is a separate section dealing specifically with the relationship between doctor and patient. One flaw I see here is that the authors spoke of a "contract for treatment"[939]. This is perhaps unfortunate where the United Kingdom is included. One of the remedies for non-performance is damages and causation must be shown. Causation must then be shown between damage and the physician's act or omission. Causation is prima facie based on a "consequential" analysis. However, other notions such as policy, foreseeability and probability, but not, and this is important, "general political considerations" according to the drafters are also to be taken into account. The DCFR also allows for alternative causes and the "defence" of contributory fault.

With medical records we see again, there are different suggestions and practices throughout Europe in this regard: the similar practice in France and the United Kingdom, Germany's presumption in the BGB and the causal presumption as suggested by the DCFR. I note this to further my contention that there can be no common understanding of causation on a European level.

Given this consequentialist approach in the DCFR at first principle level, I submit that this supports my theory that there is no one, simple common-sense notion of causation. PETL choses the conditio sine qua non. I do not think it matters. As has been stated, it is often just a question of "feeling" or indeed of morality.[940] Courts often refer to one or the other so there can be no idea of common sense causation.

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[938] see the GMC's guidance at http://www.gmc-United Kingdom.org/guidance/ethical_guidance/13427.asp

[939] Book IV, Art 8: 110, DCFR

[940] H and L MAZEAUD, A TUNC, *Traité*, 1471; HLA HART and T HONORE, *Causation in the Law*, p301

So while I think the DCFR may mean well, I suggest that it fails in understanding what causation truly is. It says that we should not reduce causation formulaically (and I agree) but then it uses the word "consequence" – a highly charged word in the world of causation. Perhaps worse than this, the DCFR framers attempt to define "consequence" thereby further entering deeper into the causal quagmire. They bring in notions that the word "consequence" can be interpreted using all the usual causal armoury (foreseeability, probability, even policy) but then exclude "general political considerations" for some reason. They also fail to see the fact that one way of establishing whether *b* is a consequence of *a* is to perform the equivalence test hypothetical counterfactual. The framers here shy away from this. I think that their commentary, however, on causation was bound to end in confusion, as causation will remain the mercurial and indefinable concept it is I submit my research shows this. There is no need to define causation.

6.7.3 The Principles of European Tort Law (PETL)

The Principles of European Tort Law were published in 2005 and are the fruit of work dating back to 1992 when a group (of mainly academics) met to discuss fundamental issues of tort law as well as recent developments and the future direction of tort law in Europe.[941] This group was formerly called the "Tilburg Group". The principles have even been mentioned in certain cases around the world.[942] PETL, as we shall see, have some similarities to, and some differences from, the DCFR. They sit along side the DCFR. PETL are not to be considered as a restatement of tort law in Europe (as there is not yet a core of European tort law).[943] PETL are simply a proposition of what the majority of its drafters "deem best".[944] As per the DCFR then, I propose first to consider briefly the essentials of PETL before concentrating on its treatment of causation. My purpose in considering PETL is to show that its principles with respect to causation are unnecessary. It is therefore my contention that the project should delete any expansion on its reference to causation.

The basic norm then in PETL is the following

> TITLE I. Basic Norm
>
> Chapter 1. Basic Norm
>
> Art. 1:101. Basic norm
>
> (1) A person to whom damage to another is legally attributed is liable to compensate that damage.
>
> (2) Damage may be attributed in particular to the person
>
> a) whose conduct constituting fault has caused it; or
>
> b) whose abnormally dangerous activity has caused it; or
>
> c) whose auxiliary has caused it within the scope of his functions.

[941] *Principles of European Tort Law*, p12 ; The European Group on Tort Law's mission statement, as found on its website is to " …contribute to the enhancement and harmonization of tort law in Europe through the framework provided by its Principles of European Tort Law (PETL) and its related and on-going research, and in particular to provide a principled basis for rationalisation and innovation at national and EU level." : www.egtl.org

[942] see www.egtl.org for references

[943] *Principles of European Tort Law*, p16

[944] ibid

"Damage" as later defined[945] necessitates harm to a legally protected interest including here, for our purposes, bodily integrity. So here PETL and DCFR are similar. We see at (2)(a) above the requirement of causation and at (b) the requirement of causation attributable to an "abnormally dangerous activity". This would seem to be more stringent than the DCFR's "source of danger for which that person is responsible".[946] With the PETL, an activity must be shown to be "abnormally dangerous". I wonder to what extent this could be applied to iatrogenic procedures, perhaps to experimental ones. The corresponding title in the DCFR could even give rise to liability resulting from an X-ray as this could be classed as a "source of danger" but hardly an "abnormally dangerous" activity. Title II PETL then goes on to deal with damage and causation. It provides

> TITLE II. General Conditions of Liability
>
> Chapter 2. Damage
>
> Art. 2:101 Recoverable damage
>
> Damage requires material or immaterial [sic][947] harm to a legally protected interest.
>
> Art. 2:102 Protected interests
>
> (1) The scope of protection of an interest depends on its nature; the higher its value, the precision of its definition and its obviousness, the more extensive is its protection.
>
> (2) Life, bodily or mental integrity, human dignity and liberty enjoy the most extensive protection.

This inventory of legally protected interests is similar to the German provision of such rights at §823 BGB. It is also similar to the categorisation of torts in the common law; for example, wrongful imprisonment would be a breach of bodily integrity. French law, however, does not as such list these subjective rights and nor is its Civil Code framed in such a way but protection would be afforded civilly to someone who had suffered a battery. So thusfar, it seems that the DCFR and the PETL are much of a muchness even though there may be on occasion some slight differences in emphasis. For the purposes of medical liability, protection is afforded

[945] Art 2: 101, PETL

[946] VI :4 :101, DCFR

[947] why not just "harm"?

to a patient who has had his bodily integrity violated. Before moving on to article 3, it is worth drawing attention to Art 2:105 which deals with proof of damage. It reads

> Article 2:105
>
> Damage must be proved according to the normal procedural standards. The court may estimate the extent of damage where proof of the exact amount would be too difficult or too costly.

Here the PETL, unlike DCFR, mention proof in its core document. The DCFR mentions it but only in its commentary. To say only that "normal procedural standards" apply is not revolutionary – not that I am advocating revolution necessarily but I think the drafters could have gone further if they are to glean from a survey of European tort law what they "deem best", especially in the area of causation in medical negligence.

Although I have shown in this paper that some jurisdictions require "next to certainty" to be persuaded and some only "on the balance of probabilities",[948] it appears to me that there really is no fair way of telling these standards apart *a fortiori* when use is made of presumptions, the prima facie case or even a reversal of the burden of proof in the case of gross negligence. While I am sympathetic to the argument that procedural matters are usually governed by the *lex fori*,[949] I find that procedure is so caught up with the proof of causation as to be inseparable from the substantive law. Procedure is often determinative of who will win a case. For example, if we think of a grossly negligent German doctor, it is a procedural rule that will determine that it is he who must prove that he did not cause the damage. The plaintiff is relieved of the burden of proof all together. The burden of proof is reversed. In such a case, procedure, it could be argued, is more important than substance. I suggest that if the drafters of the PETL wanted to try to find what was "best", then perhaps they should have recognised how important procedure is when establishing causation. I fail to see how appeal to "normal procedural standards" could allow for consistency of decision making in European tort law. There is no harmonisation in this regard. It falls now to consider causation in the PETL.

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[948] even then Germany uses both in its causal analysis

[949] *Principles of European Tort Law*, p40

6.7.3.1 Causation in PETL

Article 3 PETL states that

> Art 3:101 Conditio sine qua non
>
> An activity or conduct (hereafter: activity) is a cause of the victim's damage if, in the absence of the activity, the damage would not have occurred.

The drafters of the PETL choose the conditio sine qua non as their starting position. I have already mentioned what this is and there is no need to describe it further. It is perhaps noticeable that, in contrast to the DCFR, the PETL have a principled position when tackling causal questions.

Unlike the DCFR, the PETL have opted for, what I would say, is a more or less traditional dichotomy of causation: the conditio sine qua non approach followed by some kind of filter of this. Interestingly, the PETL commentary note that

> Only in Belgium is conditio sine qua non probably the sole causal criterion, but the outcome of cases does not seem significantly different compared with other legal systems. According to some doctrine and case law, the same holds true for France.[950]

It is true that the United Kingdom and Germany adopt a two- or even three-tier approach to causation following an equivalence theory (conditio sine qua non), legal causation (scope of liability) and then public policy criteria. France, for its part, dithers between both equivalence and adequacy and it has still to make up its mind (if it feels it has to) which of the two it favours. Nonetheless I would hesitate to agree with the drafters of the commentaries to the PETL when they state that

> For practical purposes the difference between the approaches seems of very limited importance.[951]

This may be true in that in cases before the courts there may not be much ink spilt over the "approach"; that is, the legal philosophical theory of causation in itself. I think what the drafters of the commentaries were contemplating here was outcome

[950] ibid, p43

[951] ibid

or results. However, we must be careful to differentiate "approaches" from results. Just because the difference in approach (if that is indeed what was intended) with regard to theory might be of limited importance does not mean that the results are similar. I would suggest that results are not similar in medical negligence cases in the jurisdictions considered as I have shown.

Progressing from this, the PETL then deals with concurrent causes of causation. Article 3:102 states

> In cases of multiple activities, where each of them alone would have caused the damage at the same time, each activity is regarded as a cause of the victim's damage.

This is the classic situation where A and B both shot C in the head at the same time. It would be absurd to leave C's widow without a remedy based on the conditio sine qua non. Jourdain writes

> …les PETL décident que chacune des causes dites "concurrentes" doit être retenue comme cause du dommage. Cette solution qui est conforme à notre jurisprudence, mais aussi à celles des autres systèmes juridiques, prend ses distances avec le test sine qua non car en l'absence l'une ou l'autre activité le dommage se serait quand meme produit…[952]

In so far as the word "activities" can be interpreted, the above principle at article 3:102 also makes me think of the case of *Wilsher v Essex Area Health Authority*.[953] In *Wilsher*, it might be remembered, it was held that the defendants were not responsible for the baby's blindness where, although they had introduced noxious agent (a) (oxygen) into the baby, there were five other agents that could have caused it. It could not have been said on the balance of probabilities that the introduction of noxious agent (a) caused the baby's condition. What would have to be shown to fulfil proof under this article is that each of the agents alone could scientifically have caused the damage. So where four agents (b) to (d) could have caused the RLF and agent (a) could not have caused RLF but could have induced (say) a myocardial

[952] P JOURDAIN, "La causalité", p5 GRERCA paper at http://grerca.univ-rennes1.fr/digitalAssets/288/288515_pjourdain2.pdf

[953] [1988] All ER 871

infarction, then (a) could not be said to be the cause of the victim's damage, where recovery is for deafness as described in the writ. As the PETL drafters make clear

> It will not always be clear whether or not the conditions of article 3:102 are met. At the end of the day, it is a matter of evidence. This gives manoeuvering room for the court to solve cases by means of procedural law (ie one party has the burden of proof)…[954]

Yet in *Wilsher*, there was one dissenting judge at the Court of Appeal who said that there could be causation where one party creates a risk that injury will be caused to a second party where the first and the second party stand in a particular relationship even though "…the existence and extent of the contribution cannot be ascertained." [955] So here we see two quite different approaches in possible interpretation of this article. Article 3: 102 seems to reflect the German provision of the BGB.[956] So by using the notion of "risk creation" to overcome the causal hurdle, then perhaps judges could interpret Article 3:102 as applying here.

Art 3:103 PETL states

> (1) In case of multiple activities, where each of them alone would have been sufficient to cause the damage, but it remains uncertain which one in fact caused it, each activity is regarded as a cause to the extent corresponding to the likelihood that it may have caused the victim's damage.
>
> (2) If, in case of multiple victims, it remains uncertain whether a particular victim's damage has been caused by an activity, while it is likely that it did not cause the damage of all victims, the activity is regarded as a cause of the damage suffered by all victims in proportion to the likelihood that it may have caused the damage of a particular victim.

From reading this, and the commentaries thereto, I think the first article could be applied to *Fairchild*. There is a condictio sine qua non. Both E1 and E2 could have introduced the "guilty" mesothelioma fibre into the deceased's lungs but it could not

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[954] *Principles of European Tort Law*, p45

[955] *Wilsher v Essex Area Health Authority* [1987] QB 730, 771-772

[956] §830 BGB: (1) If more than one person has caused damage by a jointly committed tort, then each of them is responsible for the damage. The same applies if it cannot be established which of several persons involved caused the damage by his act.

be evidenced which employer was responsible using the "but for" test. Presumably here the length of time that each the plaintiff was working at each employer would be used to show "likelihood" all other things being equal although jurisdictions might opt for other determinants. My understanding, from the analogy of the classic "hunters in the forest case" provided is that each employer would be responsible according to the likelihood.[957] They continue

> We see no compelling reason to justify why someone should pay for the whole of a loss which he possibly…did not bring about. On the other hand, it would be harsh to leave the victim empty handed.[958]

So I presume the intention, if *Fairchild* were to be a PETL case, is that the same result would follow. It appears liability would be solidary as per Article 9:101 PETL as the damage would be the same and there would be no basis to attribute only part of the damage to "each of a number of persons liable to the victim."[959] Yet in one important aspect this article differs significantly from *Fairchild*. The *Fairchild* ratio is only applicable where the agents are the same or comparatively the same. If different agents had contributed to a plaintiff's injury for which two or more employers were responsible then my contention is that British law is not at the stage clearly to allow recovery for the plaintiff as these principles may suggest. Further, of *Barker v Corus*[960] were to be litigated in PETL, I suggest that it reflects British law at statute. That is fine but statute holds only for joint and several liability in so far as mesothelioma is concerned: nothing else.

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[957] *Principles of European Tort Law*, p48

[958] ibid, p48

[959] Art 9: 101(3) ; Art 9 :101 more generally deals with the solidary [sic] liability of multiple tortfeasors. It holds at Art 9: 101(1) that liability is "solidary where the whole or a distinct part of the damage suffered by the victim is attributable to two or more persons. Liability is solidary where: …(b) one person's independent behaviour or activity causes damage to the victim and the same damage is also attributable to another person." Interestingly, according to Art 9:102 (4) where liability is solidary, then where it is not possible to enforce a judgement against one of the defendants, that defendant's proportion is allocated among the other defendant's in proportion to their responsibility.

[960] [2006] UKHL 20

Such articles also remind me immediately of cases like *Bailey v Ministry of Defence*[961] where it could not be said with certainty what caused Mrs Bailey's brain damage: was it the pancreatitis that she had developed or was it the lack of care of the hospital? However, although it could not be said with certainty that "but for" the substandard care, Mrs Bailey would not have contracted pancreatitis, the ratio of "material increase in risk" was employed. Again, Article 3:103 seems contrary to the prevailing case law in the United Kingdom. There is not an evaluation of the "likelihood" that one, as opposed to another cause, may have contributed to the damage. There is not necessarily a condictio sine qua non here as suggested by the commentary to the PETL rather there may be a material increase in risk.[962] As Jourdain notes, in France, where each has contributed to causing damage, then each is considered as the cause of the damage.[963]However, in contrast to France, the PETL solution is to advocate proportional liability – a solution which the PETL drafters state as being both "innovative" and "…not (entirely) in line with the common core."[964] They seem concerned that a defendant should not be liable for a loss that "partially is or may be caused by other activities…".[965] Yet even considering Fairchild as an example, would not the defendant be liable to the plaintiff where the loss "may" not have been caused by that company? The law does not deal with truth. It deals with what can be proven. If the PETL have chosen likelihood as a measure of liability, then I submit that in some cases, the defendant will be liable for damage he **may** not have caused. They continue that

> It does not appeal to the group that a tortfeasor has to compensate a loss not caused by him; ie an activity that is not even a csqn of the loss. [966]

I have yet to encounter a case in my research where a defendant was held liable for a damage that the court said he did not cause.

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[961] [2008] EWCA Civ 883

[962] *Principles of European Tort Law*, p48

[963] P JOURDAIN, "La causalité", http://grerca.univrennes1.fr/digitalAssets/288/288515_pjourdain2.pdf , p6

[964] *Principles of European Tort Law*, p46

[965] ibid

[966] ibid

Article 3:102(2) shouts the adoption of a *Sindell* market-share ratio.[967] So again, a further contrast with DCFR where this was specifically not adopted. We can imagine the example of a particular generic drug causing damage to women during pregnancy where there are (say) ten manufacturers of this drug. M1 has a market share of 51%, M2 20% and M3-10 share the rest. There are pros and cons. It does have the advantage for a plaintiff that no balance of probabilities test need be met and so could recover 20% from M2. Yet if M1 and M2 went bankrupt, the maximum that any plaintiff could recover would be 29% as solidary liability would be denied.[968]

Yet as the article presently stands, a defendant with a small market share, say M5, would not have to pay everything – he would be limited to the likelihood that his particular drug, based on market share, caused the injury. None of the jurisdictions under consideration has adopted the market-share liability ratio.[969] France could do it by loss of chance; the United Kingdom by material increase to harm or to risk of harm with the caveat, of course, that such risk was on the balance of probabilities; in Germany, §830(1) could be applied. It states that

> If more than one person has caused damage by a jointly committed tort, then each of them is responsible for the damage. The same applies if it cannot be established which of several persons involved caused the damage by his act.

Each jurisdiction could, of course, just decide to adopt the doctrine. The PETL drafters then encourage the market-share liability doctrine but deny joint and several liability on the basis that it "…it is obviously an unattractive scenario, it is insufficient justification to hold someone liable for a loss he cannot have caused."[970] This may be

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[967] *Sindell v Abbot Laboratories* 26 Cal 3d 588, see supra for the facts

[968] *Principles of European Tort Law*, p50: "In our view, it would be unfair to oblige one or more manufacturers to pay the entire damage in [such a case]. After all, it is *impossible* that each victim's loss has been caused by anyone of them." (original italics)

[969] although the Netherlands has adopted it on the basis of joint and several liability; see *Van Baallegooijen v Bayer Nederland BV* 9 Oct 1992, NJ 1994, 535

[970] ibid

true but uncertainty in fact can become certainty in law where there is a possibility that one of the defendants caused the damage.

In any case, it seems to be excluded in England as even if the plaintiff brought an action against D1 who put on the market over 50% of a defective drug, this does not establish that D1 caused the plaintiff's damage. WVH Rogers says in *Unification of Tort Law: Causation*

> People with brown eyes outnumber those with blue eyes. But if you were mugged on a dark night I doubt if you would conclude from this that your assailant had brown eyes.[971]

Another article where the potential for loss of chance could be developed is in Article 3:106 with regard to uncertain causes within the victim's sphere. It reads

> The victim has to bear his loss to the extent corresponding to the likelihood that it may have been caused by an activity, occurrence or other circumstance within his own sphere.

The drafters of PETL freely admit that this is partly based on loss of chance.[972] They note some reluctance in the application of this principle especially where scientific opinion differs. Yet, is this not closing the door after the horse has bolted? Surely the use of the verb "may" in Article 3:106 above necessitates scientific uncertainty. Scientific uncertainty is often central to many of the medical cases considered here.

From the common law viewpoint, this article would apply only to the extent that the victim would have to bear his loss where such loss is 49% of the chance he caused it himself. If he can prove to 51% that the tortfeasor caused his loss, he can recover everything. Their comment is also interesting in that it allows for the possibility of differing scientific experts which is not the norm in Continental jurisdictions. For example then, scientific opinion could differ over the cause of someone's contracting lung cancer. Was it the result of his smoking forty cigarettes a day or did other factors such as lifestyle contribute? From the commentary, there is a sense of distancing from the balance of probabilities. They note

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[971] *Principles of European Tort Law,* p50

[972] ibid, p57

> …in our view, it is quite harsh to leave the victim empty-handed, if –eg-the chance is "only" 49%, whereas it does not appeal to most of us that a tortfeasor would have to pay 100% of it is at least greatly uncertain whether or not he actually caused the *entire* loss.[973]

They then consider how difficult it would be for European jurisdictions to accept this approach bearing in mind that common law doctrine is "canvassed" in its procedural law / law of evidence. They write

> Seen from a European angle, there is hardly a common core to support the balance of probabilities doctrine.[974]

The loss of chance case of *Gregg v Scott* comes to mind. The plaintiff argued that he lost a chance from 42% to 25% due to a misdiagnosis. Recovery was denied. I am sure this would have been decided differently if heard in France, Germany or under PETL.

Other applications of this article could perhaps be postulated in hospital acquired infections. A patient would have his damages reduced by (say) 10% if it could be shown that there was a 10% chance that the patient would have fallen ill naturally rather than through some hospital negligence. This would be in his own "sphere". Yet in the United Kingdom there is an "all or nothing" approach to damages. These solutions would not lend themselves to the United Kingdom. In the United Kingdom, a plaintiff must have contributed to his own damages for them to be reduced and so this article would not have any application in nosocomial infections in the United Kingdom for procedural reasons. In France (say) if it can be shown that the patient would have fallen ill naturally, then the patient may well have to bear this loss.

The drafters are wise to remind us here of statistical standard deviations. If in a group of 100, 6 people would normally acquire an infection while in hospital, but in our particular case, it is 7, this may simply be a "normal deviation" from

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[973] ibid

[974] ibid, p58

statistics and should not necessarily, of its own and by itself, show causation.[975] So it is prudent to remember that when considering expert reports deviation from the norm does not show causation.

What can be seen from this article is that to introduce the terminology of "sphere" is a novelty. It is found in German law but not so much in British or French law. What is found in these jurisdictions is the notion of contributory negligence or indeed "victim's fault" where damages are reduced or indeed denied because of the particular acts of the victim. I am not sure therefore how receptive the British judiciary would be to the introduction of notions of "sphere" when they have legal devices that work quite adequately to do the same thing. The drafters' comments are also correct in that there is no common core to support the introduction of a "balance of probabilities" notion of proof across Europe. Causation is inextricably linked with procedure and proof. I submit once again therefore that this shows how there can be no common notion of causation across Europe given these differing standards of proof. The sequitor being necessarily that if there can be no common standard of proof then causation must be seen to be treated differently in the various jurisdictions under consideration here. I have shown in this paper how the use of procedure, be it loss of chance, reversal of the burden of proof and the use of presumptions, can often be crucial when accounting for contradictory outcomes.

[975] ibid

6.7.3.2 PETL: Scope of Liability

The final article with regard to causation concerns the scope of liability. This is an important article as all the jurisdictions under consideration here use some kind of filter to the conditio sine qua non test where this test is used initially. The PETL are to be contrasted with the DCFR here. The PETL set out factors to be taken into account when determining the scope of liability. They are factors to be found in all the jurisdictions under consideration here but courts will just pick and choose from among them to obtain a satisfying result. Indeed I am reminded of the German Pharmaceutical Products Act 1976 when reading the factors to be taken into account when establishing a causal connection. As I hope I have emphasized throughout this paper, there is no such thing as common sense when answering a causal question which means there can be no objectively correct answer.

Article 3:201 states

> Where an activity is a cause within the meaning of Section 1 of this Chapter, whether and to what extent damage may be attributed to a person depends on factors such as
>
> a) the foreseeability of the damage to a reasonable person at the time of the activity, taking into account in particular the closeness in time or space between the damaging activity and its consequence, or the magnitude of the damage in relation to the normal consequences of such an activity;
>
> b) the nature and the value of the protected interest;
>
> c) the basis of liability;
>
> d) the extent of the ordinary risks of life; and
>
> e) the protective purpose of the rule that has been violated.

I also see no reason in listing criteria from which courts should (must(?)) discriminate. It is perhaps encouraging to note that every European jurisdiction recognises that the sky cannot be the limit[976]and some kind of causal dam is required to hold back floodgates in the disparate causal questions that come before the courts. The PETL differ from the DCFR and the other codified jurisdictions here. It suggests factors to be taken into account when "attributing" liability. Neither of the national codes nor the DCFR does this. In fact, I think the drafters are right when they note that

[976] ibid, p60

> The real difference between the various legal systems seems to be that some perceive the issue dealt with in Article 3:201 as part of causation, whereas others perceive it as an unrelated legal vehicle.[977]

How right they are. Causation is in the eye of the beholder. There are disagreements about it and there is no consensus about it. I do not understand the point then of the heading "Scope of Liability" as I have seen that there is often no agreement about causation in fact. So that I am not accused of selective quoting, the drafters of PETL finish the paragraph "So for practical purposes, the differences are very limited".[978] I disagree.

The PETL drafters, however, quoted what I found to be a particularly pertinent case in their commentaries on this article. They quoted that of *Blue Cross & Blue Shield of New Jersey Inc v Philip Morris Inc*[979] where it was noted

> "Proximate cause" is an amorphous concept even under common law. See *Associated Gen Contractors v Cal State Council of Carpenters* 459 US 519 536-37, 103 S Ct 897, 74 L Ed 2d 723 (1983).
>
> (T)he infinite variety of claims that may arise make it virtually impossible to announce a black-letter rule that will dictate the result in every case. Instead, previously decided cases identify factors that circumscribe and guide the exercise of judgement in deciding whether the law affords a remedy in specific circumstances.

However, notwithstanding this apposite quote, the drafters nonetheless attempt to relate stateable principles which have been gleaned from the various jurisdictions applicable. I can confirm that this is the case with regard to the factors in the article except "foreseeability" where France, though not excluding it all together, prefers to opt for the dichotomy of directness and indirectness. The protective purpose rule is hardly to be found in France.

The drafters then give some consideration to the relevant factors themselves. I shall consider them here:

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[977] ibid

[978] ibid

[979] 178 F Supp 2d 198 (EDNY 2001)

(a) Foreseeability

As is noted, this is probably the most important and most applied factor.[980] This can be applied in causation in many ways as we have seen. What is deemed foreseeable in a given situation necessarily has an impact in a causal judgement. In Germany, we have seen the BGH state this with regard to the case of the pregnant woman's child being born a spastic[981]in that it need not be "foreseeable" what kind of damage in detail would occur but that some damage to the foetus would occur. In France, the notion of foreseeability is used when determining what is cause étrangère.[982] However, notions such as foreseeability are simply used as a controlling device by the courts when they can cross the causal bridge from fault to damage. In cases of medical negligence, foreseeability itself can be linked to questions of statistics and expert evidence. Do the statistics provided show not only a generalising connection but also an individualising connection between the damage and the alleged fault? Further, is there any dispute in these statistics and how can this be resolved? Unfortunately, PETL do not give any consideration to expert evidence which I believe is central to the question of proving causation.

(b) The Ordinary Risks of Life

"The ordinary risks of life is a somewhat amorphous concept."[983] Thus begins the commentary on this factor with regard to the scope of liability.

Every medical intervention poses some kind of risk. Yet I have found that often the causal link between damage and alleged fault is to a great extent attenuated on the Continent. In the medical sphere in particular, I see a move away from allowing patients to be subject to the vagaries of the ordinary risks of life. One would not necessarily prima facie think this to be the case given the higher levels of proof required in France and Germany with regard to causation (except for *haftungsausfüllende Kausalität* in Germany where the level of proof is on the balance of

[980] *Principles of European Tort Law*, p61

[981] BGH NJW 1972, 1126

[982] P JOURDAIN, "Effets de la responsabilité" (2009) *Revue trimestrielle de droit civil* 543

[983] *Principles of European Tort Law*, p62

probabilities). Yet if we consider the regimes that exist for medical hazards (France), medical risks (Germany), security obligations (France and Germany), the potential for presumptions (France), loss of chance (France) and reversal of the burden of proof (Germany) and the national solidarity fund (France), we begin to see how, what starts out as a principle of conditio sine qua non, is significantly diluted and weakened in its application. These aspects of medical law do lessen the force of the idea that we are all subject to the ordinary risks in life. Yet there may well be policy reasons for doing this. Of course, the purpose of this paper is not to say that one of these is "better law" or one policy is better than another but rather to show that similar problems do not have similar answers in the jurisdictions concerned. With the examples I have given already, I think it is clear that the different jurisdictions opt for different solutions.

(c) The Protective Purpose of the Rule

This, I submit, can most clearly be seen in Germany and in the United Kingdom. Germany applies the *Schutzzwecklehre* (the protective purpose rule). This is often studied together with *wertende Überlegungen* (evaluation considerations). We have seen how this has been applied already above in wrongful life cases and cases where a handicapped child has been born where the doctor had failed to diagnose rubella.[984] In the United Kingdom, we have seen a protective purpose rule openly being applied in *Chester v Afshar* where a doctor negligently failed to warn of risks inherent in a procedure. This was that of a patient's right to autonomy.[985]

Article 3:201 is also confirmed in the *Unification of Tort Law: Causation*.[986] So while the drafters did well to identify certain principles that may on occasion be found in case law in all of the jurisdictions under consideration here, I would argue that it serves next to no purpose to state them especially given how jurisdictions frame their judgements. Lawyers will select the principles they require for their arguments and judges will select the ones they require to justify their decisions. The case of *Chester v Afshar* again comes to mind. Here, if we remember, the

[984] BGH NJW 2005, 891

[985] *Chester v Afshar* [2004] UKHL, as per Lord Walker of Gestingthorpe at para 90

[986] see in particular the comparative table at pp136-137

patient had not decided what she would do had she been informed of the dangers inherent in the procedure. The conditio sine qua non test had not been satisfied. All that had been shown was that she would have taken further advice. This was a 3:2 decision in the House of Lords so there was no "common sense" solution. Resort was had to (e) in particular – the protective purpose of the rule violated.

In my opinion, the stating of such principles with regard to the scope of liability is inherently vague as a check on conditio sine qua non. Even if we could agree on what factual causation actually was, there will always be a normative element to legal causation. This can be framed using any of the judicial devices that are, practically, set out in Article 3:201. More can even be added. Judgements can be framed in terms of foreseeability, temporal and special closeness, mores, policy, magnitude of the damage, "normal" consequences of such an act, common sense and so on. This does not even begin to cover the special regimes that exist in the different jurisdictions (asbestos, medical hazards) or account for shifts in the burden of proof. I am really not convinced that courts, lawyers and legal scholars need to be reminded of what constitutes or could potentially constitute cause. They know it already though they may not agree on it. The arguments are there in their own jurisprudence and academic writing. Given that courts have been cherry-picking as to what constitutes cause, and the different results in medical liability can be seen, I think that such articles are unnecessary. I am not saying thereby that it is useless to define any word in the law, simply that it is pointless with regard to causation. It evades all attempts at definition.

6.7.3.3 Consent

Only a brief word need be said on PETL's approach to consent as the drafters themselves do not treat the subject in any great detail as compared to the DCFR. Article 7:101 PETL states that

> (1) Liability can be excluded if and to the extent that the actor acted legitimately ...d) with the consent of the victim, or where the latter has assumed the risk of being harmed.

I am not certain that the PETL discussion necessarily included consent to medical procedures and the causal issues behind them. I have shown already the number of

complex issues that the idea of *volenti non fit iniuria* raises in the context of medical negligence. It is not possible simply to say that a procedure is unlawful if the patient has not "consented" to it. If codification is an aim, surely more is required. Not one of the jurisdictions treats this in the same way. France requires that the patient be informed in a manner that is "claire, loyal et approprié"; German consent must now be in conformity with the Improvement of Patients Rights Act 2013 and in the United Kingdom, there must be informed consent à la *Montgomery*. The issue then of a counterfactual hypothetical must be dealt with. What would the patient have done had she been properly informed? This is an essential question to which it is necessary to know the answer if a court is to make a decision. A decision making tribunal may not opt for a strict counterfactual analysis but may replace the *in concreto* responses of a victim with that of what a reasonable patient would do in the circumstances as we have seen in Germany. If harmonisation inter alia is the aim, more needs to be said of consent here as the idea of consent is not the same in the jurisdictions under consideration. I do not advocate any principles. Before I am accused of being too strict or of ignoring PETL's statement that for "practical purposes, differences are very limited", I would disagree. Differences are indeed, very different. For example, if a doctor in the United Kingdom does not warn his patient about a one in ten thousand chance of a risk then there could still be informed consent. As we have seen in Germany, the patient may not have consented if not so informed and there could even be criminal liability. I think this is not an insignificant difference.

6.7.3.4 Summary: PETL

While the drafters of the PETL may conceive to create a notion of causation in European tort law based on principles gleaned from various jurisdictions, my submission is that it is not possible. The PETL have adopted the German codification of certain subjective rights as their "basic norms", and these are set out at Article 2:102. I am not going to comment on this. European law has already had to grapple with such issues in the interpretation of the European Convention of Human Rights.[987] What I do believe is that the PETL are not workable in their present form as there is no agreement on one of the fundamental pillars of tort law: causation. I believe this is the case, based on the fact, that there is not one complete, all-embracing, total idea or concept of causation in the law among the jurisdictions. I believe my research in case law and academic writing shows this. Hamer inter alios shows that there is no one understanding as to what factual causation actually is.[988] To what end does it serve, for example, to state that the basic principle is that of conditio sine qua non[989] when, first of all, as I have shown above, there is no one answer as to what it is? And to what end does it serve to have factors with regard to the scope of liability set out?[990] This is already done in all the jurisdictions and we have seen that there is no uniformity of decision-making. The drafters readily admit in their commentaries that there is confusion over this even though practically differences from jurisdiction to jurisdiction are "very limited". To attempt artificially to create some common notion of causation, without even first standardising rules of proof, experts' reports and taking account of the special systems of recovery that exist in all the jurisdictions seems foolhardy at best. Even if we were able to standardise rules relating to proof and experts' reports, this does not by any means imply causation would be a non-issue. This does not really bode well for harmonisation. Just to take the example of Article 3:102 with regard to concurrent causes. The rule here is that where there are multiple activities and where each of them alone would

[987] European Convention of Human Rights: Article 2 (right to life), Article 3 (prohibition of torture and inhuman or degrading treatment or punishment), Article 4 (prohibition of slavery, servitude and forced labour), Article 5 right to liberty and security)

[988] D HAMER, " 'Factual Causation' and the 'scope of liability': what's the difference?", (2014) 77 *Modern Law Review* 155

[989] Art 3: 101, PETL

[990] Art 3: 201, PETL

have caused the damage at the same time, each activity is regarded as a cause of the victim's damage. In the commentary thereto the drafters note it will not always be clear whether or not the conditions of Article 3:102 are met.[991] They admit that it is a matter of evidence and procedural law.

This shows that causation is inextricably linked to matters of evidence and procedural law. It leaves me thinking that the PETL are trying to be all things to all people. Articles 3: 102 may seem exciting in themselves but the commentaries seem rather like a damp squib rather than something that could actually revolutionise European tort law. Of course, at the end of the day it is a matter of evidence – not just in European cases but in all cases. It is also a matter of procedural law in all cases. I am not sure to what extent I would agree that this gives "manoeuvring room" but certainly a judge is free to say that the standard of proof has not been met. If the judge wants "manoeuvring" room then I imagine he would just refer to some vague notion of legal causation not having been met and that would be an end to it.

This brings me on to Article 3:103. Paragraph (1) states that where there are multiple activities but it is **not certain** which one in fact caused the damage, then each activity is regarded as a cause to the extent that it **may** have caused the victim's damage. This, as we have seen, reflects the idea of "likelihood" but as we have seen this interplays enormously with the balance of proof and has consequences for solidary liability. If the likelihood is lower than 51% then there is no full recovery in the United Kingdom. Also, PETL freely admit going against the common core of systems by introducing proportional liability.

Similarly, Article 3:102(2) PETL seems to go against the "common core" by allowing for only causal link to be attributed to the activity proportionally. This is the market-share liability test, which has not yet been adopted in any of the jurisdictions under consideration mainly for problems of linking defendants to plaintiffs. This would be particularly relevant for damage resulting from marketed drugs. It does not exist in Germany, the United Kingdom or in France. Germany has not excluded the

[991] *Principles European Tort Law*, p45

possibility.[992] France would allow for a full recovery against any of the tortfeasors according to Jourdain (*in solidum*) but Galand-Carval notes that the problem of identification is a bar to liability.[993] The United Kingdom maintains its balance of probabilities burden of proof so any plaintiff would have to show a tortfeasor's share of the market was more than 50% and thereby recover 100%.

In summary, Jourdain writes of the PETL (and DCFR) together that

> Sur le fond, les divergences entre le droit français et les projets européens sont donc plus apparentes que réelles.[994]

I do not agree with this. There is no use of market-share liability in any of the jurisdictions. Yet the PETL endorse it. Article 3:106 deals with the loss of chance. Neither the United Kingdom nor Germany recognises this. France does not adopt a sina qua non as a first principle. The PETL do. There is also no indication on the burden of proof or the use of expert's evidence or science. It has been seen already that France has admitted causation even in the absence of scientific evidence.[995] I submit neither the United Kingdom nor Germany would allow this to such an extent. So it would appear that even after considering a number of European law systems, the PETL drafters have nonetheless decided to be innovative and adopt solutions that cannot be derived as generalities from research: for example, proportional liability, market-share liability and loss of chance. I submit again then that the PETL appear to go against some solutions that would be found in the jurisdictions under consideration here. Of course, they had to adopt a solution one way or the other. They had to chose and I freely admit this. Yet it is because outcomes can be so different that I believe there is no common core with regard to causation. I contend therefore that PETL themselves further show in what a confused state the law in Europe is with regard to causation. Again this is not a criticism and actually I find it rather unsurprising. I do not foresee its becoming

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[992] U MAGNUS, *Unification of Tort Law : Causation*, p72;

[993] P JOURDAIN, "La causalité", p6; S GALAND-CARVAL, "Causation under French Law", *Unification of Tort law: Causation*, p53 at p61

[994] P JOURDAIN, "La causalité", p4

[995] hepatitis B and multiple sclerosis

"unconfused" any time soon. Solutions in fact differ significantly. It is my contention, that codification in this current form with regard to causation is undesirable.

6.8 Summary of PETL and DCFR

The PETL and the DCFR are both proposals which could have an effect on causation and how it is understood at a European level. I think Winiger, diplomatically puts it

> Compared to the national codes, which scarcely mention the concept of causation, the extensive norms established in the…PETL constitute a major innovation.[996]

They do indeed. The PETL go into a lot of expansion under their causation title whereas the DCFR is more succinct. The PETL accept the conditio sine qua non as a starting point whereas the DCFR does not really give any guidance simply stating that a person causes legally relevant damage if it is "consequence" of the person's conduct or a source of danger – it being presumably left up to the national courts to determine what "consequence" means. I have argued above that this notion is more like adequacy theory than equivalence theory. I have also shown that it can be impossible to agree on the notion of the word "consequence". Yet with the DCFR there is no cause-in-law / cause-in-fact dichotomy as it could be argued exists in the PETL. The DCFR, I find, is much somewhat more "laissez-faire" and somewhat more honest when it comes to causation in that it while it may expand to some extent in the commentary, it does recognise that

> The formulation has been deliberately kept flexible ("is *to be regarded* as a consequence") so as to ensure that, in the context of causation, differences between individual attributive causes and legally relevant damage can be taken into account.[997]

In any case, judging from the research I have done for this paper, I am certain this is what courts would do anyway. They would adapt, interpret and modify the word "consequence" so as to arrive at a satisfactory result. England (not Scotland) is known for arriving at equitable results; France is known for its victim-friendly solutions in these cases and Germany is known for its liberal approach to prima facie cases and even changing the burden of proof. These overall policy considerations will trump any attempt to hem in the idea of causation.

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[996] B WINIGER, "Multiple Tortfeasor" [sic] (L TICHY (ed), Prague, E Rozkotova, 2007) p79 at p92

[997] *Principles and Models*, p3424

The notion of "informed consent" is not, in my opinion, the same in its content as consent that must be "loyal, claire et approprié" in the circumstances and nor does the simplicity of the idea conform to the broader notions as enshrined in the German Improvement of Patients Rights Act 2013. "Informed consent" holds as per *Montgomery* that a patient must be informed of all material risks. Material risks are such risks which a reasonable person in that patient's position would consider significant if he knew about them. In France, a doctor must inform the patient of "les risques graves" even if they are not exceptional.[998] Additionally, it is for the doctor to prove that he has carried out this *obligation d'information*.[999] German law is stricter. The DCFR provides for the defence of consent and gives three pages commentary on it. The PETL comment only on it briefly as we have seen. To replace fully the idea of consent to a medical operation in all jurisdictions, I suggest, would be an uphill struggle and the approach to counterfactuals in each jurisdiction is different.

I contend again that "practical purposes the differences are very limited" is not what I appreciate from my analysis of causation, albeit in one particular area of tort. There are quite significant differences when it comes to rights recognised (or remedies offered) with regard to loss of chance, strict liability (notably with nosocomial infections in hospitals), medical accidents (*aléa thérapeutique*), recovery for the effects of vaccinations, the use of science and epidemiology and burdens of proof to name but some. I submit therefore that in the matter of medical causation, results **differ significantly** from jurisdiction to jurisdiction and I would counter the drafters' suggestion by the case law to be found in this paper.

However, although I think even the DCFR went too far in trying to define causation, I believe its version is to be preferred, if I had to chose. Its strength lies in its vagueness. It is vague enough as to mean almost nothing and I agree with the DCFR drafters that it is not necessary to begin with conditio sine qua non as a starting point. France sometimes does, sometimes it begins with adequacy: it really depends. Germany and the United Kingdom may purport to have causal principles in theory but they are quickly jettisoned when required. This is not to

[998] CC 1 27 May 1998, Bull n°187; D 1998, p530 note F LAROCHE-GISSEROT

[999] CC 1 25 Feb 1997, Bull n° 75

say, of course, that we ought to eschew consistency in France but it is rather to appreciate, as an outsider, that the tradition in France is different from that of the common law where precedent is the aspiration. Neither does the DCFR try to limit causation later by listing factors to be taken into account in the scope of liability (or legal causation in the United Kingdom). I am sure the drafters of the DCFR knew as well as the drafters of the PETL that such factors appeared time and time again in the case law and in academic writing, but I am just not convinced of the utility of their being listed. Hence I would opt for the more "minimalist" DCFR approach in this regard in the first instance if I had to choose between the two. My purpose in stating my preference over PETL is simply to show that the less that is said about causation, the better.[1000] Causation cannot be defined. As van Dam has noted "an important reason why legislators have refrained from providing causation rules is that it is hard fruitfully to design a generally applicable causation test."[1001]Notions such as the conditio sine qua non or adequacy theory can be thrown around and used liberally in writs but ultimately, the judge will make her decision according to how she understands (or indeed "feels") how causation should be applied. As we see especially from case law in the United Kingdom, there is no one understanding of causation at the highest courts, so why should there be an understanding of what it means across Europe?

[1000] at least in legal codes

[1001] C van DAM, *European Tort Law*, p307

6.9 European Court of Justice Case Law, the Environmental Liability Directive and the Product Directive

The thrust of this paper is to show that projects such as the DCFR and the PETL are unworkable on the basis that there is no common European (or other) idea of what causation is. Nonetheless causation as a model must be considered on a European level to a certain extent. On a supranational level, there are these important sources of European law that treat causation. I should like to consider them. One of these is Article 340 TFEU. It sets out the general basis for non-contractual liability. There is very little case law on Article 340 treating causation as such but nonetheless it enshrines non-contractual liability in the TFEU. If some kind of pan-European notion of causation is therefore envisaged, it is important to know how it is to be formed, what its sources are and how scholars and lawyers might be able best to argue causation based on previous cases. Causation at this level of pan-European understanding is here to stay.[1002]

Aside from this, two significant directives use the word "cause". These are the Product Directive and the Environmental Liability Directive 2004.[1003] The latter brings in the principle that an operator whose activity has caused environmental damage should be financially liable therefor. The former seeks for maximum harmonisation and sets out simply that a producer is liable for damage caused by a defect in his product. Understanding "cause" here is important and, even more so for the purpose of this paper, when it relates to "medical products". Admittedly there is not much by way of case law either at a supra-national level or at indeed at a national level but there are green shoots of development that I shall consider herein.

I shall consider first Article 340 TFEU and the case law under it that is relevant to causation. I shall consider the case law under the Environmental Liability Directive, and then the Product Directive. I shall then finish with a word on experts' reports at the ECJ.

[1002] The current United Kingdom government has proposed a referendum on the United Kingdom's continued membership of the European Union by the end of 2017.

[1003] 2004/35 EC and 85/374/EEC respectively

6.9.1 European Court of Justice Case Law

Non-contractual liability of EU institutions and their civil servants is set out in Article 340 TFEU. It states that

> In the case of non-contractual liability, the Union shall, in accordance with the general principles common to the laws of the Member States, make good any damage caused by its institutions or by its servants in the performance of their duties.

Three matters stand out immediately. First of all, that this is all the TFEU has to say with regard to non-contractual obligation. There is nothing more. Second, the word "caused" is used yet it is not defined. Third, that there would appear to be principles "common to the laws of the Member States". The first of these need not strike as particularly surprising. Many jurisdictions have short written provisions in their codes and allow case law to fill the gaps. The second one is interesting in that the drafters of the TFEU have chosen not to define causation even thought they had the chance – a wise move. The third one, however, may seem more remarkable. The drafters of the TFEU must have thought that there were indeed general principles common to the laws of the Members States with regard to tort or at least, that they could be found without undue difficulty. If they did not think this, they would not have inserted such a provision. Notwithstanding the fact that this provision has been extant since the Treaty of the Rome was drawn up, there has been plenty of time to amend or indeed remove it if later drafters thought otherwise. At the time when there were six members of the European Economic Community, French law was selected as the spur in this area and it will be seen that French law has a large influence in ECJ case law here.[1004] It is my position, that there are no principles common to the laws of the Member States as I think my research in medical causation alone has shown. However, my contention at this supra-national level of law may seem redundant as the ECJ is in fact mandated to follow, find and deduce general principles common to the laws of the Member States. I shall consider the case law so far with regard to causation. There is not much and to understand it one must take a global view of recovery in tort to understand what exactly has caused

[1004] C SCHOUSBOE, "The Concept of Damage as an Element of the non-Contractual Liability of the European Community", p6 http://law.au.dk/fileadmin/site_files/filer_jura/dokumenter/forskning/rettid/2003/2003.afh-3.pdf

what damage. I shall first consider how the ECJ approaches causation and then move on to consider how the ECJ considers damages.

So where and how then are these "general principles common to the laws of the Member States" to be found? First, plaintiffs cannot simply pick a principle in their own legal system and have a right to insist that it be followed. A plaintiff could not, for example, refer to German law, insist that given there has been gross negligence and therefore that the burden of proof be reversed. This would be a principle in German law but it would not be correct to regard it as a "common" principle. On the other hand, the ECJ should feel free to develop its own jurisprudence in this area but reality is that French law has had a dominating influence. Whether it will continue to dominate in the future given the expansion of the European Union is a moot point and this remains to be seen. In order to assess how the ECJ treats causation in this area, it is necessary to have a cursory look at how the ECJ treats loss and damages in general.

Loss must be set out with clarity and precision and it must be "certain", "direct", "specific" and "serious".[1005] This is quite similar to French notions of recovery. A hypothetical loss would not be sufficient and therefore this does bring into question as to whether a loss of chance would be recognised.[1006] Schousboe refers to other European case law noting that the court has also not just used the adjective certain but also "actual and certain", "concrete" and "real".[1007] This need not concern us overly but damage which falls into this category is derivative economic loss, that is, for example, loss of earnings following from an stay in hospital caused by medical negligence.

[1005] LESIEUR Cases 67-85/75

[1006] C STEFANOU and H XANTHAKI, *A Legal and Political Interpretation of Article 215(2) – The Individual Strikes Back* (Dartmouth Publishing, 2000), p94

[1007] Case 26/74 *Roquette Frères* and Case 74/74 *CNTA*; T-231/97 *New Europe Consulting* at para 25; see C SCHOUSBOE, "The Concept of Damage as an Element of the non-Contractual Liability of the European Community", p6 http://law.au.dk/fileadmin/site_files/filer_jura/dokumenter/forskning/rettid/2003/2003.afh-3.pdf, at p11

My argument in this paper is that causation is not an area where any commonality or "general principles" are to be found, and, by dint, there can be strictly no implementation of Article 340 TFEU as it stands should a case of this nature ever come to court.[1008] This is because there are no "common general principles". I suggest nonetheless that it is an article with which the ECJ has to work[1009] and the ECJ shall attempt to discover these common general principles. I propose now to consider a certain amount of case law that may allow us to reflect on how the ECJ has treated causation and how it may treat causation in the future when cases come before it. I am not attempting to forward any principles at all as I believe this is a futile exercise.

6.9.2 ECJ Causation

In *Kampffmeyer v Commission*,[1010] there was no development of the Advocate General's treatment of causation, precisely because the parties themselves had not brought up the subject. He stated

> In order that the Community should be liable it is not sufficient that the action of the Commission was wrongful, it is necessary that it should have been the cause of the damage; that is the intention of Article 215 which speaks of damage caused by the institutions. More exactly, it is necessary that there should have been a direct causal link between the action or decision in dispute and the alleged injury.[1011]

So what appears to be necessary then in European law is that there be some kind of "direct causal link", however this is to be interpreted. The Advocate-General notes some possible interpretations

> One may regard any event without which damage would not have occurred as the cause of it; one may keep to the most recent event; one may attribute the damage to the events preceding it which were likely to cause it in the natural course of things.[1012]

[1008] I accept that this argument might be somewhat existentialist

[1009] the ECJ has not deemed itself incompetent to rule under this article

[1010] C 13-24/66, [1967] ECR 245

[1011] ibid, at 278

[1012] ibid

So the Advocate-General spoke quite liberally of causation. There is the possibility for the conditio sine qua non theory (without which the damage would not have occurred) and adequate causation (natural course of events). He even suggests the prospect of a proximate cause ("one may keep to the most recent event"), an idea which has been rejected in France. It is interesting that these indeed are philosophies that can be gleaned from the United Kingdom, France and Germany: conditio sine qua non and adequacy. Yet as we have seen, theories can be interpreted to suit the case and I suggest this is exactly what would happen at the European level, regardless of the fact that lip-service is paid to one or another theory. This quote from the Advocate-General would seem to justify this.

This case concerned damage resulting from an illegal act under the law of a Member State and under Community law. It appeared there were two concurrent—or successive—acts: that of the Federal Republic of Germany which took the protective measure and refused certain licences and that of the Commission which, by validating that measure, increased the damage or refused to require the German Authorities to eliminate it. If the Federal Government was the primary cause that did not prevent the Commission also from having caused the damage. Mr Advocate-General Roemer stated in the *Vloeberghs* case which appears to me to apply mutatis mutandis to the present case

> The fact that the attitude of a Member State contrary to the Treaty is the basis of a relationship of cause and effect does not exclude the consecutive omission of the High Authority from the original conduct of a Member State contrary to the Treaty.[1013]

Terminology such as "direct" cause could be accepted into a later European idea of causation were a well-defined one to be developed at a European level. We perhaps see a kind of joint liability (in this case potentially the Federal Republic of Germany and the Commission) along the lines of the British mesothelioma cases and French case law. This idea of a direct causal link in European law is also to be found in other cases.[1014] One case also speaks of the Community's only being held liable for

[1013] Joined Cases 9 and 12/60 Rec 1961, at p 475

[1014] *Brinkmann Tabakfabriken v Skatteministeriet* [1998] ECR I-5255; *Lüttcke v Commission* [1971] ECR 325

"sufficiently direct consequences".[1015] So the idea of cause has now morphed into a reference to "consequences"[1016] and only those consequences which are "sufficiently direct". In the context of causation at European law, there also exists a duty on the plaintiff to show that he acted with "reasonable diligence in limiting the extent of the damage which it claims to have suffered."[1017] So the plaintiff must act to prevent causation continuing to increase damages unnecessarily. He must mitigate the damages.

Van Dam writes in his *European Tort Law* that

> As in all national jurisdictions, the basic requirement for causation is that the conditio sine qua non test or but for test is met. Causation is not established if the same damage would have occurred in the same way in the absence of the wrongful Community act or omission in question.[1018]

Yet as we have seen this is not true. I have not seen anywhere that it is a "basic requirement". He footnotes citing the case of *Compagnia Italiana Alcool v Commission*.[1019] It is certainly an argument that can be used but as I have quoted above, other notions of what causation is actually exist, one not being more "basic" than the other. I am not of the opinion that this case lays down any such a radical rule.

In the *Compagnia Italiana Alcool* case, the ECJ considered whether the damage suffered by the plaintiffs could be in some way related to a deficiency in providing a reason of a decision dated 18 October 1990. The court had – albeit not openly – used the theory of equivalence of conditions, or the conditio sine qua non. If the deficiency had not existed then the damage **would have been** the same.[1020] I assume that van Daam was referring to the last sentence here when he made his generalisation about

[1015] *Fresh Marine Company SA v Commission of the European Communities* [2000] ECR II-3331 (CFI)

[1016] the word used in the DCFR

[1017] *Fresh Marine Company SA v Commission of the European Communities* [2000] ECR II-3331 (CFI) at II-3334

[1018] C van DAM, *European Tort Law*, p28

[1019] C-358/90

[1020] at para 47

the adoption of the equivalence theory as there is no other mention of causation in the case. For me, the Court is simply making an observation rather than proclaiming a new theory of law. It certainly does not appear in declaratory language and to say the rule for causation at Community level is the "but for" test is in anyway a basic rule is perhaps wishful thinking. There is nothing, it seems to me, to prevent the ECJ starting from an equivalence, proximate, or other theory that might be expounded. The caveat I would add to this, however, would be that any theory that is developed at this level would have to have some justification by its presence in the national law of more than one Member State.

Indeed to support my above contention, the ECJ has also suggested that it could use a "sphere of risk" theory. When one thinks of "sphere of risk" theory, one immediately thinks of the German law of causation. The ECJ noted in *Mulder v Council*[1021]

> The Court has also consistently held that, in order for the Community to incur non-contractual liability, the damage alleged must go beyond the bounds of the normal economic risks inherent in the activities in the sector concerned.[1022]

This case concerned inter alia non-contractual liability of the Commission by the adoption of an economic measure allegedly breaching legitimate expectations of producers in the milk industry. With regard to the damages that the Community had to pay, the basic principle was set out that this should be

> …the difference between, on the one hand, the income which the applicants would have obtained in the normal course of events from the milk deliveries which they would have made if, during the period between 1 April 1984 (the date of entry into force of Regulation No 857/84) and 29 March 1989 (the date of entry into force of Regulation No 764/89), they had obtained the reference quantities to which they were entitled and, on the other hand, the income which they actually obtained from milk deliveries made during that period in the absence of any reference quantity, plus any income which they obtained, or could have obtained, during that period from any replacement activities.[1023]

[1021] C-104/89

[1022] ibid, at para 13

[1023] ibid, at para 26

Interestingly, in calculating such amounts of milk, reference was made to "farms representative of the type of farm run by each of the applicants, taking into account such factors as lack of profitability for start-up farms." So what we see in this case is reference to a certain risk; the Community is liable when damage alleged goes beyond that of normal economic risks. The counterfactual is also used by the Court here is, in my opinion, a kind of objective adequacy counterfactual. What profit would the farm have made **in the normal course of events**?

So it can be seen then that from case law, the ECJ is at a nascent stage when it comes to developing a theory of causation. Indeed, I submit that many of the theories expounded by the Advocate-General in *Vloeberghs* may be used from time to time. There has even been the adoption of risk theory and counterfactuals: all important language when it comes to understanding what causation is and I commend the Court for this. It has stayed clear of trying to invoke principles and at the same time embracing all potential causal arguments.

6.9.3 Damages

Perhaps first and foremost, Member States are liable to persons as a result of damage caused to them for a breach of European Community law based on article 340 TFEU.[1024] There are two kinds of loss to consider: *damnum emergens* and *lucram cessans*. The former is the reduction in any asset that one owns and the latter is the loss of potential profit. It is important to consider damages, as, in my opinion, this is precisely where the court stops the causal chain. If damages are recoverable then a court is saying that the plaintiff caused the recoverable damages. If they are not recoverable then the court is simply saying the plaintiff did not cause the damage: remember it is causation in the law with which we are concerned. The ECJ has never actually pronounced on the different kinds of damages that are recoverable as such. In the case of *Ireks-Arkady*, Advocate General Caporti stated that

> The legal concept of damage covers both a material loss *stricto sensu*, that is to say, a reduction in a person's assets [*damnum emergens*], and also the loss of an increase

[1024] *Francovich v Italian Republic* [1991] ECR I-5357 and joined cases *Brasserie du Pêcheur SA v Germany* and *R v Secretary of State for Transport, ex parte Factortame* [1996) ECR I-4845; [1996) QB 404

> in those assets which could have occurred if the harmful act had not taken place [*lucram cessans*].[1025]

Examples of the different kinds of losses have been set out in detail in the case of *Embassy Limousines*.[1026] This case was concerned with certain damage incurred by Embassy Limousines following information received by it on a certain date. Interestingly in the case report, the ECJ made specific reference to causation and stated

> It follows that the aforementioned investments show a direct causal link with the telephone conversation of 4 December 1995.[1027]

It is noteworthy here that the ECJ has chosen to use the adjective "direct" in the description of the causal link. It has used this adjective before as we have seen. This is similar to French case law.

The damages themselves which were recoverable in this case "included expenses and charges incurred by reason of its certainty of winning the contract", and, "expenses of recruitment, medical examinations, training and familiarisation expenses for the drivers" and "preparation, negotiation for fleet of vehicles, telephone contract and parking". The ECJ did not allow recovery for loss of profit, for, "…that would result in giving effect to a contract which never existed."[1028] The ECJ also allowed recovery for non-material loss.[1029]

Another kind of loss with which this paper has been concerned is that of loss of chance. I have shown that loss of chance is recoverable in France and Luxembourg in medical situations but not in the United Kingdom. Loss of chance is not recoverable at all in Germany. So what of loss of chance at a European level? Is the chance that has been lost to be considered as an asset? This is a difficult question and I am not certain that it can be stated categorically that

[1025] Case 238/71

[1026] T-203/96, para 104

[1027] ibid, para 101

[1028] ibid, para 96

[1029] Case 238/78, at para 108

were a question of medical negligence where the plaintiffs are requesting damages based on a loss of chance to be raised in the ECJ that this would necessarily result in recovery. First, a more rounded appreciation of recovery for loss of chance would have to be made in the 28 European jurisdictions, if we are to deduce "common principles". Thereafter it could be argued that loss of chance is permissible in financial or economic situations but not in the case of medical negligence, as appears to be the case at the moment in the United Kingdom, although the United Kingdom has not totally closed the door to recovery for loss of chance in medical situations. It would depend surely on whether the loss was specific and direct. In the latest case I found dealing with the matter, the Advocate-General stated in his opinion

> la jurisprudence de la Cour a reconnu à plusieurs reprises que le caractère certain d'un préjudice ne doit pas nécessairement être absolu, un tel caractère pouvant être établi dans le cas d'une perte de chance sérieuse, directement provoquée par un acte illégal de l'Union. À ce stade, je ne vais pas répéter ce que j'ai déjà exposé en détail aux points 38 à 69 des conclusions dans l'affaire Giordano et, en l'espèce, il suffit de rappeler qu'une perte de chance sérieuse constitue un préjudice réel et certain susceptible d'indemnisation.[1030]

The Advocate-General even speaks in terms of probability, eschewing a common law all-or-nothing approach to recovery

> C'est précisément parce que la perte de chance ne couvre pas le montant total du profit non réalisé que les arguments invoqués par la Commission confirment simplement que la probabilité que les requérants continuent à exploiter leurs quotas durant la semaine allant du 16 au 23 juin 2008 n'était pas absolue, mais ils ne privent en rien la chance perdue de son caractère sérieux.[1031]

So interestingly, the request for damages does not simply cover a part of the final damage but rather it is framed in terms of probability. So, although there was no loss of profit on a non-existent contract recognised in *Embassy Limousines*, this does not exclude loss of chance all together. The door is not closed, it would seem, to loss of

[1030] *Buono and Others v Commission*, C13-13, Advocate General's opinion of 20 March 2014, at para 90

[1031] ibid, at 93

profit on an existing contract but, as in the common law, the loss of profit, or the **chance** to make a profit on something that does not yet exist, is not recoverable. Loss of chance is recoverable provided that there chance lost is serious and real. Further, there is not as yet any dichotomy between medical loss of chance and loss of chance in other situations as there is in British law as yet.[1032]

The other side of the coin is that loss of profit itself would not appear to be recoverable if it is deemed to be speculative. So, for example, where a patient had to stay in hospital longer due to medical negligence and he had already entered into a contract before he had gone into hospital and was unable to carry it out and suffered loss thereon, then I think the ECJ would argue that the patient could recover. The profit there would be easier to quantify provided it is "actual", "certain" and quantifiable". Where, however, the patient had not entered into a contract, but had hoped to enter into the contract, as yet then I think the court would be more reluctant to say that the medical negligence had actually caused the loss in profit. Notions of the profit's being too "speculative" would be used, rather than common law notions of the loss's being reasonably foreseeable. This we have seen in *Embassy Limousines*.

Other principles and expressions thereof can be seen in *Grifoni*.[1033] In this case, the question was whether the Community was liable for breaching local rules concerning the prevention of industrial accidents. The court stated

> The Court has consistently held that the Community' s non-contractual liability and the right to compensation for damage suffered depend on the coincidence of a set of conditions [sic] as regards the unlawfulness of the acts alleged against the institution.[1034]

This is surprising language from the ECJ. It is particularly philosophical and logical in its expression. The ECJ talks about the "coincidence of a set of

[1032] interestingly, van DAM notes that in twelve EU countries the concept of loss of chance is unknown or rejected, whereas in France and the Netherlands it exists. In other countries, it is applied in a modified form: C van DAM, *European Tort Law*, p342

[1033] C 308/87

[1034] ibid, at para 6

conditions". As I have tried to explain "conditions" herein, I understand it as something "in the background"; but causation requires something more and to express a right to compensation as the coming together of certain "conditions" is unfortunate. The causation which is usually in dispute oftentimes refers to something out-of-the-ordinary and not something that happens in the normal course of things. Also, a "set" of conditions is spoken of.

Perhaps more familiar to us is what the court stated in paragraph 7

> It is therefore necessary to consider whether the Commission's acts were unlawful and whether there is a direct link in the chain of causality between those acts and the damage suffered by Alfredo Grifoni.

Again the notion of "direct" link is employed à la française. There is no mention in this case of causation sine qua non. It appears in other cases as we have seen.

The ECJ also treated problem of contributory negligence or proportionate liability when it held

> In those circumstances, the damage suffered was caused not exclusively by the conduct of the Commission but also by that of the applicant who, even though he could have prevented the accident had he taken the necessary care, did not do so and therefore partly contributed to bringing it about. Consequently, responsibility must be shared equally between the parties.[1035]

In the case, the plaintiff was held 50% responsible for his own injuries.

Should the case arise then, the ECJ may rely then on expert medical reports and will rely on them as fact to show causation.[1036] The ECJ will then calculate consequential loss.[1037] Calculating future consequential loss where there has been a natural or "overtaking" event has not come before the ECJ as yet.

[1035] ibid, para 17

[1036] C SCHOUSBOE, "The Concept of Damage as an Element of the non-Contractual Liability of the European Community", p8 http://law.au.dk/fileadmin/site_files/filer_jura/dokumenter/forskning/rettid/2003/2003.afh-3.pdf p23

[1037] in this case, consequential loss in the first instance was calculated simply by the number of days away from work multiplied by the person's daily income.

Further, in as much as the loss must be proved specifically, it seems to be the case that the ECJ would insist on concrete statistical evidence affecting that particular individual.[1038] We have already seen reference to our objective counterfactual: *Mulder v Council*. The questions related to how the plaintiffs would have spent certain sums if such sums had been paid to them. The ECJ held that

> In those circumstances, it must be observed that it would be impossible, except in particular circumstances, to establish how the applicants would have spent the arrears of remuneration which were due to them if the arrears had been paid to them in good time. However, in the present cases it is not a question of seeking evidence of individual losses, but of verifying whether facts exist which can be objectively proved on the basis of precise data which have been made public. By producing relevant statistics, which have not been contested by the defendant, the applicants have thus proved to the requisite legal standard the deterioration in purchasing power which affected their arrears of remuneration during the period in question.[1039]

So here the loss that has been caused can be shown by statistics. It seems that resort can be had to a counterfactual (conditio sine qua non) where this is appropriate but only where it is possible to determine the counterfactual and not where it is "impossible". So, like the jurisdictions under consideration here, statistics will play an important part in determining loss. Schousboe notes that the standard of proof is very high and that many cases have been lost on the grounds of insufficient proof of damage.[1040]

I imagine that it may well be rare that cases involving medical causation come before the ECJ. They may, however, where employees of European institutions are treated by doctors of the European institutions. Nonetheless, it is noteworthy how the highest civil court in Europe treats the issue of causation. It has no

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[1038] *Brazzelli Lualdi*, joined Cases T-17, 21 & 25/89

[1039] ibid, para 40

[1040] C SCHOUSBOE, "The Concept of Damage as an Element of the non-Contractual Liability of the European Community", p8 http://law.au.dk/fileadmin/site_files/filer_jura/dokumenter/forskning/rettid/2003/2003.afh-3.pdf p12

guidance from the TFEU and it has left the door open to the import of a number of prospective theories.

6.9.4 The ECJ and Experts' Reports

As I have also insisted, reports of experts are crucial when it comes to establishing causation. An expert can either make or break a case. With regard to expert evidence in the ECJ, the ECJ has chosen a non-adversarial procedure. Article 70 of the Rules of Procedure of the Court of Justice of the European Communities provides that

> 1. The Court may order that an expert's report be obtained. The order appointing the expert shall define his task and set a time-limit within which he is to submit his report.[1041]

There is no right of cross-examination of the reports as this is subject to the control of the President.[1042] There exists a possibility to object to a witness within two weeks of his being summoned to give evidence.[1043] It seems then that a Continental style approach to establishing causation is used rather than an adversarial approach as in *Daubert*, as we shall see later. This is very different from the common law. There is no rigorous and testing cross-examination of experts and their reports. I am curious to see how this will develop in the event that science genuinely has two conflicting opinions of how damage was caused. I accept the fact that procedure is not subject to the implementation by the ECJ of "general common principles" to be found in the Member States – an impossible task – but I simply note the chasm in causation that exists between the general principle of preferring a court's report and that of permitting each side to instruct an expert and affording each side the opportunity to cross-examine and test as appropriate. I have some suggestions in this regard below.

[1041] to be found online at http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32012Q0929(01)&from=EN

[1042] Rules of Procedure of the Court of Justice of the European Communities, Art 70(4)

[1043] ibid, Art 72

6.9.5 Environmental Liability Directive 2004

Certain guidance may also be obtained from the ECJ's interpretation of the Environmental Liability Directive 2004.[1044] In this Directive, the polluter pays principle was established. There are two measures of liability: the first, one of strict liability; the second, one of fault-based liability. The proof of a causal link between the activity and the damage is always required. Although the ECJ does refer back to national laws, there is some guidance of what the ECJ may favour when faced with future decisions on causation. It found in the case of *Raffinerie Mediterranae (ERG) Spa v Ministero dello Sviluppo economico* that

> Accordingly, the legislation of a Member State may provide that the competent authority has the power to impose measures for remedying environmental damage on the basis of the presumption that there is a causal link between the pollution found and the activities of the operator or operators concerned due to the fact that their installations are located close to that pollution.[1045]

However, since, in accordance with the 'polluter pays' principle, the obligation to take remedial measures is imposed on operators only because of their contribution to the creation of pollution or the risk of pollution,[1046] in order for such a causal link to thus be presumed, the competent authority must have plausible evidence capable of justifying its presumption. Such evidence could be as the fact that the operator's installation is located close to the pollution found and that there is a correlation between the pollutants identified and the substances used by the operator in connection with his activities.

Where the competent authority has such evidence, it is thus in a position to establish a causal link between the operators' activities and the diffuse pollution found. In accordance with Article 4(5) of Directive 2004/35, such a situation therefore falls within the scope of the directive, unless those operators are able to rebut that presumption.[1047]

[1044] Directive 2004/35/EC

[1045] C378/08 at para 56

[1046] see, by analogy, Case C-188/07 *Commune de Mesquer* para 77

[1047] para 56 et seqq

So what the ECJ has done is to approve the adoption of presumptions: something that is more akin to France than the United Kingdom and to a lesser extent in Germany. Certainly, of course, such legal manoeuvres can be deduced from methods such as prima facie case or *Anscheinbeweis* but a more "French-friendly" route is taken on the causal road. Then the question arises, so we want to establish a presumption, what kind of presumption must it be? There seems no blatant translation of a serious, precise or concordant presumption[1048]so instead the adjective chosen is "plausible".[1049] This is a reasonable enough adjective but again my point is that I do not know from which of the Member States' general principles of law the invoking of plausible presumptions is permitted? It is commendable then that the ECJ goes further and gives us an example of how such a presumption might be established, ie that the installations are located close to the *lex loci delicti*. I see this as similar to the French case of a patient's having contracted multiple sclerosis a month after her vaccination for hepatitis B as I have considered before.[1050] There is no scientific evidence but a presumption could be permitted. In these cases, factors such as the fact the plaintiff was in good health before the vaccination and the fact that other claimants had also contracted the disease were all put forward as establishing causal presumptions. The ECJ went on

> Second, the competent authority is required to establish, in accordance with national rules on evidence, a causal link between the activities of the operators at whom the remedial measures are directed and the pollution.[1051]

So, although we see some nods to moving away from a strict application of either the equivalence or the adequacy theories, by the use of presumptions, the ECJ always refers back to national rules of evidence which are, in my opinion, inextricably linked with the substantive rules of causation. So it would appear to me then that presumptions are permitted in tort at a European level at least in environmental law provided they are plausible. Notwithstanding this, the national authority has been mandated by the ECJ to bring a case based on the national

[1048] presumably this would be going too far

[1049] *Raffinerie Mediterranae (ERG) v Ministero dello Sviluppo economico*, para 57

[1050] CC 1 23 Sept 2003, Bull n° 188

[1051] *Raffinerie Mediterranae (ERG) v Ministero dello Sviluppo economico*, para 65

laws of evidence. I am curious to see further implementation of this, especially in the United Kingdom, where the use of presumptions in themselves is not often used.[1052] How presumptions may be used at a European level to establish causation remains to be seen.

[1052] the United Kingdom does, in this one area permit presumptions. In the famous case of *Rylands v Fletcher* [1868] UKHL 1, it was held that where someone brings on to their land something that it is unnatural and that thing causes damage, then there is a prima facie case of liability against that person.

6.9.6 The Product Directive: Introduction

According to the Product Directive's Preamble, it was necessary inter alia because

> "…the existing divergences may distort competition and affect the movement of goods within the common market and entail a differing degree of protection of the consumer against damage caused by a defective product to his health or property".[1053]

This may have been true but it has also had the effect of encouraging judges further to develop notions of tort law, including causation in this area. The aim of the Product Directive was to introduce a system of strict liability for damages arising from defective products. The "producer" is liable.[1054]

The Product Directive aims at maximum harmonisation in the European Union.[1055] In the cited case, a plaintiff in Spain attempted to rely on a more favourable Spanish law of strict liability. Although the Product Directive introduced a system which was less favourable than the extant Spanish system, the ECJ held that

> Article 13 of the Directive cannot be interpreted as giving the Member States the possibility of maintaining a general system of product liability different from that provided for in the Directive.[1056]

Special systems based on other grounds such as fault or warranty in respect of latent defects could exist. However, as far as the Product Directive was concerned, "complete harmonisation" was the goal.[1057]

[1053] 85/374/EEC, Preamble

[1054] Article 3 of the Product Directive defines the producer thus : 'Producer' means the manufacturer of a finished product, the producer of any raw material or the manufacturer of a component part and any person who, by putting his name, trade mark or other distinguishing feature on the product presents himself as its producer. 2. Without prejudice to the liability of the producer, any person who imports into the Community a product for sale, hire, leasing or any form of distribution in the course of his business shall be deemed to be a producer within the meaning of this Directive and shall be responsible as a producer.

[1055] C-183/00 *González Sánchez v Medicina Asturiana* SA [2002] ECR I-3901

[1056] ibid, para 4

[1057] C-52/00 *Commission v France* [2002] ECR I-3827, para 24

6.9.6.1.History of Product Liability in the United Kingdom, France and Germany

All countries under consideration here have a history of consumer protection before the implementation of the Product Directive. In the United Kingdom the case law had famously developed from *Donoghue v Stevenson* [1058] where it was held a manufacturer owed a duty of care to the ultimate consumer (even if there was no contractual nexus). In France, protection had been awarded the consumer on the basis of two aspects of the law of contract, namely the obligation to guarantee against defects (*garantie contre les vices caches*) and the "latent defect warranty" (*obligation de sécurité*). Presumptions have been developed that professional sellers were actually aware of defects at the time of sale enabling buyers to recover.[1059] Liability is strict.[1060] Although contractual actions were the usual way to bring actions, courts invented the *action directe* and the *obligation de securité* to allow the ultimate consumer to sue further up the supply chain.[1061] In tort law, there is protection of Article 1382 and 1384 of the Civil Code in fault and more particularly with case law related to the *gardien de la chose*. This has been used to introduce strict liability in delict. In Germany, contract law does not play a big role in product liability.[1062] There the basis of liability is tort law.[1063] This is based on breach of a general duty of care (*Verkehrspflicht*) and breach of a statutory duty (*Schutzgesetz*). It was not really until the 1960's and 1970's until after the thalidomide tragedy and the Turkish aircraft crash in Paris in 1974 (cargo-hold designed by a German company) that the German courts began more and more to appear victim-friendly. It is not the purpose of this paper to give an outline of product liability in each of these jurisdictions but rather to note those areas where a different result has been achieved, or there exists a potential for a different result. This is important as, in such areas as infections caused by blood transfusions and vaccination damage, it is still necessary that the consumer show that

[1058] [1932] UKHL 100

[1059] CC 1 21 Oct 1925, DP 1926

[1060] ibid

[1061] CC plén, 12 July 1991, JCP 1991.II.21743

[1062] S LENZE "German Product Liability Law: between European Directives, American Restatements and Common Sense" at p100 in D FAIRGRIEVE (ed), *Product Liability in Comparative Perspective* (Cambridge University Press, 2005)

[1063] ibid

the damage was caused by a defect in the producer's product. Causation remains a key element in understanding the essence of the Product Directive.

Although issues such as causation will tend to be considered according to national principles (as there are few principles at a European level offering guidance on the matter), courts should be trying to aim towards a complete harmonisation of this directive on a European level. In this respect, one case I admire is *A & Others v National Blood Authority*.[1064] I hold it in esteem not because it attempts to find common principles of European causation for their own sake but rather there is a hard piece of European law where ideas such as "produce", "producer" and more importantly "cause" are scrutinized. Although it was decided in the United Kingdom, I think it has broader implications for European jurisprudence. I shall now consider the case of *A & Others v National Blood Authority* and the consideration of European authority therein.

This case was about 112 people who were infected by hepatitis C as a result of a blood transfusion. Although the claimants were successful it was, apparently, a "close-run thing".[1065] The reason why the plaintiffs wanted to bring the case under the Product Directive was that it would obviate the need for proving negligence. Europe was not particularly fecund ground for research on the implementation of the Product Directive.[1066] There were few decided cases and judicial reasoning tended to be much shorter than that in the United Kingdom. As it turned out, **both** German and French law were consulted.[1067] Both parties admitted that blood was indeed a product. Counsel for the plaintiffs noted that

> Bearing in mind that he [the judge] should be alive to there being an "autonomous" or Community meaning or construction for harmonising pan-European legislation, the judge welcomed the guidance to be obtained from considering the official different language versions of the Directive and was tentatively prepared to look at

[1064] [2001] 3 All ER 289

[1065] M BROOKE QC and I FORRESTER QC, "The Use of Comparative Law in *A & Others v National Blood Authority*" at p13 in D FAIRGRIEVE (ed), *Product Liability in Comparative Perspective* Cambridge University Press, 2005); this article was written by the protagonists in the case, namely by plaintiff and defendant's counsel and with an afterward by the judge.

[1066] ibid, p20

[1067] ibid, together with Spanish, Dutch, Belgian, Italian and Portuguese law

how the Directive had been implemented and judicially applied in other Community countries.[1068]

What is interesting for the purposes of causation in this case is that the judge held that for non-standard products it is the courts' role to determine the legitimate expectation of the product which may be higher or lower than the public expectation. In Germany, by contrast, just because blood is infected with *HIV* or hepatitis C does not mean that the product is defective as there is no agreement on the product "blood".[1069]

In France, however, a blood transfusion centre has been held liable to a claimant who contracted hepatitis C following a transfusion.[1070] The same has also been held in France for infection by the HIV virus.[1071]This is an autonomous action which was available before the Product Directive came into force in France but as Taylor notes, it does show how French courts are willing to find victim-friendly solutions.[1072] The same also applies to suppliers of a growth hormone who were held strictly liable to the victim of Creutzfeldt-Jakob disease based on article 1147 and in a case where the plaintiff's daughter developed vaginal and uteral infections following the mother's use of the drug *distiblène* and the manufacturer was also held strictly liable.[1073] As it can be seen then, parallel systems exist in France and harmonisation will be subject to the ECJ's acceptance or not of these systems.

[1068] ibid, p29

[1069] this is taken from S LENZE's article "German Product Liability: between European Directives, American Restatements and Common Sense", p101, ibid where he refers to the English case of *A & Others*; note, however, in Germany that there is a no-fault liability scheme that was created in 1995 to cover patients who had been infected with HIV as a result of receiving infected blood

[1070] CC 1 9 May 2001, D 2001 2149, note P SARGOS

[1071] CC 1 12 Feb 2001, Bull n° 35

[1072] S TAYLOR, "Harmonisation or Divergence? A Comparison of French and English Product Liability Rules", in FAIRGRIEVE D (ed), *Product Liability in Comparative Perspective* (Cambridge University Press, 2005), p221

[1073] TGI Montpellier, 9 July 2002, JCP 2002.II.158, note F Villa and TGI Nanterre, 1 chambre, 24 May 2002 *Revue trimestrielle de droit civil* 2002, p527 obs P Jourdain, both as cited by S TAYLOR, ibid

One area that caused some difficulty in causation has been the "development risks defence". The implementation of the development risks defence by virtue of Article 7(e) of the Consumer Protection Act 1987 in the United Kingdom states that a producer can avoid liability by showing that

> The state of scientific and technical knowledge at the time when he put the product into circulation was not such as to enable the existence of the defect to be discovered.

This effectively negates causation if proven. The ECJ has held that this knowledge must be "accessible" when the product was put into circulation.[1074] The ECJ noted that the word "accessible" will create problems in interpretation.[1075] In the French insertions into the Civil Code, its Article 1386-12 states that

> Le producteur ne peut invoquer la cause d'exonération prévue au 4° de l'article 1386-11 lorsque le dommage a été causé par un élément du corps humain ou par les produits issus de celui-ci.

This article was inserted following the HIV-contaminated blood scandal in France in 1984 and 1985. In Luxembourg also, the French case law seems also to have been adopted in that a transfusion centre must provide blood "exempt de vices" even where they are "indécelable".[1076] So it can be seen here how France and the United Kingdom have arrived at the same norm but by different means.

In Germany, the BGH has stated that this defence cannot be used with regard to manufacturing defects.[1077] The question on whether a batch of blood infected with hepatitis C is defective is undecided in Germany although it is likely that plaintiffs will be able to avail themselves of a reversal of the burden of proof following the *German Bottle Case*.[1078] The court stated in this case that a product is defective under § 3 I of the German Product Liability Act 1989[1079] if it does not afford the safety which in all

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[1074] C – 300/95, 29 May 1997 *Commission v United Kingdom*, para 28

[1075] ibid, para 29

[1076] G VOGEL, *Les grands principes du droit medical et hospitalier*, p195

[1077] BGH NJW 1995, 2126

[1078] BGH judgment of 9 May 1995, ZIP 1995, p1094

[1079] This states "*§ 3. Defects* (1) A product is defective if it does not provide that degree of safety which can be justifiably expected, having regard to all the circumstances, in particular (a) its

the circumstances can justifiably be expected. Consumers expect soda water bottles to be free from faults such as hairline splits and microfissures which could make them explode. The consumer's expectation that bottles be free from faults would not be diminished even if it were technically impossible to identify and remove such faults. The presence of such a hairline crack constitutes, as the court below rightly held, a manufacturing fault, even if it is one which "got away".[1080]

As the note to the case in English states, there is a *Befundsicherunspflicht* that applies a presumption that the defect arose in the producer's sphere unless he can show that he took all measures to ensure that the product was free from defects.

Again this is something recognised by Mr J Burton in the *A & Others* case in that unless and until there is some common pan-European agreement on essential principles, each jurisdiction may well be arriving at different results.[1081]

So it can be see then that the system for Product Liability in Europe is *sui generis*. A maximum harmonisation at a European level is sought here. There is not much case law on a European level as yet. Yet I believe cases such as *A & Others* already show some judicial goodwill on the part of British courts to consider how other European jurisdictions have interpreted the Product Directive. Such extensive judgements I do not believe will be forthcoming either from France or Germany. It is not in their tradition. Interpretations of such aspects as "product", causation and the developments risk defence become important when considering how causation is to be understood using hard-law on a European level. I am certain that nations will continue to apply their own notions of causation where this becomes an issue in Product Liability. Indeed as Mr Justice Burton has written "The decisions of other

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presentation;(b) its use which may be reasonably expected;(c) the time when it was put into circulation. (2) A product is not defective for the sole reason that later on an improved product was put into circulation; this is helpfully translated from the German by The University of Texas Project at: https://law.utexas.edu/transnational/foreign-law-translations/german/case.php?id=1397

[1080] at 2(a) of the English translation of the judgement to be found at http://www.iuscomp.org/gla/judgments/tgcm/z950509.htm

[1081] Mr J BURTON in M BROOKE QC and I FORRESTER QC, "The Use of Comparative Law in *A & Others v National Blood Authority*" at p37 in *Product Liability in Comparative Perspective*

national courts in Europe are, of course, of great interest, but they are normally at best persuasive."[1082] I think Nicholas Underhill QC, defendant counsel in *A & Others* goes to the heart of the matter when he notes

> But the fact is that English lawyers cannot hope to educate either themselves or the Court to a full understanding of the subtleties of foreign legal systems. Comparative law materials are best used to illustrate or illuminate broad points of principle.

I think this must be correct. The forays by the British courts into comparative law in this case are certainly to be commended. It can be helpful to note how other systems resolve problems but I suggest there remains a "homing instinct" among courts to apply what they know best: their own law. I do find it fascinating to discover how foreign jurisdictions appraise similar problems. I suggest all lawyers and scholars can indeed learn from such a comparative exercise, and causation is a fruitful area of comparison. Yet I do not admit of broad principles that can be applied overwhelmingly in this area. The Product Directive is here to stay and it can be argued that its primary purpose is the boosting of consumer protection. I say this as any previous system of consumer protection which gave more protection is not allowed to continue. In general then, we have seen how the different jurisdictions have tackled the problems that the Product Directive have thrown up. Causation in itself may not have been treated explicitly by the ECJ in this matter as yet but it is likely that a victim-friendly approach is to be taken if common principles are to be adopted, be they from interpretation of the Product Directive itself, as in *A & Others*, or various parallel systems that existed before the Product Directive.

As we have also seen, the Pharmaceutical Products Act 1976 in Germany affords consumer protection for those who have suffered damage as a result of taking a marketed drug. The "pharmaceutical enterprise" is liable to the consumer if the drug, used correctly, has harmful effects, which, taking into account the state of medical knowledge, exceed a tolerable level.[1083] So here the drugs can be marketed,

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[1082] Mr J BURTON in M BROOKE QC and I FORRESTER QC, "The Use of Comparative Law in *A & Others v National Blood Authority*" at p38 in *Product Liability in Comparative Perspective*; see also J REITZ, "How to do Comparative Law" (Autumn 1998) 46 *American Journal of Comparative Law* 617 where he states "Without explicit comparison to the home country explaining the relevance of the foreign law for the domestic legal system, most domestic lawyers will have little interest in reading a piece about foreign law. There are, no doubt, exceptions…" at 619

[1083] Section 84 Pharmaceutical Products Act 1976

licenced and sold but even thereafter a risk / benefit analysis of the drugs can be made by the courts. The drug in question must be capable of causing the harm in question and there is a presumption that the drug caused the harm in an individual case only, taking into account the factors listed in Article 84(2) of the Act, which include inter alia the temporal relationship between the taking of the drug and the onset of the damage. Familiar undertones are seen here with PETL which also includes "closeness in time" with regard to attributing liability to someone.[1084] This is unique among European legislation in so far as it outlines certain factors to be taken into account when establishing presumptions. However, another drug which may also have caused the harm, is not to be regarded as another fact which could cause the damage thereby excluding a causal presumption under this Article. The Act has a limited scope, it is true. It does not cover products, but only drugs. Yet it is interesting to see how certain principles that have been adopted by the German legislator with regard to causation could possibly be used in European law with regard to product protection. Emphasis is made on causation in the individual case indicating that any epidemiological evidence would necessarily have to be individualised.[1085] Such kinds of causal principles have also been adopted in France in case law with regard to the onset of multiple sclerosis following vaccination for hepatitis B. There was no scientific proof that the vaccinations caused, or that there was a risk they would cause, multiple sclerosis and yet the French courts thought above this. Scientific proof is a part of the evidence, but courts also exist to enforce social norms and to protect the public. As we have seen, a **legal** causal connection in these cases was established. Now, this would not necessarily be the case in Germany. In fact, I doubt it would be the case at all. Physicians in German have responsibility under statute and case law to warn of risks. There is a heavy duty in Germany. Even small risks if their eventuation would grave consequences for the patient must be disclosed. The BGH has even held that risks of up to one in ten to twenty thousand need to be disclosed.[1086]

[1084] Art 3 :201 Scope of Liability, PETL

[1085] Pharmaceutical Products Act 1976, §84(2)

[1086] BGH NJW 1984, 1395

So although the telos of the Product Directive may be maximum harmonisation in this area, we can see that what causes damage and what is a defect in product liability in this area is fragmented. Parallel systems to the Product Directive exist in France by virtue of recovery allowed under tort. We have already seen the Pharmaceutical Products Act 1976 in Germany and other no-fault systems exist in the United Kingdom, for example, the Vaccine Damage Payment Scheme 1979 which allows certain people who were severely disabled as a result of a vaccination to recover. It is a no-fault system but again causation between the vaccine and the disability must be shown. My aim here is not to have a raid of product liability in the European Union but rather to show how difficult it is going to be extract causal norms from such disparate systems. Yet overall policy may well trump traditional national interpretations of causation (this does not exclude, of course, the fact that policy is an element of causation nationally) and the ECJ may well decide matters of causation based on the Product Directive on this basis.

In conclusion then, although there is hardly any case law at the ECJ on the Product Directive, there has been some case law on it at a national level and I think the most important for the purposes of this paper is *A & Others* which gives an overview of recovery systems in other jurisdictions. It does this very well. Both plaintiffs and defendants agree the Burton J did a first class job in his reasoning and this could be part of the reasons that the case was not appealed. It remains to be seen how the ECJ will interpret causation in the event of any Article 267 references to it under the Product Directive.

6.9.7 Conclusions

So the article 340 TFEU instructs that the ECJ develop European tort law taking into consideration general principles that are common to the Member States. This may have been feasible when there were only six Member States[1087] but to apply this to a European Union of 28 seems hopeful at best. Yet this would be an empty statement were I not to show that at least in one area in tort law there is no agreement among the Member States and even within the Member States themselves. This is in the area of causation – cases of medical causation in tort have not yet come before the ECJ at the time of writing. The ECJ has an impossible task and I suggest amendment of the TFEU in this case. I have shown that the Member States of France, Germany and the United Kingdom have certain approaches to causation but that these principles are flexible to suit the case. I do not make a comment on such flexibility but I merely note it. Similarly at the ECJ level, there seems to be no agreement as to what constitutes causation, notwithstanding some suggestions that the sine qua non theory seems to be the "basic" theory. I have shown that there have been suggestions that it could be theory of equivalence (the conditio sine qua non theory), the adequacy theory, proximate cause theory and even sphere of risk theory. There seems to be some notion of "directness" taken from French law. This idea is not known in British or German law. The ECJ has even sanctioned presumptions in the case of environmental law. Overall, however, there is no one accepted understanding or consistent agreement as to what causation is at a European level. A cynic may say that the ECJ has adopted the common principle of disorder! And yet behind such a statement there is a truth. Each of the jurisdictions in consideration adopts a different theory at different times; a country may start out with a basic principled theory (equivalence theory filtered by adequacy theory) yet in certain cases may apply a sphere of risk theory. Germany comes to mind. And why should the ECJ not do the same? There is no reason why not as it is also my submission that causation is impossible to define. Justice has to be done in the individual case rather than a rigid adherence to theory. Yet the difference between the ECJ and other "soft law" projects with which we are confronted such as the DCFR or the PETL is that such projects in their current form are simply not realistic with regard to causation. I make no comment on their utility more globally. My

[1087] then article 215 of the Treaty of Rome of 25 March1957

proposition is simply that reference to causation in these projects should be modified and I hope my research as cited corroborates this. It is futile to attempt to define causation in code. The ECJ, on the other hand, must work within its mandate. I suggest it is picking and choosing so far from among the jurisdictions, with a strong predilection towards France. I am not critical of this as the TFEU does not attempt to define causation in tort law. What appears at least to be common among the Member States under consideration here is uncertainty in causation in difficult cases. The ECJ also seems to be flexible with regard to potential future causal solutions in which new causal theories may well be introduced which in itself will also create further uncertainty. It is for lawyers to argue these new ideas in causation as suggested by the ECJ, or, as may be further adopted by a Member State or Member States. I commend the ECJ in its approach. My submission simply here is that there are no general principles common to the Member States in the area of causation. They do not exist and they cannot be "made" to exist. The ECJ will define causation as case law comes before it and lawyers will argue causal theories according to their own clients' case. These causal theories will no doubt come from European jurisdictions where they have found favour but that does not guarantee that the ECJ will indulge them. We can certainly have a "feeling" for causation from the cases I have cited. This may guide lawyers but nothing is excluded when ascertaining "common principles". Consequently, I can only recommend that the TFEU be amended to remove any reference to general principles common to the Member States. Causation is part of tort law. There is no such common pan-European agreement on what causation is.

6.10 Proving Causation: Evidence

As we have seen above, it is not necessary for a plaintiff to prove causation in law on the basis of certainty. The plaintiff must simply satisfy the particular burden of proof in a given court. Anecdotal evidence is by no means excluded yet the weight attached to it will depend on the jurisdiction. In Continental jurisdictions, for example, hearsay is admitted, while in the United Kingdom, it is not.[1088] Anecdotal evidence does not just date from another century (see below). We have seen how this is also part of modern day case law with regard to such matters as the hepatitis B vaccination in France.[1089] Causation in science does not always mean causation in law. Other policy considerations of society, politics and morality have been considered. We can see from this how the idea of causation has developed in medicine and how even though medicine is a science, it is oftentimes an inexact science and other elements are crucial when it comes to establishing causation. I propose to give some brief examples of "cause by anecdote" before going on to consider how cause is established scientifically by expert evidence.

6.10.1. Anecdotal Evidence

John Snow (1813-1858) was a Victorian physician who made studies into cholera. He noted that cholera was a disease primarily of the gastrointestinal tract and this he tested by observations on clinical and epidemiological features of cholera. He postulated that it was a local infection of the mucosal membrane of the alimentary tract, passed from one patient to another by swallowing.[1090] He was the first to realise that cholera spread by a self-propagating agent by contaminated food and water. Snow used different epidemiological methods to calculate mortality rates. In one case study of 1854, the Golden Square outbreak showed a distribution of fatal cases: 61 of the deaths had used water from the Broad St pump, six had not and six were indeterminate. A nearby brewery had no deaths. Snow noted in his interviewing

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[1088] F DAVIDSON, *Evidence*, p11 et seqq

[1089] and a doctor in France must now warn his patient of the risk of developing multiple sclerosis : Bordeaux, CA 14 November 2014, n° 11/1179. Interestingly this case was not based on loss of chance

[1090] taken from P FELDSCHREIBER's presentation "Causality in Medicine and Law" from Aberdeen University's seminar "Perspectives on Causation" held on 22 and 23 June 2009.

> The men are allowed a certain quantity of malt liquor and Mr Huggins believes they do not drink water at all; and he is quite certain that the workmen never obtained water from the pump in the street.[1091]

He noted another crucial observation when investigating the case of a widow from Hapstead

> I was informed by this lady's son that she had not been in the neighbourhood of Broad Street for many months. A cart went from Broad Street to the West End every day and it was the custom to take a large bottle from the pump in Broad Street, as she preferred it. The water was taken on Thursday 31st of August and she drank of it in the evening and also on the Friday. She was seized with cholera on the evening of the latter day and died on Saturday…A niece who was on a visit to this lady also drank of the water; she returned to her residence in a high and healthy part of Islington, was attacked with cholera and died also. There was no cholera at the time either at west End or in the neighbourhood where the niece died.

What is interesting here is that even from anecdotal evidence and non-scientific evidence as such, cause was apportioned.

Another example of causation existing by anecdote was the seroxat episode. Seroxat is a trade name for paroxetine, an SSRI (selective serotonin reuptake inhibitor).[1092] During phase I studies, no problems were identified; during Phase II and III studies, there was even positive benefits for all. Post-marketing, however, there were sudden and anecdotal reports of akasthisia (extreme agitation) and suicidal ideation in children and adolescents. The problem was that it was difficult to distinguish between events of underlying depressive illness and drug induced events. Epidemiological data were insufficient to show that the drug should be withdrawn from use. As it turned out, GlaxoSmithKline who had made the drug had failed to report certain studies which it had done in children.[1093] I think then that, even in cases of product liability, it can be difficult to show cause.

[1091] on page 3 of the handout

[1092] anti-depressants used to treat depression and anxiety

[1093] http://www.antidepressantsfacts.com/2004-06-15-shamed-GSK-reveals-data-paxil.htm; Pharmacy Times, source Daily Mail newspaper, London

Anecdotal evidence is evidence and not only (or even) epidemiological reports. Courts, as we have seen already in France, will differ with regard to the weight they attach to anecdotal evidence.

6.10.2 Scientific Evidence and *Daubert v Merrell Dow Pharmaceuticals*[1094]

Another area where I think that European projects to harmonise tort law have not taken sufficient account of in their attempts to mould causation is that of evidence and burdens of proof. It cannot be possible to harmonise or move towards a European law of tort when standards of proof are so different. In the United Kingdom, to win his case, a plaintiff must persuade the judge that his version of events was more likely to happen than the defendant's. This is the "balance of probabilities standard". In France and in Germany, we have seen that the standard of proof is much higher although this may be attenuated by various procedural devices to alleviate this habitually heavy burden of proof.

Often scientific causation is determined by reports from experts. Experts will often have to pronounce on whether a causal link can be established or not. Often a report will be framed in terms of probability. The tendency in the United Kingdom is for each side to commission its own reports and for them to be tested through thorough cross-examination. On the Continent, however, it is usually the court that appoints its own expert.

This must be seen then as a potential divergence in the area of causation. For example, we have seen in France that French courts are willing to allow recovery for multiple sclerosis "caused" by a hepatitis B vaccination although there was no scientific evidence showing this. I would like now to consider the case of *Daubert v Merrell Dow Pharmaceuticals* which, although an American case, I believe highlights many of the many of the shortcomings of the Continental system when it comes to the acceptance or otherwise of expert reports.

[1094] 509 US 579

In this case, it was alleged that the drug Benedictinee had caused serious birth defects in two children. The defendants, at first instance, had argued based on scientific literature that Benedictine had not been shown to be a risk factor for human birth defects. The plaintiffs attempted to refute this based on evidence that Benedictine had caused birth defects in animal studies, chemical structure analyses, and unpublished "re-analysis" of previously published human statistical studies. The court held that this evidence did not meet the "general acceptance" standard for the admission of expert evidence under the *Frye*[1095] rule. In the *Frye* case it was held that expert opinion was only permissible where it was based on a scientific technique generally accepted as reliable in the scientific community. The United States Supreme Court held that the Federal Rules of Evidence superseded *Frye*. In particular, Rule 702 provided that

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

"Scientific…knowledge" is to imply grounding in science's methods and procedures, while "knowledge" connotes a body of known facts or ideas inferred from such facts or accepted as true on good grounds. Where there is a "proffer" of expert evidence then a judge should make a preliminary assessment of whether the testimony's underlying reasoning or methodology is scientifically valid to be applied and a number of factors should weigh in the fact-finder's mind, such as (i) whether the technique has been subject to peer review and publication; (ii) its error rate; (iii) the existence and maintenance of standards controlling its operation; and (iv) whether it has attracted widespread acceptance within the scientific community. The scientific method, as opposed to other areas of human inquiry is the generating of hypotheses and the testing of them to see if they can be falsified.[1096]

[1095] *Frye v United States*, 54 App D C 46

[1096] *Daubert*, at 593, referring also to Karl POPPER, *Conjectures and Refutations: The Growth of Scientific Knowledge* 37 (5th ed. 1989) ("[T]he criterion of the scientific status of a theory is its falsifiability, or refutability, or testability")

In this case, for example, part of the expert evidence presented to the court was a meta-analysis of epidemiological studies but this meta-analysis had not been subject to peer review itself and it was even found to be generated solely for the purposes of litigation.[1097] Where there was sufficient epidemiological data, it was held that studies in animals could not be admitted.[1098]

The question under *Frye* was when did a concept, an idea or knowledge become "generally accepted" within the scientific community. The test in *Frye* was the following

> Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognised, and while courts will go a long way in admitting expert testimony deduced from a well-recognised scientific principle or discovery, the things from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.[1099]

In matter of fact, the evidence was rejected as it had not at the time been generally accepted. However, although this *Frye* test was displaced by the Rules of Evidence, it did not mean that these Rules placed no limits on the admissibility of purportedly scientific evidence – the so-called "gate-keeper" role of the judge.[1100]

In discovering scientific knowledge, what is sought is not what is immutably true, but rather how phenomena can best be explained.[1101] It represents a process for proposing and refining theoretical explanations about the world that are subject to further testing and refinement. Further, the evidence must also be relevant. Rule 401 of the Rules of Evidence determined relevant evidence as

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[1097] *Daubert* at 589

[1098] ibid

[1099] *Frye*, at 47

[1100] *Daubert*, at 589

[1101] *Daubert*, at 590

> Any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.

Finally, vigorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence.[1102] It was also held that

> …open debate is an essential part of both legal and scientific analysis. Yet there are important differences between the quest for truth in the courtroom and the quest for truth in the laboratory. Scientific conclusions are subject to perpetual revision. Law, on the other hand, must resolve disputes finally and quickly.[1103]

This is correct. I think that open debate in court about these matters is essential. Where we have a report for the plaintiff and one for the defendant. These can be challenged, debated and disputed viva voce.

Why this is important for the purposes of this paper is that it would appear that at least England and Wales have been inspired by this decision and have consulted on the adoption of scientific evidence based on *Daubert*.[1104] The United Kingdom House of Commons Science and Technology Committee also suggested the establishment of a Forensic Science Advisory Council to normalise standards for forensic evidence and noted that

> The absence of an agreed protocol for the validation of scientific techniques prior to their being admitted in court is entirely unsatisfactory. Judges are not well-placed to determined scientific validity without input from scientists. We recommend that one of the first tasks of the Forensic Science Advisory Council be to develop a "gate-keeping" test for expert evidence. This should be done in partnership with judges, scientists and other key players in the criminal justice system, and should be built on the US Daubert test.[1105]

[1102] ibid at 596; in the USA, juries are still competent in many civil trials

[1103] ibid

[1104] Consultation Paper No 190, *The Admissibility of Expert Evidence in Criminal Proceedings in England and Wales* (http://www.lawcom.gov.United Kingdom/docs/cp190.pdf)

[1105] House of Commons Science and Technology Committee (2005) *Forensic Science on Trial*

6.10.2.1 Assessment of *Daubert*

First, and most importantly for the purposes of this paper, there are two different ways of tackling expert evidence: the common law way and the Continental way. The common law way generally allows for each side to commission their own reports. We have a thesis (the plaintiff's report), an anti-thesis (the defendant's) and it is to be hoped a synthesis (the judgement of the court). In this way, I believe the court can pursue a dialectic towards what is true in as much as this is possible for the purposes of resolving disputes. Yet this is still not adequate, in my opinion, as the House of Commons Committee suggested above. In Continental jurisdictions, however, there appears to be one commissioning of a report without much questioning of its contents. There is no *Daubert* approach. I would doubt therefore whether an expert preparing one report for use by the court would highlight (i) to what extent the expert's methods are accepted within the scientific community; (ii) to what extent the expert's peers may disagree with his findings; (iii) error rate and standards of control of his report. I doubt moreover that a Continental (or any) judge would necessarily pose himself such questions. Such questions must be posed by the opposition. On the Continent, however, there is no, or little, opportunity for open debate or cross-examination of a report in court. This would suggest to me that there is a simpler "acceptance" of reports than there would be if both sides were permitted to allow their own reports in evidence as standard. This in itself must have consequences for proving causal links in science and in law. Given these two different procedural approaches to the nature of proving causation, I do not believe that this contributes to any kind of harmonisation in this field. We can even see the example of where French courts permitted recovery for damage purportedly caused by the hepatitis B vaccination. There was not even any scientific proof of a causal link and yet the plaintiffs were successful. I suggest this would be no application either of the DCFR standard of causation in "consequential" terms and *a fortiori* of the PETL conditio sine qua non standard. I submit that such a decision would not have been followed in the United Kingdom or in Germany. While courts are indeed there not just to take account of social policy, it must surely be dangerous to base a decision on this alone. Scientific causation would most probably be part of the evidence and *a fortiori* the opportunity would have to be afforded to both sides in the United Kingdom to scrutinise such evidence.

On the Continent, the right of the parties to ask questions is much more limited. The parties, in France, it would appear, only have a right to ask questions through the judge.[1106] More discerning questions might result if the expert's report were open to challenge from another expert. My purpose again is not to say which is better but simply to state that arriving at causal decisions involves a procedural approach in Germany and France that is quite different from that adopted in the United Kingdom. Given that there is less chance to cross-examine, question and interrogate an expert on the Continent, it is my submission that scientific causal conclusions may often be different. I can only offer in support of such a contention what was said in the House of Commons Science and Technology Committee above in that "Judges are not well placed to determine scientific evidence without input from scientists." Therefore if scientific causal conclusions are different then there can be no one common understanding or appreciation of causation in the law. Causation is inseparable from procedure. To attempt a fixed approach on it – for that it what the DCFR and the PETL are doing - is disingenuous. Even if the drafters of the DCFR admit that there is no "one size fits all" solution to causation, so I do not see the need even to attempt to define it, to describe it, or to amplify the verb "cause" in any way whatever. None of the jurisdictions under consideration here does and therefore none of any projects that attempt to harmonise European law should attempt it.

[1106] Art 193 French Code of Civil Procedure

6.11 Strict Liability or Negligence in General

Whether a system takes an approach to causation based on proving negligence or on strict liability plays a vital role for the characterisation of causation in that particular system. Whether a plaintiff must prove that a hospital was negligent in the organisation of its particular disinfecting procedures on a particular ward or whether a court will assume that there is some kind of "protective" obligation as soon as the patient enters the ward will be crucial in determining the ease with which a patient can show causation if he alleged he contracted an infection during his hospital stay. I hope it has been clear from the research that I have advanced that some jurisdictions are more "patient-friendly" than others and that in that "patient-friendly" approach, the necessity to prove the causal link, although by no means abrogated, is mitigated to a considerable extent. After I have considered whether a country generally relies on strict liability or negligence, I shall then consider special indemnity systems adopted by some of the countries.

6.11.1 The United Kingdom

The United Kingdom stands out perhaps as never allowing the requirements of causal proof to be mitigated in any significant way. It insists always that the plaintiff prove that his version of events was more likely than not. This is the balance of probabilities test and remains the test for all delictual liability cases. In the United Kingdom, there has been a general rejection of no-fault liability for medical negligence claims. The history of this goes back to the Pearson Report in 1978. One of the arguments at the time was that accidental injury should be socialised and that the welfare state should cover it, especially with the recent history of the Thalidomide disaster.[1107]

The Commission looked at the different problems that claimants faced when bringing claims and one issue that was considered was reversing the burden of proof on the basis that physicians were "in a better position to prove absence of negligence than patients were to establish liability".[1108] This was, however, ultimately rejected for fear of the floodgates. The plaintiff must therefore

[1107] M STAUCH, *The Law of Medical Negligence*, p137

[1108] Lord PEARSON, *Report of the Royal Commission on Civil Liability and Compensation for Personal Injury*, (Chairman: Lord Pearson) Cmnd 7054 (London, HMSO, 1978)

convince a judge that there has been fault on behalf of the hospital trust which has not (say) cleaned the ward in accordance with standard procedure and that it was this non-sterilised environment which caused the bacteria to multiply which then caused the plaintiff's hospital-acquired infection. This is prima facie quite a heavy burden. Similarly, if there are a number of agents which could have caused an iatrogenic infection, then the plaintiff must show that the one introduced by the doctor's actions or omissions was actually and scientifically capable of causing the infection. Again this may also be a tough burden, especially where there is conflicting scientific evidence (there are no court-appointed experts in the United Kingdom) but it is a burden from which a court rarely departs.

We have seen above that a court may, on occasion, help a plaintiff using the procedural device of *res ipsa loquitur*. It must be remembered, however, that this only changes the tactical burden of proof. The legal burden of proof remains squarely with the plaintiff. A *res* is simply something that needs explaining or elucidating; it is something that a defendant would do well to explain if he can lest he lose his case on a presumption. His explanation may find favour with the judge or it may not. For example, if a patient enters into hospital and has the wrong leg amputated then this would be a *res*. Nonetheless, the plaintiff still must obtain proof (usually by discovery) to 51% that the surgeon was negligent. The burden of proof still remains with the plaintiff. There is no kind of strict liability in medical negligence in the United Kingdom.

What is interesting also is that the Commission thought there would be problems in where to delineate those risks that the patient should bear and those which arise from a natural progression of the accident. This is interesting when, as we shall see, comparing the regime for medical accidents that exists in France.[1109] No-fault liability was therefore ultimately rejected.[1110] However, one area of no-fault liability which was introduced was the Vaccine Damages (Compensation) Act 1979 which provides for payment to certain individuals where the cause of the injury has been vaccination.

[1109] ibid, paras 1365-6

[1110] ibid, paras 1370-71

In 2000, the Secretary of State for Heath announced that he would set up a scheme for those people who had been infected by variant Creutzfeldt-Jakob disease.[1111]

A special compensation scheme also exists for those who have been infected with hepatitis C or HIV as a result of contaminated blood transfusions.[1112] In addition to this, protection for claimants now exists following *A & Others* under the Product Directive.

There also exists a trust in the United Kingdom providing compensation for those whose injury was as a result of the drug Thalidomide.[1113]

With regard to mesothelioma, following the case of *Barker v Corus*, there now exists special legislation in the form of the Compensation Act 2006 which provides for joint and several liability among those people who have exposed the victim to asbestos and this exposure has resulted in the victim's contracting mesothelioma and only mesothelioma.[1114]

There exists an intra-United Kingdom difference with regard to the treatment of pleural plaques. Pleural plaques are of themselves benign but can indicate that there is an increased risk of asbestos-related diseases in the future. In *Grieves v ET Everard & Sons Ltd*,[1115] it was argued in England that this exposure put the claimants at an increased risk of developing mesothelioma at some stage in the future and that recovery should be allowed for a psychiatric illness resulting from such fear. The

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[1111] details of the scheme can be found at http://vcjdtrust.co.United Kingdom/the-compensation-scheme

[1112] details of the scheme can be found at http://webcache.googleusercontent.com/search?q=cache:fjlwbGHinu4J:www.parliament.United Kingdom/briefing-papers/sn05698.pdf+&cd=2&hl=en&ct=clnk&client=safari

[1113] details of the scheme can be found at http://www.thalidomidetrust.org

[1114] Compensation Act 2006, Article 3. The fulll text can be found here http://www.legislation.gov.United Kingdom/United Kingdompga/2006/29/pdfs/United Kingdompga_20060029_en.pdf

[1115] [2007] UKHL 39

House of Lords ultimately agreed with the Court of Appeal in holding that fear of a future illness was not a stand-alone head of damages.

However, the Damages (Asbestos-related Conditions) (Scotland) Act 2009 now provides in section 1 that[1116]

> **1. Pleural plaques**
>
> (1) Asbestos-related pleural plaques are a personal injury which is not negligible.
>
> (2) Accordingly, they constitute actionable harm for the purposes of an action of damages for personal injuries.
>
> (3) Any rule of law the effect of which is that asbestos-related pleural plaques do not constitute actionable harm ceases to apply to the extent it has that effect.

This Act shows now that there exists a difference with certain kinds of damages within the United Kingdom and therefore although causation might be able to be proved, the damage is one which is not recognised in England and Wales. Therefore damage cannot be legally caused by pleural plaques in England as it can be in Scotland. There is no causation in the law across the Scottish border for pleural plaques.

6.11.2 France

In France, *faute* is still necessary for the defendant to be held liable. This is a principle of *droit commun* and it is confirmed in the CPS. The burden of proof as we have seen is in theory quite high but again causal presumptions can come to the aid of a plaintiff if they are *graves*, *précises*, *et concordantes*. Yet like with Germany above, is it fair to equate this to strict liability? To a certain extent, I think it is. If we can show certain facts that are *graves*, *précises et concordantes* then this will raise a presumption of causation that can only be defeated by evidence close to certainty.[1117] As we have seen, there does not even have to be scientific proof in the cases of multiple sclerosis following the vaccinations for hepatitis B. Sometimes temporal, policy and other factors will be sufficient to establish causation. We have seen already how there is strict liability in the area of hospital-acquired infections and medical hazards. So

[1116] this Act has been held to be within the competences of the Scottish Parliament following a challenge that it was ultra vires in *Axa Insurance v The Scottish Ministers* [2011] 3 WLR 871

[1117] L KHOURY, *Uncertain Causation*, p45

although in theory none of the jurisdictions in question has adopted a no-fault system of tort liability, France does come very close to it in certain situations which is far from British approach.

As we have also seen, in France there exist special compensation systems for the most serious medical hazards and hospital-acquired infections. For medical hazards the law of 4 March 2002 permits claimants to obtain compensation from the national solidarity fund where no fault can be attributed to the doctor. Even when there has been a fault that is not causally linked to the damage, it is still possible to obtain reparation from the fund.[1118] Similarly since the law of 4 March 2002, it has been possible to obtain reparation for hospital acquired infection save where the hospital can bring proof of a cause étrangère where there is a AIPP greater than 25%. Article L-1142-22, al 2 also ensures that the national solidarity fund is responsible for providing compensation where damage has resulted from

- an obligatory vaccination;[1119]
- HIV;[1120]
- Hepatitis C resulting from a blood transfusion;[1121]
- Damages that have been directly incurred as a result of prevention, diagnostic or care provided in the course of a serious threat.

Alinéa 3 further provides that the national solidarity fund takes over the provision of compensation from Creutzfeldt-Jakob disease.[1122]

[1118] CC 1 11 March 2010, Bull n° 63

[1119] including diphtheria, tetanus, poliomyelitis, tuberculosis, and in certain circumstances, endemic typhus, smallpox, typhoid fever and with regard to certain persons, typhus, flu, and hepatitis B.

[1120] since 9 August 2004 ; before this date compensation was provided by FITH by virtue of the law of 31 December 1991

[1121] since 11 March 2010, ONIAM has taken over compensation once provided for by the *établissement français du sang* (EFS)

[1122] ONIAM took over the obligations of France-Hypophyse by virtue of the law of 30 December 2002

What is interesting here is that, with regard to hepatitis C infections, the damage caused could be quite far-reaching. The Cour de cassation specified that the damages recoverable by way of a "prejudice spécifique de contamination"

> comprend l'ensemble des prejudices de caractère personnel tant physique que psychiques resultant de la contamination, notamment les perturbations et craintes éprouvées, toujours latentes, concernant l'espérance de vie et crainte des souffrances; qu'il comprend aussi le risqué de toutes les affections opportunists consecutives à la découverte de la contamination, les perturbations de la vie sociale, familiale et sexuelle et les dommages esthétiques générés par les traitements et soins subis.[1123]

As far as the "serious threat" above is concerns serious health threats in response to which the Minister of Health has decided to take action. In such circumstances, a physician will not be liable for any damage caused where he prescribes or administers a medicine and a claimant will have recourse to the national solidarity fund. It follows then that where medical hazards, medical negligence or nosocomial infections in this regard fall within the ambit of the national solidarity fund then a would-be plaintiff will consider such an option certainly before embarking on litigation.[1124]

As we have seen, at *droit commun* for medical hazards, a plaintiff can recover from a hospital in the public sector if he cannot recover from a private sector. Such an obvious dichotomy does not exist in any of the other jurisdictions here. In order for a patient to recover for a medical hazard, he must show the four conditions.[1125] Although the Cour de cassation has not accepted this idea yet, as I noted, it might only be a matter of time. Here the liability is strict and based on remote risk. I submit that this is one area where France goes far to protect victims. France's policy is that we all benefit from the advancement of scientific knowledge and therefore one who suffers injury thereby should be compensated. Recovery for "medical hazards" can, of course, be obtained from national solidarity fund where the required level of

[1123] CC 2 24 Sept 2009, Bull n°226, quoted also in J-R BINET, *Cours: droit médical* (Montschestien, 2010), p283

[1124] ibid

[1125] as a reminder, first, that the risk was known; second, that there was no reason to think that the patient was particularly exposed to such a risk; third, that the condition of the patient has no relation with the initial state of the patient or its evolution; and fourth, that the character of the hazard is extremely serious.

seriousness has been reached.[1126] Again, we have new notions of causation here. There is no adequate causation here. So, and I think this is perhaps the most striking difference along with loss of chance in the jurisdictions, if a plaintiff suffers a known risk to which the patient was not particularly exposed during an operation, he may be able to recover. This would certainly not be the case in the United Kingdom or in Germany assuming all disclosure obligations have been fulfilled. This is another important difference among the jurisdictions under consideration here.

6.11.3 Germany

In Germany, there has been a general rejection of no-fault liability.[1127] The 1970's were the time for reform initiatives particularly in the light of the Thalidomide disaster. In 1971 the *Contergangestz* was set up to recompense Thalidomide victims from a fund financed by a lump-sum contribution by the federal government and drug manufacturers.[1128]

I have also shown how the Pharmaceutical Products Act 1976 should apply though it should be noted that its provisions have rarely been used in court.[1129] A claimant could not, for example, claim against a manufacturer simply because a drug produced adverse effects.

In 1995, the *HIV-Hilfgesetz* was created to provide a basis of no-fault liability for those who had experienced proof difficulties under article 84 of the Pharmaceutical

[1126] as a reminder this is fixed at an AIPP (*atteinte à l'intégrité physique et psychique*) greater than 24%, not being able to work for 6 months consecutively, or a length of ceasing professional activities of 6 months non-consecutively in the period of one year or with temporary functional impairments greater than 50% for 6 months consecutively, or a length of ceasing professional activities of 6 months non-consecutively in the period of one year

[1127] C WENDEHORST, "Compensation in the German Health Care Sector" in J DUTE, M FAURE and H KOZIOL (eds), *No Fault Compensation in the Health Sector* (Vienna, Springer, 2007) 672 et seqq

[1128] M STAUCH, *The Law of Medical Negligence*, p144

[1129] ibid

Products Act 1976.[1130] However, it should be remembered that *Anscheinbeweis* has also been applied where a patient had contracted HIV following a blood transfusion.[1131]

[1130] ibid, p146

[1131] BGH NJW 1991, 1948

6.12 Comparative Commentary

Neither the DCFR nor the PETL has much to say on the subject of strict liability for the purposes of this paper. The DCFR provides for strict liability for damages caused by dangerous substances or emissions[1132]while PETL allows for strict liability for abnormally dangerous activities while permitting national laws to provide for further categories of strict liability for dangerous activities even if they are not abnormally dangerous.[1133] I am unsure what this adds. Both Germany and the United Kingdom have rejected no-fault tort systems in the strict sense along the lines of Sweden and New Zealand and the basic principle in France still remains liability with *faute*. In each jurisdiction under consideration here, proving causation between the damage and the alleged tortious act of the defendant remains essential. Even with the special liability systems outlined above, a plaintiff still has to show that the tortious act was "caused by" the vaccination, asbestos-exposure or whatever it may be. So while I do not seek to argue that either PETL or DCFR are defunct simply because these systems exist, I do think that these special systems contribute considerably to a divergence in notion of causation based on "common rules". Yes, there are some rudiments of commonality in the jurisdictions in special regimes. For example, we see that France, the United Kingdom and Germany (the *Anscheinbeweis* for HIV) have special systems for damage caused by blood transfusions. However, there is no commonality with regard to damage caused by asbestos. A claimant seeking to recover compensation for a hospital-acquired infection will more likely be successful in France than in the United Kingdom. On the other side of the coin, a plaintiff who seeks to recover for pleural plaques, I suggest, will have more chance of being compensated in Scotland than in any other part of the United Kingdom. So again it is my submission that what these special indemnity systems do is highlight the differences between societies and what protection is to be afforded people in these societies. I am not suggesting that it is simply because there are special indemnity systems in these societies that show that causation is to be understood differently in the jurisdictions. It may be rather that *iniuria* is understood differently in the jurisdictions but I believe all these ideas of causation, damages even fault all become one at the end of the day. I believe it does tend to show how legislatures are

[1132] Article VI: 3: 206 DCFR

[1133] Art 5: 102 PETL

prepared to protect and defend people in a given situation. This necessarily has an effect on what is understood by public policy. Some of these special systems have even come after court decisions, for example, that of *Barker v Corus*. It shows how societies in certain situations have changed their causal norms, be it through actually defining what a damage is, by placing a damage at the charge of some kind of national solidarity fund or indeed by providing a system for reparation where a drug itself could possibly have caused loss in the German Pharmaceutical Products Act 1976. These different systems show how the jurisdictions diverge. Special systems of liability, in my opinion, reflect policy. Policy is recognised as a causal instrument in all jurisdictions under consideration here. They show further how there can be no understanding of common principles of causation. The retort from those in favour of some kind of European project favouring harmonisation in tort law might well be that such codes would permit special systems. This was, after all, what the PETL drafters stated with regard to strict liability. I would counter argue by noting that my highlighting of these special indemnity systems does not of itself show that causation differs fundamentally with regard to medical liability in each jurisdiction. How could it? I would simply suggest that this is a portion of evidence, that when put together with all the other research in this paper, shows that there can be no commonality in causation in its refinement in either the DCFR or, especially, in the PETL.

6.13 Conclusions of this Paper

I hope to have shown through this paper the different approaches in causation in three of the main jurisdictions in Europe (plus Luxembourg) in particular with regard to liability in the medical domain. As I said at the outset, I chose these jurisdictions for varying reasons: the United Kingdom representing my home and a common law jurisdiction, Germany and France representing two major families of the Civil Law tradition and moreover because Germany is fruitful ground for modern philosophy on causation (as is, it has to be admitted the United Kingdom now with Hart and Honoré's seminal *Causation in the Law*!). I believe they are large jurisdictions in Europe which it would be impossible to pass over when attempting to formulate any kind of European notion of causation but also which are representative of three distinct approaches to causation in Europe: crudely, the common law approach (the United Kingdom), the dare-I-say-it "empirical" civil law approach (France and Luxembourg) and the philosophical-based approach of Germany.

My hypothesis in this paper was to evaluate the PETL and the DCFR having regard to the traditions in these jurisdictions and potentially to advocate new principles or better principles where I thought these principles were deficient or wanting in any way. Yet my research simply in the matter of causation has led me to the conclusion that any principles in tort law with regard to causation are unworkable and this is only in the medical field. I dare not imagine the disparate case law which exists in other areas. It may be laudable for the drafter of PETL to forward the first principles as conditio sine qua non, concurrent causes or alternative causes, yet I hope that I have shown that the outcome in the jurisdictions concerned is not "…of very limited importance".[1134] We have seen just to what extent differences in jurisdictions exist and I need not repeat them here.

My hypothesis of improving or adding to the European projects in tort law with regard to causation was wishful thinking. My research led me to the conclusion that there are no common principles of causation in European case law.

[1134] *Principles of European Tort Law*, p43

Admittedly, all jurisdictions may well apply the conditio sine qua non but as I have shown above, it can be difficult first to agree on what this actually is. Second, it is not certain jurisdictions will apply it. Furthermore, not all jurisdictions apply it as a first principle as I have shown: France sometimes does, sometimes it does not. It depends. My conclusions that I have drawn from my research are therefore the following:

First, I have shown that not only are first principles in causation quite discrete in the jurisdictions under consideration but also the results in case law can be quite different. Even in cases where one would think the result must necessarily be the same across the board raise doubts about the solution. To take the example of *Barnett* where the patient in this case "would have died anyway" notwithstanding the physician's examination of him due to arsenic in his tea does not necessarily admit of a uniform solution. Britain would not hold the physician liable based on conditio sine qua non. France, I suspect, though I am by no means certain, would have found some way to hold the doctor liable based on fault. This is a victim-friendly solution. Germany, I believe, may have come to the same solution as the United Kingdom, but it might also have held that given the doctor was in breach of his duty to at least examine the patient that this was either gross negligence justifying reversal of the burden of proof or that there are over-riding policy considerations that the doctor must be held liable. I wonder also whether had this case come before the Supreme Court now for the first time if there would not be some overriding policy consideration which would require that the doctor be held liable. Policy is, after all, a valid causal argument. Sometimes, it is just necessary that "legal consequences must follow….".[1135]

Second, in cases that are perhaps even more on the fringes, the solutions differ yet further. First, with the idea of fault itself, a British doctor can avail himself of the *Bolam* standard where there is a responsible body of medical opinion that would hold that the defendant's actions were not negligent then the court is more or less bound to follow this behaviour with regard to putative negligent conduct. With regard to

[1135] as per Lord Hope at para 74 in *Chester v Afshar* [2004] UKHL 41

the advising of a patient of risks, *Montgomery v Lanarkshire Health Board*[1136] has recently become law in the United Kingdom, which adopts the doctrine of "informed consent". In France the standard is appreciated *in abstracto* in accordance with the bon père de famille standard.[1137] In Germany, this is the standard of care "a respectable and conscientious medical professional of average experience in the relevant field" would afford and a doctor would be liable for risks that a reasonably skilled doctor would not have taken.[1138] Germany is perhaps stricter than England in this regard as just because a defendant follows a particular accepted practice does not exclude negligence.[1139] So although this might appear at first as having little to do with causation, I believe that is inseparably linked with it. If the standards to which a professional is held differ from country to country then causation must also differ.

Third, I have also demonstrated how France allows recovery for loss of chance and Germany and the United Kingdom do not. This is not an insignificant difference and one that again shows how there is no common approach to causation. Decisions such as *Hotson* and *Gregg v Scott* would be held otherwise in France. I think there is no doubt on this.

Fourth, standards of proof are different in the United Kingdom, Germany and France. In Germany and France there is generally a higher standard of proof whereas in the United Kingdom, proof in civil cases is on the balance of probabilities. This of course must take into account the different attenuations of proof that we have seen in this paper, namely, the French presumptions in the event of facts which are *précises*, *concordantes* and *graves*. In Germany, there is *Anscheinbeweis* and even a reversal in the burden of proof where the professional has been grossly negligent. The United Kingdom also has its version of *Anscheinbeweis* in *res ipsa loquitur* . PETL may pay lip-service to this in Article 4:201 where it states that the burden of proving fault may be reversed in the light of the gravity of the danger presented by the activity. As I read this, this would allow courts in the United Kingdom to reverse the burden of proof:

[1136] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11

[1137] Art 1137 French Civil Code

[1138] BGH NJW 1961, 600 (600)

[1139] BGH NJW 1953, 257 and BGH NJW 1965, 345

this is something which has been totally excluded by the judiciary and it remains on the plaintiff for him to prove his case to the balance of probabilities. Acceptance of this article would be a seismic shift in procedural rules for the United Kingdom and it is not one, I suspect, that would be welcomed. In any case, I am sure it would be left to parliament. In France, the position might be subtly more different. A claimant must still prove his case but causal presumptions often come to his aid and there is never really a theoretical change in the need to prove one's case although showing a certain presumptions that can only be defeated by a cause étrangère may come close. In Germany, by contrast, there exists a full reversal of the burden of proof as I have shown. So again, one principle does not fit all the jurisdictions here.

Fifth, and linked to this, we have seen how Continental ways of establishing proof of causation differ from the United Kingdom. In the United Kingdom, expert reports are tested thoroughly. They are questioned and cross-examined. In France and Germany, there is little opportunity for this. Generally speaking, the experts remain court-appointed although there is some latitude for litigants to gather evidence for their own side. There has even been some push for acceptance of *Daubert*-style analysis in the United Kingdom. Without uniform procedure across the board and therefore uniform ways of establishing causation, and uniform remits given to experts, there can be no common understanding or possible hope of common principles in European causation.

Sixth, we have also seen how there are special regimes for certain areas in the jurisdictions concerned. France has *aléa thérapeutique*, which has no counterpart in any of the jurisdictions; it also has a special regime post 4 March 2002 for nosocomial infections; the United Kingdom has special liability for asbestos and mesothelioma cases (reacting against case law). Germany has codified provisions for patient consent. Scotland also recognises that pleural plaques are a legally caused damage. France and Germany also have notions of subsidiary obligations of patients *ex contractu* with regard to the patient's security and safety when she is in a hospital that know no counterpart in the United Kingdom.

Seventh, however, I think that the idea of "causation" on some kind of supra-national level, ie a European level, is here to stay, whether we are comfortable with it or not.

The TFEU gives power to the ECJ to develop law on non-contractual obligations in accordance with general principles common to the laws of the member states where damage has been caused by one or more of the institutions in accordance with its duties. Although my argument is that there are no such common principles, at least with regard to causation, the ECJ has nonetheless a certain amount of case law in this area. The jurisprudence has tended to be French-influenced with a predilection for the conditio sine qua non theory. Be that as it may, I am not going to advocate any principles with regard to causation as such that the ECJ may wish to follow in the future with regard to causation as principles are so mercurial and volatile in this area. I shall merely suggest some possible changes with regard to procedure. Policy will trump everything, for example, if ever an Article 267 TFEU reference is ever made on the Product Directive. A solution using causal principles such as "direct" causation may be attempted at an ECJ level but at the end of the day, if the result is not satisfactory, policy will be called on to the stage.

In conclusion then I would submit that there is no common law, no European ius commune and no central notion of what causation is either in the jurisdictions under consideration here and even within those jurisdictions themselves. Causation is simply a controlling device that is used to obtain a given outcome in a particular case. It plays a central role in a legal relationship.[1140] It can either deny liability totally or reduce quantum through contributory negligence. Therefore it does not really matter what notion of causation is taken. The DCFR and the PETL should not pronounce on causation. They must not try to lay down rules in its interpretation. Legal arguments on causation are to be welcomed; yet even within the jurisdictions themselves there is no agreement. Such is the nature of causation.

However, causation must be modelled on a European level for cases at the ECJ and for this the ECJ should, I believe, think carefully about what road it is going to follow in this regard. I have already suggested one improvement with regard to

[1140] F BYDLINSKI, "Causation as a Legal Phenomenon", in L TICHY (ed) *Causation in Law* (Prague, E Rozkotova, 2007) 5 at 12

experts' reports. It may in substance, as it seems to be doing, choose to be mainly French-influenced.

Therefore, in short, my conclusions for this paper are the following

1. There is no common notion of causation in European tort law that can be gleaned from a study of France (and Luxembourg), Germany and the United Kingdom;

2. Results in medical cases do **differ significantly** from jurisdiction to jurisdiction where causation is the issue at stake;

3. Results differ in part because of the procedural traditions of the jurisdictions in question. This includes procedure (including burden of proof) and expert evidence reports;

4. Given that there is no common notion of causation in European tort law, and given that causation is of the essence when establishing liability, the idea of defining or expanding ideas of causation such as can be seen in the DCFR or in the PETL is pointless. Attempts therefore to define causation in these projects should be deleted;

5. Both plaintiff and defendant should be allowed to advance its own expert reports so that they be subject to cross-examination and debate à la *Daubert*. I strongly believe that judges are not aware of the subtleties of cases to the extent that counsel and experts for each side are. Cross-examination on reports by each side will enable matters to be focused, properly assessed and studied, and individually scrutinized.

6. The ECJ does have the authority to create a certain body of European tort law in its jurisprudence and causation is part of this so causation at this European level is here to stay. It remains flexible on causation in its case law.

Given (6), I would like to suggest the following methods for ECJ case law as it develops:

7. Causation is not worth defining. The ECJ appears to have adopted the conditio sine qua non but has left the door open to other causal theories. It will be interesting to see how they tackle questions of omissions. Nothing prevents them from adopting other principles. They have tackled causation well.

8. The burden of proof should always continue to be with the plaintiff though I see nothing wrong with the court's adjusting this by means of presumptions (as we have seen in the Environmental Liability Directive) where there is substantive inequality between the parties in terms of their ability to prove the necessary facts;[1141]

9. My recommendation with regard to experts' reports applies equally for the ECJ.

[1141] C 10/55 *Mirossevich v High Authority* [1954 to 1956] ECR 333 at 343-344

BIBLIOGRAPHY
BOOKS

ARISTOTLE, *The Metaphysics* (London, Penguin Books, 2004)

ARISTOTLE, *The Nichomachean Ethics*, (London, Penguin Books, 2004)

von BURI, *Die Kausalität und ihre strafrechtlichen Beziehung* (Stuttgart, Verlag von Ferdinand Ente, 1885)

The Bible, The New International Version (Sevenoaks, Hodder and Stoughton Limited, 1990)

van DAM C, *European Tort Law* (2nd ed, Oxford, Oxford University Press, 2014)

DAVIDSON F, *Evidence* (W Green, Edinburgh, 2007)

DEMOGUE R, *Traité des obligations* (Paris, Rousseau, 1931)

DEUTSCH E and SPICKHOFF A, *Medizinrecht*: *Arztrecht, Arzeimittelrecht, Medizinproduktrecht und Transfusionsrecht* (Berlin, Springer, 2008)

ESSER J, *Grundsatz und Norm in der richterlichen Rechtsfortbildung des Privatrechts* (Tübingen, JCB Mohr, 1956)

FOSTER N and SULE S, *German Legal System and Laws* (Oxford, Oxford University Press, 2003)

GEIß K and GREINER H-P, *Arzthaftpflichtrecht* (5th ed, Munich, Beck, 2006)

van GERVEN W, *Tort Law* (Oxford, Hart Publishing, 2000)

GIESEN D, *International Medical Malpractice Law*: *a Comparative Law Study of Civil Liability arising from Medical Care* (Tübingen, JCB Mohr, 1988)

GIGLIO F, *The Foundations of Restitutions for Wrongs* (Oxford and Portland, Hart, 2007)

GLASER J, *Abhandlung aus dem österrichen Strafrecht* (Vienna, Tendler, 1858, Bd 1)

GORDLEY J (ed), *The Enforceability of Promises in European Contract Law* (Cambridge, Cambridge University Press, 2001)

GRUBB A, LAING J, McHALE J, *Principles of Medical Law* (2nd ed, Oxford, Oxford University Press, 2004)

GRUNSKY W, *Münchener Kommentar Bügerliches Gesetzbuch* (3rd ed, Beck, München, 1994), Band 2

HART HLA and HONORE T, *Causation in the Law* (Oxford, Oxford University Press, 1985)

HUME D, *A Treatise of Human Nature* (Mineola, New York, Dover Philosophical Classics, 2003)

JANDA C, *Medizinrecht* (Konstanz, UVK, 2010)

KANT I, *Critique of Pure Reason* (New York, Dover Publications, 2003)

KATZENMEIER C, *Arzthaftung* (Tübingen, Mohr Siebeck, 2002)

KEREN-PAZ T *Torts, Egalitarianism and Distributive Justice* (Aldershot, Ashgate, 2007)

KHOURY L, *Uncertain Causation in Medical Liability*, (Oxford, Hart, 2006)

KÖTZ H and AGNER G, Deliktsrecht (Munich, Franz Vahlen, 2010)

KLUNZINGER E, *Einführung in das bürgerliche Recht* (Munich, Vahlen, 2007)

von KRIES J, *Die Prinzipien der Wahrscheinlichkeitsrechnung* (Freiburg, Mohr, 1886)

LARENZ K and CANARIS CW, *Lehrbuch des Schuldrechts* (Munich, CH Beck, 1994)

MACKIE JL, *The Cement of the Universe* (Oxford, Oxford University Press, 1980)

MARKESINIS B and DEAKIN S, *Tort Law* (Oxford, Oxford University Press, 2003)

MARKESINIS B and UNBERATH H, *The German Law of Torts*: *a Comparative Treatise* (Oxford, Hart Publishing, 2002)

MAZEAUD H, MAZEAUD L and TUNC A, *Traité théorique et pratique de la responsabilité civile délictuelle et contractuelle* (volume 3, 5th ed, Paris, Montchrestien, 1958)

MEDICUS HC and LORENZ S, *Schuldrecht I* (Munich, Beck, 2008)

von MEHREN A and GORDLEY J, *The Civil Law System* (2nd ed, Boston, Brown and Co, 1977)

MILL JS, *A System of Logic Ratiocinative and Inductive* (8th ed, London, Longman Green and Co, 1886) (taken from the Project Gutenberg Ebook online project)

PEARL J, *Causality: Models, Reasoning and Inference* (Cambridge, Cambridge University Press, 2006)

PENNEAU J, *Faute et erreur en matière de responsabilité médicale* (Paris, LGDJ, 1973)

POWERS M, HARRIS N, BARTON A, *Clinical Negligence* (4th ed, Haywards Heath, Tottel, 2008)

PLANIOL M, *Traité élémentaire de droit civil conforme au programme official des facultés de droit avec collaboration de G RIPERT* (Paris, LGDJ, 1935)

QUEZEL-AMBRUNAZ C, *Essai sur la causalité en droit de la responsabilité civile*, thesis (Paris, Dalloz, 2010)

RABEL E, *Das Recht des Warenkaufs Bd 1* (Berlin and Leipzig, de Gruyter, 1936)

RAVARANI G, *La responabilité civile des personnes privées et publiques* (Luxembourg, Pasicrisie luxembourgeoise, 2006)

ROGERS H, Country Report England, in FAURE M and KOZIOL H (eds) *Cases on Medical Malpractice in a Comparative Perspective*, (Vienna, Springer, 2001)

RÜMELIN M, *Die Verwendung der Kausalbegriffe im Straf- und Zivilrecht* (Tübingen, Mohr, 1900)

SPICKHOFF A, *Medizinrecht* (Munich, Beck, 2011)

STARK B, ROLAND H and BOYER L, *Les Obligations* (volume 3, 4th ed, Paris, Litec, 1992)

STAUCH M, *The Law of Medical Negligence in England and Germany* (Oregon, Hart Publishing, 2008)

STEFANOU C and XANTHAKI H, *A Legal and Political Interpretation of Article 215(2) – The Individual Strikes Back* (Ashgate, Dartmouth Publishing, 2000)

TERRE F, SIMLER P and LEQUETTE Y, *Les obligations* (Dalloz, Paris, 2005)

THOMSON J, *Delictual Liability* (Edinburgh, Butterworths, 1999)

THOMSON J and MACQUEEN HL, *Contract Law in Scotland* (Edinburgh, Butterworths, 2000)

TRAEGER L, *Der Kausalbegrif im Straf- und Zivilrecht* (Marburg, NG Elwert'sche, 1904)

VINEY G, *Le déclin de la responsabilité individuelle*, (thesis, Paris, LGDL, 1965)

VINEY G and JOURDAIN P, *Traité de droit civil: Les conditions de la responsabilité* (3rd ed, Paris, LGDJ, 2006)

VOGEL G, *Les grands principes du droit médical et hospitalier* (2nd ed, Luxembourg, Promoculture, 2001, 2nd ed)

VOGEL G and RUDLOFF E, *Lexique de droit medical et hospitalier* (Luxembourg, Promoculture, 2009)

WEIR T, *Tort Law* (Oxford, Oxford University Press, 2002)

ARTICLES

BERG O, "Les infections nosocomiales en droit allemand", paper submitted to GRERCA conference of 14 and 15 December 2012, at the University of Louvain-la-Neuve

BINET J-R, *Cours: droit médical* (Montchrestien, 2010)

BROOKE QC, M and FORRESTER QC, I "The use of Comparative Law in *A & Others v National Blood Authority*" in FAIRGRIEVE D (ed) *Product Liability in Comparative Perspective* (Cambridge University Press, 2005) 13

BYDLINSKI F, "Causation as a Legal Phenomenon", in L TICHY (ed) *Causation in Law* (Prague, E Rozkotova, 2007) 5

CALABRESI G, "Concerning Cause and the Law of Torts: An Essay for Harry Kalven, Jr" (Autumn 1975) 43 *The University of Chicago Law Review* 69

CLERMONT KM and SHERWIN E, "A Comparative View of the Standards of Proof" (2002) 50 *The American Journal of Comparative Law* 243

COLLINS J, HALL N and PAUL LA, "Counterfactuals and Causation: History, Problems and Prospects" in COLLINS J, HALL N and PAUL LA (eds) *Causation and Counterfactuals* (Cambridge, Massachusetts, MIT Press, 2004) 1

DAVIDSON D, "Causal Relations" in SOSA E and TOOLEY M (eds), *Causation*, (Oxford, Oxford University Press, 2007) 75

DIERRAT M, "De la distinction entre obligations de moyens et obligations de résultat: pile ou face?" (2011) 15 *Journal des tribunaux Luxembourg* 61

DOLL R and HILL AB, "Smoking and Carcinoma of the Lung: Preliminary Report" (1950) 2 *British Medical Journal* 739

EVIN C, "L'indemnisation des accidents médicaux" (2001) *Revue générale du droit médicale* 71

FAURE M and BRUGGEMENT V, "Causal Uncertainty and Proportional Liability" in L TICHY (ed) *Causation in Law* (Prague, E Rozkotova, 2007) 105

GALAND-CARVAL S, "Causation under French Law", in SPIER J (ed) *Unification of Tort law: Causation*, (The Hague, Kluwer, 2000) 53

GALAND-CARVAL S, Country Report France, in FAURE M and KOZIOL H (eds), (Vienna, Springer, 2001)

GILIKER P "Can 27 + 'Wrongs' Make a Right? The European Tort Law Project: Some Sceptical Reflections" (2009) 20 *Kings Law Journal* 257

GOLDBERG R, "The Contraceptive Pill, Negligence and Causation: Views on *Vadera v Shaw*", (2000) 8 *Medical Law Review* 316

GOLDBERG R, "Using Scientific Evidence to Resolve Causation Problems in Product Liability: UK, US and French Experiences." in R GOLDBERG (ed) in *Perspectives on Causation* (Oxford, Hart Publishing, 2011), 149

GORDLEY J, "The Universalist Heritage", in LEGRAND P and MUNDAY R (eds) *Comparative Legal Studies: Traditions and Transitions* (Cambridge, Cambridge University Press, 2003) 31

HAMER D, " 'Factual Causation' and the 'scope of liability': what's the difference?", (2014) 77 *Modern Law Review* 155

HOGG M, "The Role of Causation in Delict", (2005) *Juridical Review* 89

HOGG M, "Re-establishing Orthodoxy in the Realm of Causation", (2007) 11 *Edinburgh Law Review* 8

HONORE AM, "Causation and Remoteness of Damage", in TUNC, A (ed) *International Encyclopaedia of Comparative Law*, ch 7, vol XI (The Hague, Tübingen, 1971)

Le HOUEZEC D, "Evolution of Multiple Sclerosis in France since the beginning of the Hepatitis B Vaccination", (2015) 60 *Immunologic Research* 219

HYSLOP E, "Causal Theories in *Chester v Afshar* [2004] UKHL 41" (2008) 16 *European Review of Private Law* 629

INFANTINO M, "Making Tort Law: The Game and its Players" (2010) *Journal of International Comparative Law* 46

JONES M, "Informed Consent and Other Fairy Stories", (Summer 1999) *Medical Law Review* 103

JOURDAIN P, "L'ndemnisation des accidents médicaux: que peut faire la Cour de cassation?" (1997) *La semaine juridique* I.4016.181

JOURDAIN P, "Sanction de l'obligation d'information du médicin sur les risques d'un acte medical" *Dalloz*, 2000, N°44, 471

JOURDAIN P, "Obligation d'information médicale: le recul de la sanction", (2003) *Revue trimestrielle de droit civil* 98

JOURDAIN P, "La causalité"
http://grerca.univrennes1.fr/digitalAssets/288/288515_pjourdain2.pdf

JOURDAIN P, "Effets de la responsabilité" (2009) *Revue trimestrielle de droit civil* 543

JOURDAIN P, "Responsabilité médicale: quelle critère distinctif de la faute et de l'aléa thérapeutique en cas de lesion consecutive à une intervention chirurgicale?", (January / March 2009) *Revue trimestrielle de droit civil* 123

KINSCH P "Probabilité et certitude dans la preuve en justice" (2009) 2 *Journal des tribunaux Luxembourg* 37

KOZIOL H "Natural and Legal Causation" in L TICHY (ed) *Causation in Law (*Prague, E Rozkotova, 2007) 53

KOZIOL H and STEININGER BC(eds), *Tort and Insurance Law Yearbook*, *European Tort Law 2008* (Springer, Vienna, 2009)

von KRIES J, "Über die Begriffe der Wahrscheinlichkeit und Möglichkeit und ihre Bedeutung im Strafrecht" (1889) *Zeitschrift für die gesamte Strafrechtswissenschaft* 9: 528

LAMPIN F, avocat au barreau de Lille, "Revirement de jurispreudence du Conseil d'Etat sur les infections nosocomiales endogènes", *Alin&As*, (Feb 2012) n°1: http://cclin-sudest.chu-lyon.fr/Newsletter/2012/01/Juriste.pdf

LANDO O, "Optional or Mandatory Europeanisation of Contract Law" (2000) 8 *European Review of Private Law* 59

LARROUNET C, "L'indemnisation de l'aléa thérapeutique", (1999) *Receuil Dalloz* 33

LEGRAND P, "The Return on the Repressed: Moving Comparative Legal Studies beyond Pleasure", (2001) 75 *Tulane Law Review* 1033

LEGRAND P, "Paradoxically, Derrida: For a Comparative Legal Studies" (2005) 27 *Cardozo law Review* 631

LENZE S, "German Product Liability Law: between European Directives, American Restatements and Common Sense" in FAIRGRIEVE D (ed), *Product Liability in Comparative Perspective*, (Cambridge, Cambridge University Press, 2005)

LIENHART A, "Survey of Anaesthesia-related Mortality in France", (2006) *Anaesthesiology* 105

LLOYD-BOSTOCK S, "The Ordinary Man, and the Psychology of Attributing Causes and Responsibility", (1979) 42 *Modern Law Review* 143

MACKIE J, "Causes and Conditions", in SOSA E and TOOLEY M (eds), *Causation*, (Oxford, Oxford University Press, 2007) 33

MAGNUS U, "Causation in German Tort Law", in SPIER J (ed) *Unification of Tort law: Causation*, (The Hague, Kluwer, 2000) 63

MAGNUS U, "Causation by Omission", in L TICHY (ed), *Causation in Law* (Prague, E Rozkotova, 2007) 95

MICHAELS R, "The Functional Method of Comparative Law", (2005) *Duke Law School Legal Studies Research Paper Series*, No 87, http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2033&context=faculty_scholarship

MISALWSKI R, "Vaccin contre l'hépatite B et sclérose en plaque: retour sur la causalité", (2010) *Médecine et Droit* 105

MISTRETTA P, "La loi no 2002-303 du 4 mars 2002 relative aux droits des maladies et à la qualité du système du santé, Réflexions critiques sur un droit en pleine mutation", (2000) *La semaine juridique* I.141.1080

MOUSOURAKIS, G "Comparability, Functionalism and the Scope of Comparative Law", (2008) 41 Hosei Riron 1

MÜLLER G, "Beweislast und Beweisführung im Arzthaftungsprozeß", (1997) *Neue Juristische Wochenschrift* 3049

NUOTIO K, "Some Remarks on the General Philosophy of Causality and its Relation to Causation in the Law", in L TICHY (ed) *Causation in Law* (Prague, E Rozkotova, 2007) 27

PARZELLER M, WENK M, ZEDLER B and ROTHSCHILD M, "Patient Information and Informed Consent before and after Medical Intervention", (Deutsches Ärteblatt: 104: 576-586) http://data.aerzteblatt.org/pdf/DI/104/9/a576e.pdf , p10

RADE C "Vaccination anti-hépatite B et sclérose en plaques: le tournant" (July-August 2008) *Responsabilité civile et assurance* 8

REITZ J "How to do Comparative Law" (Autumn 1998) 46 *American Journal of Comparative Law* 617

SARGOS, P "Réflexions sur les accidents médicaux et la doctrine jurisprudentielle de la Cour de cassation en matière de responsabilité médicale" *Dalloz* 1996 *chron* p365 n°8

SARGOS P, "Le nouveau regime juridique des infections nosocomiales, loi no 2002-303 du 4 mars 2002" *La semaine juridique* 2002 *Actualité* 117

SCHIEMANN G, "Problems of Causation in the [sic] Liability for Medical Malpractice in German Law" in L TICHY (ed) *Causation in Law* (Prague, Rozkotova, 2007) 187

SCHOUBSBOE C, "The Concept of Damages as an Element of non-Contractual Liability of the European Community", Aarhus University Dissertation,

http://law.au.dk/fileadmin/site_files/filer_jura/dokumenter/forskning/rettid/2003/2003.afh-3.pdf

SHAW J, "Informed Consent: A German Lesson", (1986) 35 *International and Comparative Law Quarterly* 864

STAPLETON J, "Law, Causation and Common Sense", (1988) 8 *Oxford Journal of Legal Studies* 111

STAPLETON J, "Cause-in-Fact and the Scope of Liability for Consequences" (2003) 119 *Law Quarterly Review* 388

STAPLETON J, "Choosing what we mean by 'Causation' in the Law" (2008) 73 *Missouri Law Review* 433

STEINLE-FEURBACH M-F, "La responsabilité des fabricants de medicaments", (February 2006) *Journal des accidents et des catastrophes* 61

SPIER J and HAAZEN O, "Comparative Conclusions on Causation", in *Unification of Tort Law: Causation*, SPIER J (ed), (Dordrech, the Netherlands, Kluwer, 2000) 127

TARUFFO M, "Rethinking the Standards of Proof", (2003) 51 *The American Journal of Comparative Law* 659

TAYLOR S "Clinical Negligence Reform: Lessons from France?", (July 2003) 52 *International and Comparative Law Quarterly* 737

TAYLOR S "Harmonisation of Divergence? A Comparison of French and English Product Liability Rules" in FAIRGRIEVE D (ed), *Product Liability in Comparative Perspective* (Cambridge University Press, 2005)

THOMSON J, "The Raising of Lazarus: The Resurrection of *McGhee v National Coal Board*", (2003) 7 *Edinburgh Law Review* 80

VAYRE P, PLANQUELLE and FABRE H, "Le lien de causalité en matière de responsabilité médicale", (2005) *Médecine et droit* 78

WEDENHORST C, "Compensation in the German Health Care Sector" in DUTE J, FAURE M and KOZIOL H (eds), *No Fault Compensation in the Health Sector*, (Vienna, Springer, 2007)

WESTER-OUISSE V, "Définition de la causalité dans les projets europeéens sur le droit de la responsabilité" in *Receuil des travaux du Groupe de Recherche Europeén sur la Responsabilité Civile et l'Assurance* (GRERCA) (Paris, 2012) 391

WINIGER B, "Multiple Tortfeasor" [sic] in L TICHY (ed) *Causation in Law*, (Prague, E Rozkotova, 2007) 79

WRIGHT R, "Causation in Tort Law" (1985) 73 *California Law Review* 1735

WRIGHT R, "Liability for Possible Wrongs: Causation, Statistical Probability, and the Burden of Proof", (Summer 2008) *Loyola of Los Angeles Law Review* 1295

WRIGHT R, "Proving Facts: Belief versus Probability" in the *Tort and Insurance Law-Yearbook*, *European Tort Law* 2008 (Vienna, Springer, 2008) 79

WORKING PAPERS AND REPORTS

Report of the Royal Commission on Civil Liability and Compensation for Personal Injury, (Chairman: Lord Pearson) Command Paper 7054 (London, HMSO, 1978)

"Communication to the European Parliament and the Council – A more coherent European Contract Law: An Action Plan", 12 February 2003 (COM (2003) 68

Forensic Science on Trial, House of Commons Science and Technology Committee (2005) (London, HMSO)

Principles of European Tort Law, Text and Commentary (Vienna, Springer, 2005)

Draft Common Frame of Reference in *Principles, Definitions and Model Rules of European Private Law* (Sellier, Dissen, 2009)

The Admissibility of Expert Evidence in Criminal Proceedings in England and Wales: *A New Approach to the Determination of Evidentiary Reliability* (The Law Commission, 325, March 2011)

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