LAW & MEDICINE

Factual and Proximate Causation

Question: An internist prescribed increasing doses of cholestyramine for a patient with hypercholesterolemia with resulting constipation. The constipation worsened after codeine was used to relieve abdominal pain. A month later, the patient experienced severe abdominal distress, and a barium enema revealed a perforated sigmoid colon. She underwent emergency surgery, and the colon was found to be distended, with impacted feces the size of tennis balls. She sued the internist, alleging that his negligence in prescribing the various medications led to the intestinal perforation. Which of the following statements best fits the situation?

BY S.Y. TAN, M.D., J.D.

A. The internist will lose the case because he should have chosen a statin over a bile acid sequestrant.
B. The internist was negligent when he prescribed codeine in combination with cholestyramine.
C. The patient was fully aware that constipation is a side effect of these medications, and so assumed the risk of injury.
D. The patient has not proved that the bowel perforation was caused by the internist's negligence.
E. The barium enema could have caused the perforation, and the proper party to sue is the radiologist.

Answer: D. Choices A and B may reflect the general medical view, but the use of these approved drugs is determined by the individual clinical situation and may not constitute substandard care. Choice C is incorrect, as the patient can hardly be said to have accepted the risk of a bowel perforation. This hypothetical case is adapted from *Roskin v. Rosow* (#301356, San Mateo Cty Super. Ct. [Cal. 1987]), which illustrates the importance of the causation factor in tort litigation. The defendant contended that the plaintiff reported only mild constipation, and that the bowel was perforated during the barium enema, not from the use of medications. There being no settlement, the case went to trial, and the jury found for the defendant because the plaintiff did not satisfy the causation element. The radiologist was apparently not sued, perhaps because the statute of limitations had lapsed.

In order to prevail in a medical negligence lawsuit, a plaintiff must prove causation even after establishing that the doctor owes a duty of care and that there has been a breach of the standard of care. There are two types of causation, factual cause and proximate cause, and both must be proved. Factual cause is established by the use of the "but-for" test, that is: "The defendant's conduct is a factual cause of plaintiff's injuries if plaintiff's harm would not have occurred but for defendant's conduct," or "the defendant's conduct is a factual cause of plaintiff's injuries if plaintiff's harm would not have occurred without defendant's conduct" (Steven Finz, 1998, "Sum & Substance Audio on Torts").

Proximate cause is not as easily ascertained. One Court of Appeals has stated: "A plaintiff proves proximate cause, also referred to as legal cause, by demonstrating a natural and continuous sequence of events stemming from the defendant's act or omission, unbroken by any efficient intervening cause, that produces an injury, in whole or in part, and without which the injury would not have occurred" (*Barrett v. Harris,* 86 P.3d 954 [Ariz. 2004]).

The key inquiry in proximate cause analysis is whether the injury was foreseeable. If the defendant could not reasonably have foreseen the resulting harm, the defendant escapes liability. Suppose Mr. A negligently broke the leg of a pedestrian as the result of careless driving. Unfortunately, the injury was worsened by a surgeon's intervening negligence. Because surgical malpractice is foreseeable, the surgeon's negligence is said to be a concurring cause, and Mr. A, the original tortfeasor, becomes liable to the pedestrian for both the original and the aggravated injury (the surgeon is of course also liable).

> **An event may occur in the interval between the defendant's negligent act and the plaintiff's injury that breaks the chain of causation.**

In a recent Florida case, the District Court of Appeals found several doctors liable for missing the diagnosis of tuberculous meningitis. The court held that since there were multiple doctors involved, i.e., concurring causes, the plaintiff was entitled to concurring-cause jury instruction. The purpose of such instruction was to negate the idea that a defendant is excused from the consequences of negligence by reason of some other cause concurring in time and contributing to the same injury (*Hadley v. Terwilleger,* 873 So.2d 378 [Fl. 2004]).

On the other hand, an event may occur in the interval between the defendant's negligent act and the plaintiff's injury that breaks the chain of causation. The law, for example, does not hold a defendant liable when an unforeseeable intervening factor has led to an unforeseeable injury. Superseding cause is "an act of a third person or other force which by its intervention prevents the actor from being liable for harm to another which his antecedent negligence is a substantial factor in bringing about" (Restatement [Second] of Torts §440).

Suppose an emergency department doctor, Dr. B, missed a fracture on an x-ray. Upon discovering Dr. B's error the following day, the radiologist informed the on-call physician, Dr. C. Unfortunately, Dr. C failed to notify the patient. Did Dr. C's negligence free Dr. B from liability? In a case with similar facts, the 6th Circuit Court held this was a superseding cause relieving the first doctor of liability (*Siggers v. Barlow,* 906 F.2d 241 [6th Cir. Ky, 1990]).

To analyze causation issues, one has to identify factual cause issues separately from proximate cause issues. To make matters worse, the term "legal cause" is sometimes used interchangeably with "proximate cause." And of course, there can be more than one proximate cause for any given injury. Reflecting this complexity, the California Supreme Court now disallows confusing jury instructions regarding proximate cause, requiring instead that the jury be simply directed to determine whether the defendant's conduct was a contributory factor in the plaintiff's injury (*Mitchell v. Gonzales*, 819 P.2d 872 [Cal. 1991]). ■

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Medicare Coverage of CT Colonography Looks Unlikely

BY ALICIA AULT

The Centers for Medicare and Medicaid Services has proposed to refuse coverage of CT colonography for colorectal cancer screening.

"The evidence is inadequate to conclude that CT colonography (CTC) is an appropriate colorectal cancer screening test," the agency said in a posting to its Web site.

The proposal follows a November Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) meeting, in which a majority of committee members expressed moderate confidence in the technology's ability to determine with adequate specificity and sensitivity the presence of polyps greater than 10 mm, but less confidence in detecting smaller polyps. Committee members expressed even less confidence in the technology's ability to increase overall cancer screening rates.

Additionally, they said that it did not appear that CTC had a similar ratio of cost per life-years saved, compared with optical colonoscopy.

There were lengthy debates about potential radiation exposure, the implications of extracolonic findings, and of CTC's apparent lack of precision in detecting smaller polyps.

At that meeting, representatives of the U.S. Preventive Services Task Force reiterated its position that there is insufficient evidence to assess the benefits and harms of CTC.

When the Centers for Medicare and Medicaid Services began its process of considering coverage of the technology in May 2008, it received 100 comments, 79 of which were in favor of adding CTC as a Medicare-covered benefit.

Among those commenting in support of coverage for asymptomatic, average-risk patients over age 50 years were the American Cancer Society, American College of Radiology, and the American Gastroenterological Association.

In its comments, the AGA said that it would support coverage only if the CMS required providers to meet technology, training, and reporting standards. CTC also should only be covered as part of Medicare's Coverage with Evidence Development process, the AGA said. At the November MEDCAC meeting, the AGA reiterated its position.

The CMS said none of the available evidence focuses on "a population more representative of the Medicare population." A younger population likely has a lower polyp prevalence, lower positive rates, and lower rates of referral to optical colonoscopy, the agency said.

Further, since Medicare already covers screening tests known to lead to positive health outcomes, a new test should show evidence of increasing overall screening, according to the proposed decision. A new test should not lead to duplicative testing or switching from one test to another, and so far, there's nothing to say that CTC would lead to either of these scenarios, which would increase resource use, the CMS said.

Finally, there are no data showing that screening with CTC leads to less cancer, the agency said.

The CMS, which accepted comments on this proposed decision until mid-March, was considered unlikely to change its direction by the time it makes its final decision shortly thereafter. ■

To view the proposed decision or to comment, go to http://tinyurl.com/dmpcok.