Delay in Breast Cancer Diagnosis

The Medicolegal Issues

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Sadly, we are witnessing a steady increase in litigation arising from the delay in diagnosis of breast cancer. An upsurge in such cases has been taking place in the USA for a number of years, and a similar trend is now being observed in the UK.

Litigation against US breast specialists has increased to the point where such cases come second only to alleged obstetric negligence involving brain-damaged babies. Claims may be directed against general practitioners for failing to refer patients, against breast surgeons for failing to establish the diagnosis in the clinic, and increasingly with the advent of screening, against breast radiologists who may miss subtle signs on mammograms.

The age of the woman concerned is a major factor. The impact of a diagnosis of breast cancer is understandably more devastating in a young woman where it impinges directly on her entire family. Whilst breast cancers under the age of 50 account for only 25% of cases, women under 50 make up 75% of claimants in breast cancer cases, and receive 84% of damages. Awards may reflect not only the loss of chance of survival, but also the additional costs of ongoing child care when the mother is ill or dies with a young family.

Difficulties with diagnosis

All patients with a discrete breast lump should undergo triple assessment in the breast clinic. Delay in diagnosing breast cancer is more likely in younger women because of the difficulties in each of the modalities of triple assessment, i.e. clinical examination, imaging and needle biopsy (cytology). Triple assessment is an accurate means of diagnosis in women attending the breast clinic overall, but in women under the age of 35 the failure rate of triple assessment approaches 10%.

This is because clinical identification of a small carcinoma may be more difficult when arising in hormonal nodular breast tissue. Cytology may give a false negative result due to a sampling error with the needle missing a small lesion. Imaging techniques are likewise less sensitive in premenopausal patients. Mammography in dense breast tissue is likely to miss up to 25% of small carcinomas in women under 40 and radiological features of malignancy may be absent until the cancer is locally advanced. Ultrasound scan, whilst more suitable in imaging dense breast tissue, may fail to distinguish between a benign lesion such as a fibroadenoma and a well-circumscribed carcinoma.

Liability and causation

What does a woman face when bringing a claim for an alleged delay in diagnosis of her breast cancer? For the court to establish that the delay in her particular case reflects clinical negligence, the case must be proved both for liability, i.e. that there was a breach in the duty of care to the patient, and for causation i.e. that she suffered harm as a result of this breach of duty. If either of these aspects is not proven in court, then the claim will fail.

If the court finds that there was no liability – i.e. the standard of medical care was reasonable – for instance, if all the correct procedures were followed but the diagnosis was nevertheless missed as a result of bad luck, then the litigation will not succeed even if the court accepts that the prognosis in that patient has been made significantly worse with the delay. On the other hand, the court may find that liability for a delay in diagnosis can be established, for instance if the clinician’s management was such that her care fell below a reasonable standard, but if the patient’s treatment, condition and long-term prognosis would have been the same whether or not the delay been avoided, then the claim will fail on causation.

Burden of proof

In a criminal court, the burden of proof that needs to be established is beyond reasonable doubt, which many people would equate to a degree of confidence of greater than 95%. In civil court, however, where clinical negligence cases are heard, the burden of proof applied is on balance of probabilities, in other words greater than 50%. If the court finds in a particular case that a patient would have had a greater than 50% chance of survival had there been no delay in diagnosis, but that
her chance of survival fell to below 50% as a direct result of that delay, then and only then is it likely that an award will be made for loss of survival.

There has been recent legal debate about whether an alternative approach might be taken to the “all or none” decisions currently made in civil court applying the test of balance of probabilities. It was argued that “loss of a chance” should be recognised by the court in scaling down of awards, for instance if the likelihood of survival is reduced by, say, 20%, the claimant should receive 20% of the total damages. In a landmark decision earlier this year, the House of Lords considered this appeal (in the case of Gregg v. Scott) and upheld the traditional approach, so the burden of proof, for the time being at least, remains unchanged.

Long-term survival is not the only issue when considering causation and is only a part of the assessment of damages by the court. If for instance it can be shown that a negligent delay meant that the patient lost the opportunity for breast-conserving surgery and required a mastectomy due to progression of the cancer within the breast, then the court might award her damages for the psychological trauma from unnecessary loss of the breast, and the extra time, expense and hospitalisation involved in a reconstructive procedure.

**How can medical practitioners do better?**

Common sense and sound clinical judgement cannot be overestimated. From time to time a delay in establishing the diagnosis of breast cancer will be unavoidable even when all appropriate steps are taken. If defensive medical practices were carried to an extreme, all women with even trivial symptoms would be referred to breast services, patients would be over-investigated and already overstretched clinics would be overwhelmed by the workload.

National guidelines for general practitioners have been published detailing the types of breast problems that require referral to a specialist clinic, including indications for urgent referral for suspected cancers. Similarly, guidelines now exist for all breast specialists, outlining standards of good practice with regard to investigation of patients in the clinic and acceptable timescales for starting treatment. If clinicians can demonstrate that they have acted in accordance with good practice, then claims of clinical negligence should be easier to deal with.