A DEFINABLE, RELATIVELY SMALL GROUP OF BREAST CANCER PATIENTS MAY HAVE BEEN VICTIMS OF THE NEGLIGENCE OF THE SECRETARY OF STATE (5486 words)

Introduction – Metastatic Skeletal Breast Cancer

If you are a woman in your prime with a school aged son and are diagnosed with breast cancer, and if that breast cancer has already metastasised to the skeleton, then after a successful mastectomy you should be able, on the NHS, to make a choice based on your priorities. You could in short order begin to take chemotherapy that prolongs life more. Alternatively, you could take hormonal therapy, which normally comes with little in the way of side effects. Either way, radiotherapy against lesions in the ribs and the spine may be received additionally.

This article concerns a real case, which first arose in 2013. We can consider it alongside a relatively small number of similar cases arising in similar circumstances also in 2013 ["the Group"]. It appears that the Group was affected by the decision of the then Secretary of State, Jeremy Hunt, to reduce to below cost the tariff paid to English hospital trusts for providing chemotherapy. The purpose of this article is to demonstrate this.

National Prices and other Funding Issues

Under the Health and Social Care Act (2012) the coalition government, through the Secretary of State in his capacity as a public authority, introduced a tariff of national prices (The National Tariff Payment System). The NHS moved from funding providers (hospitals, clinics etc) against budgets to funding according to the national tariff for delivering different types of healthcare treatment. The difference is that although the national prices have been said by the Secretary of State to include procurement, overheads, nurse time and chair time nevertheless the amount did not necessarily cover the whole cost of the treatments. National prices for chemotherapy delivery and external beam radiotherapy were first introduced, along with prices for all other NHS health care provision, in 2013/14.

National prices were expected to be used across the board in 2014/15, unless doing so would have "*an unmanageable financial impact*." If it did, then, under the Act (s. 124 (1)): "*The commissioner and the provider . . . may agree that the price . . . is . . . . modified*" if it can be shown in an application that "*it would be uneconomic for the provider to provide the service for the purposes of the NHS*" (s. 124 (5)).

"*The treatment principle for BC* [breast cancer] *patients with bone metastasis is to relieve pain, restore function and improve the quality of life, increase the survival time, and the main comprehensive therapy includes radiation and chemotherapy*"[1]. In reality, in 2013/14 a sample of 19 providers were allocated 5% less to spend on chemotherapy and beam radiotherapy as a result of the tariff. This sample spent 40% of the national total for these treatments. No provider increased spending more than 17% (£2m) and spending decreases ranged down to 49% (£5.4m)[2].

In an unrelated government policy, in 2013 -14 the funding for cancer treatments was lumped together with heart surgery, major trauma and complex care in a *"specialised commissioning*

[1] Impact of surgery on survival in breast cancer with bone metastases only, BMC Surgery volume 21, Article number: 378 (2021)

[2] Impact Assessment of proposals for the 2014/15 National Tariff Payment System, 7 October 2013, section 4.3

budget"[3]. In response to this policy, *"Macmillan's concern* [was] *that there* [would be] *a wider threat to the sustainability of cancer services"* (Mike Hobday, director of policy at Macmillan Cancer Support) as compared to other services. Additionally, concerns were aroused that "*Oncology services* [would] *be expected to contribute to these savings.*" Consequently *"tougher restrictions on eligibility for treatment or delays to the introduction of drugs"* [4] were anticipated in the coming year.

The Effect of the Characteristics of the Group

A professor of oncology, renowned for amongst other things providing expert medical evidence for legal cases, had reason to speak on the present case at a legal conference convened by a KC in April 2025. He noted that a key characteristic of the Group is that more likely than not, a patient will survive significantly longer than the prognosis that is most frequent amongst its members – around 4 to 5 years. In other words, on a graph of all its members the distribution of time from diagnosis to end of life is long-tailed (BMC Surgery). Therefore, in 2013, despite this prognosis, he pointed out that it was expected that some patients in the Group would survive as long as twenty years or more beyond the date of diagnosis; a few such patients may be alive now.

Exactly how long the patient actually survives is unpredictable. But it does in part depend on the condition and treatment of the individual patient. Two common complications are spine collapse, leading to spinal cord compression and paralysis[5], and concentration of disease in the patient's hip and attached femur, leading to fracturing[6]. In *King* (2020) EWHC at [63]:-
"*In line with the authorities I am entitled to rely upon the statistical evidence. What I must not do is fail to take into account and weigh in the balance the evidence we have which is relevant to the deceased as an individual*."

A patient in the Group by definition has, as has been said, one or more relatively young, children. The patient is therefore likely to have prioritised the prolongation of life over the quality of life. There is generally a strongly felt parental desire or sense of duty for the parent to be around for the young child as long as possible.

Patients for whom no metastatic cancer has been detected, and who therefore are being treated curatively, will take chemotherapy intensively but for only a relatively short period of time. In addition, many patients who are being treated palliatively but are not in the Group either will also undergo chemotherapy for only a relatively short period of time. This is simply because their prognosis is much shorter; their cancer has metastasised not to the skeleton but instead to a soft organ such as the lung, brain or liver.

Consequently, on the basis of both the individual priorities and the medical characteristics of the patients in the Group alone, the prospective cumulative cost of chemotherapy per patient in the Group would be likely to exceed significantly the cost per patient for cancer patients not in the Group. However, as has been set out, the Secretary of State lowered the national prices of

[3] Cancer Patients Lose Out in NHS Overspend, Pharmafile, 6 January 2014
[4] NHS reforms in England: the implications for chemotherapy commissioning, received by eCancer Medical Science on 26/03/2014, published on 05/08/2014
[5] Diagnosis and surgical management of breast cancer metastatic to the spine, World J Clin Oncol. 2014 Aug 10;5(3)
[6] Breast cancer bone metastasis in femur: surgical considerations and reconstruction with Long Gamma Nail, EJSO 30/9 2004.

chemotherapy from 2013-14 to 2014-15 and depleted the funding available from the specialised commissioning budget in 2014-15.

In response, providers were under pressure to shorten the period of chemotherapy for patients in the Group. While the Secretary of State would appear to bear primary responsibility for any consequences thus caused, nevertheless, providers and clinicians can mitigate the limitations he imposed. To this extent, his liability is shared with providers both on their own behalf and vicariously on behalf of their clinicians.

Conditions for Governmental Civil Liability

The Supreme Court in 2015 in the case of *Montgomery* appeared to recognise the possibility of an allegation of negligence against the Secretary of State and clinicians jointly being made:-
"*The treatment which they* [clinicians] *can offer is now understood to depend not only upon their clinical judgment . . . Such decisions* [those which are taken by non-medical professionals] *are generally understood within a framework of institutional rather than personal responsibilities, and are in principle susceptible to challenge under public law rather than, or in addition to, the law of delict or tort*." (Para. 75, emphasis added)
In other words, decisions made by the Secretary of State, as a non-medical professional, are in principle susceptible to challenge under the law of tort as part of private, as opposed to public, law. He is in principle accountable to a patient in the Group.

Certain tests that must be met for a private individual's, or a private body's, or a public authority's liability to be a legal possibility have entered the case law over the decades:-
"*At common law, public authorities are generally subject to the same liabilities in tort as private individuals and bodies: … Accordingly, if conduct would be tortious if committed by a private person or body, it is generally equally tortious if committed by a public authority: …*" (*Robinson v Chief Constable of West Yorkshire Police* [2018] UKSC 4, [2018] AC 736 at paragraphs 32 and 33).

For the Secretary of State to be held accountable for harm to a patient in the Group that is at least in part "*naturally and probably caused*" [*Scotts Trustees v. Moss* (1889)] by any constraint or condition he imposed on the provider under the arrangements for the provision of health care to the Group, he must have been "*bound to anticipate*" that such constraints or conditions would potentially harm members of the Group. The risk of these constraints or conditions doing so have to have been "*glaringly obvious*" [*Home Office v Dorset Yacht Co.* (1970)]. Members of the Group had to have been at "*special risk*" [*Woodcock v Northamptonshire Chief Constable* (2023)].

Legal authorities have established what is known as foreseeability and proximity. For an acceleration of symptoms and death caused by the Secretary of State's constraints or conditions to be proximate, the relationship of the parties between whom a cause and an effect is alleged must be sufficiently close that nothing else is likely to have caused the harm. The Secretary of State thus given the circumstances potentially had a duty to take reasonable care to avoid harm to those likely to be affected by his action.

He is only exempt from this duty if it would compromise his performance of his statutory duty, or otherwise conflict with public policy.
"Its [the Court's] *function is confined in the first instance to deciding whether the act or omission complained of fell within the statutory limits imposed upon the department's or authority's discretion. Only if it did not would the court have jurisdiction to determine whether or not the act or omission not being justified by the statute constituted an actionable infringement of the Plaintiff's*

rights in civil law." [Lord Diplock, in *Home Office*] If, on the other hand, what is complained of did fall within the bounds of the Secretary of State's discretion, the claimant ("*Plaintiff*") would be deprived of a cause of action. The court will not impose a liability if it would compromise the performance of the Secretary of State's statutory duty.

Even where following principles as outlined above a duty to the patient not already part of the common law could be imposed on the Secretary of State, such a duty may nevertheless conflict with public policy. For example, it may lead to insuperable adverse operational consequences. In such a case the court will weigh up the reasons for and against imposing liability, in order to decide whether the existence of a duty of care would be "*fair, just and reasonable*" [*Caparo Industries plc v Dickman* (1990)]. For example, it was said in *Ancell v McDermott* [1993] 4 All ER 355:-
"*The imposition of a duty of care on the police to protect road users from hazards caused by others would be so extensive as to divert the police from the proper functions of detecting and preventing crime*."
It was said also in *Osman v Ferguson* [1993] 4 All ER 344:-
"*The imposition of a duty of care towards a potential victim might result in the significant diversion of police resources from the investigation and suppression of crime*."

<u>No Compromise in the Performance of his Statutory Duty</u>

In the present case, the statutory duty of the Secretary of State under the 2012 Act comprises both his general duty to:-
"*… continue the promotion in England of comprehensive health service designed to secure improvement—*
(a) in the physical and mental health of the people of England, and
(b) in the prevention, diagnosis and treatment of physical and mental illness", as well as certain specific duties which have no relevance to the present case.

As already established above, the Secretary of State potentially had a duty to take reasonable care to avoid foreseeable harm to those likely to be affected by (proximate to) his action. This duty would be imposed if it did not conflict with his statutory duties. The first question is whether his actions would breach this potential duty. As already set out above, the Secretary of State introduced the national tariff and then a year later lowered the national price paid to the provider for chemotherapy, and at the same time lumped its funding with that of treatment for certain other conditions. He thus effectively reduced the amount of chemotherapy for the Group compared to what it would otherwise have been.

As already explained, chemotherapy delays the onset of symptoms and thereby prolongs life, and members of the Group typically could have a considerable number of years left to live. As set out above, the Secretary of State disincentivised clinicians from giving chemotherapy, at least for a time, by otherwise facing providers with a financial loss, and the real possibility of running up unmanageable deficits.

It is hard to see how his admittedly considerable discretion under the Act would even so have justifiably stretched to delineating, for the purpose of economising on chemotherapy, a small group of women and inflicted on them a shorter and more painful rest-of-life. Members of the Group were not remote from the Secretary of State, far from it, he singled out the Group (see National Prices and other Funding Issues above). In the words of Lord Atkin in *Donoghue v. Stevenson* (1932) they were:-

"*… persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation when I am directing my mind to the acts or omissions called in question*."

Nor were the effects unforeseeable and unforeseen. The 2012 Act admitted the need to address the effects without offering a workable solution in practice. Trusts could apply to vary the price (see the National Prices section above) but this was a process that took time and effort, and was potentially abortive. Providers would tend to reduce spending instead. One must assume that the Secretary of State's decision to implement such a process was deliberate. All his decisions must be considered ones.

The Secretary of State did not know personally each of the hundreds of women with fairly young children diagnosed with metastatic breast cancer in the bone during the course of 2013[7]. But he could have had them "*in contemplation*" and for example written to them, for he was in a position to identify them, as he had access to their patient records.

His actions brought forward the symptoms and the end of life of members of the Group, a particularly acute consequence, one of the sort foreseen by Macmillan and others at the time (Pharmafile).
It is hard to see how his broad duty to provide a national health service and improve standards of health could conceivably be perceptibly detracted from by the performance of this particular, exceptionally powerful duty toward the patients of the Group. It would only do so if it significantly took resources from the "*prevention, diagnosis and treatment of* [other] *physical and mental illnesses.*"

For illustration, two years' worth of low dosage oral chemotherapy (cyclophosphamide, £139 daily), given on detection of progression instead of being deferred (hormonal treatment instead), for five hundred women with young children recently diagnosed to have metastatic breast cancer in the bone, and also done to future members of the equivalent recently diagnosed group year-after-year, costing roughly an extra £40,000 a year each (£139 daily x 365 days – stopped hormonal £20 4 days a week x 4 days x 52 weeks), would add £40m a year to the UK health budget (2 years x 500 women per year x £40,000 per year per woman).

Spread over a total of the typically five million patients who receive treatment every year, this would cut available resources per patient actually treated during the year by only £8. Spread instead over the whole population (with a rough figure of 50 million for easy calculation), the cut would amount to as little as below about 80p a year per person. The NHS is comprehensive. Patients have heart quadruple bypass surgery and all manner of treatments that cost a lot so that they can live some years longer. The Group was no less entitled and therefore should not have been singled out to have life extending treatment withheld from them.

On these assumptions, the performance by the Secretary of State of his statutory duties would not have been impaired by the imposition of liability in tort to the patient. In performance of such a duty of care he would have added several years to the life of the women in the Group, while removing some years of pain from it. Instead, the Secretary of State potentially breached this postulated

[7] "*11,600 people die every year as a result of secondary breast cancer*" [889] and in the year to March 2013 "*7,176 patients were diagnosed or treated for recurrent breast cancer in England*" [897], Hansard 25 November 2014. It would be reasonable, given the number of organs that metastasis can occur in, to assume that therefore a tenth to a fifth of those diagnosed (1-2000) had metastasis to the skeleton. Roughly half, 500-1000, would have had young children at the time of diagnosis, the others either not having children or their children already having grown up.

private law duty of care. Lord Justice Laws encapsulated the position in the case of *Connor* (2010) at [91]:-
"*Immunity* [from private law liability] *for decisions authorised by Parliament will not apply to a decision so unreasonable that it cannot be said to have been taken under the statute."*

What is alleged in the present case therefore, is a private law duty owed by the Secretary of State to refrain from doing anything to significantly deprive terminal patients of chemotherapy, or of pre-emptive hip surgery (the need for which is a typical consequence, see the characteristics of the Group section above) and thereby accelerate the onset of symptoms and the end of life. In the end only a rare public interest consideration could conceivably preclude it.

No Conflict with Public Policy

It appears in certain circumstances, that the courts have granted what has sometimes been described as 'immunity' to a public authority from liability for the consequences of its breach of duty to people such as the Group (see above 'Conditions for Governmental Civil Liability'). The courts have done so however, only because the law was unclear and may have needed to be extended after due consideration. In such cases the court will: "*decide whether the existence of a duty of care would be just and reasonable*" (*Robinson* paragraph 29).

In the present case the precedents establish the duty of care, as has been set out in part above and is further set out in detail below. "*That general principle* [see *Robinson* paragraphs 32-33 already referred to above] *is subject to the possibility that the common law or statute may provide otherwise, for example by authorising the conduct in question: Geddis v Proprietors of Bann Reservoir* (1878) 3 App Cas 430" (*Robinson* paragraph 33).
Thorough case law searches in the last six years since notification of claim has revealed no such extension to the common law having ruled out liability on the particular facts of the present case, nor on the facts of one indistinguishable from it.

Duty to Advise on and Enable the Patient to Undergo a Reasonable Course of Treatment Appropriate to the Patient's Priorities

The present patient's preference as between the two alternative risk scenarios was made clear at a consultation in September 2013. The patient clearly indicated then, also less clearly at a previous consultation the month before, and again very clearly, repeatedly so, for the rest of her life, that for the sake of her young son she prioritised the prolongation of her life over the minimisation of side-effects. In response, to start with, the course of treatment offered was hormonal but chemotherapy was said to begin on evidence of progression of skeletal metastatic disease. The contrasting alternative for a woman averse to the side effects would have been to wait to begin chemotherapy at least until the disease became symptomatic, in terms of pain and limping or other mechanical impediment, or even longer.

The Supreme Court ruling in *Montgomery* already mentioned imposed a duty on the clinician, owed to the patient vicariously by the trust, to advise on, and enable the patient to undergo, alternative treatments appropriate to different patient priorities. This clinical duty is a professional one, in the performance of which the patient can be said to have been treated appropriately. For the reasons already set out, it subsists concurrently with the exceptional, non-medical duty owed to the patient

by the Secretary of State in the present case to enable the clinicians to perform their above-mentioned duty.

Though the *Montgomery* ruling post-dated the present patient's consultation referred to above, the case of *Montgomery* had already been heard at first instance in 2010 and at first appeal as well, and moreover it rested on much earlier precedent-setting judicial remarks, which were similar in effect to the ruling. In particular, in the case of *Sideaway* in 1985, where Lord Scarman wrote:-
"*. . . a patient may well have in mind circumstances, objectives, and values which he may reasonably not make known to the doctor but which may lead him to a different decision from that suggested by a purely medical opinion*." (pp 885-886)

A recognition of non-medical, patient-centred decision drivers was attributed to the Secretary of State in early 2014, according to the authors of NHS Reforms in England: the Implications for Chemotherapy Commissioning (ibid.). It says:-
"*Health-care providers are required to focus on such issues as patient quality of life, treatment side effects, and the avoidance of unplanned hospital admissions for the management of treatment-related ill health*."

The Scarman opinion, together with evolving practice subsequent to it, as outlined above, eventually crystallised twenty years later into the Supreme Court decision in the case of *Montgomery*:-
"*The relative importance attached by patients to quality as against length of life, or to physical appearance or bodily integrity as against the relief of pain, will vary from one patient to another.*" (Para 46)
"*An adult person of sound mind is entitled to decide <u>which</u>, if any, of the available forms of <u>treatment to undergo</u>, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under <u>a duty</u> to take reasonable care <u>to ensure that the patient is aware of</u> any material risks involved in any recommended treatment, and of any <u>reasonable alternative or variant treatments.</u>*" (Para. 87, emphasis added)

It will be noted that this duty is different from the conventional *Bolam* duty (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582) not to treat a patient in a manner unheard of by any reputable body of medical opinion. The Supreme Court in *Montgomery* seemed somewhat scathing of the easy, if not free, pass given to the medical profession by the *Bolam* defence:-
"*. . . <u>departure</u> from the Bolam test will reduce the predictability of the outcome of litigation, <u>given the difficulty of overcoming that test in contested proceedings.</u>*
. . . respect for the dignity of patients <u>requires no less</u>." (Para. 93, emphasis added)

<u>Duty to Provide Life-Prolonging Chemotherapy and Pre-emptive Hip Surgery</u>

Other patients in the Group also prioritised length of life, as the present patient did. As has been mentioned, they may well similarly have suffered from additional negligence that also caused injury from fracturing to the hip. This negligence in principle would again have been contributed to jointly by the Secretary of State and by the clinicians of the trust concerned, as was the case in relation to the present patient.

Specifically, the 'chemotherapy-at-the-outset' option was simply not delivered to the present patient, as it had to be, were the alternatives offered to the patient at the outset to be meaningful in accordance with her priorities. The *Montgomery* case was about child birth. The court said the mother had to be offered a C-section as an alternative to natural birth. It said this "*offer*" of

necessity had to include that it actually would be "*undergone*." It did not conceivably mean that it might not have been "*undergone*". Both alternatives offered must be deliverable in order that they constitute meaningful alternatives.

In the present case, chemotherapy taken daily, orally, was not begun until three or four years after it should have been. It will be recalled, that it should have begun on evidence of disease progression. It was begun only in October 2017. Disease progression had been evident since November 2013. The oral chemotherapy, once eventually started was then continued until 19 March 2019 (there was only one erroneous break of a fortnight starting in January 2019 that occurred when the hip surgery was cancelled for the first time).

The disease progressed because of the breaches of duty firstly, on the part of the trust and secondly, on the part of the Secretary of State. The trust failed to enable the patient to "*undergo*" the reasonable treatment she chose under expert guidance. The Secretary of State caused harm to the patient by his national tariff measures and abandonment of ring-fenced fund arrangements. The disease progression had started to become symptomatic by around late 2014 and early 2015.

The cause of action (commencement of liability) could, however, reasonably be said to have arisen a little later than early 2014. Time after November 2013 should be allowed for the progression to have become apparent beyond doubt to the patient. The patient would have to make an appointment to view bone scans and an appointment to have questions answered. A further period of time would then be necessary during which arrangements would be made and executed to switch over to the new treatment. These time periods should reasonably amount to 5-6 weeks, perhaps a bit more allowing for Christmas. The cause of action would therefore have arisen in February 2014. Certainly, the present patient seemed conscious of having been let down in her email to the consultant in October 2017, which was suggestive of irony at the long wait for the chemotherapy that had at last then only just ended.

Causality of the Breaches of Duty

Comparing scans near the beginning and the end of chemotherapy (October 2017 and March 2019), disease progression was strikingly reduced compared to all the preceding periods of time during which no chemotherapy was being given. The report of the scan in the first half of 2018 was "*stable*" comparing with the previous scan in late 2017. The report of the scan later in 2018 was again "*stable*" comparing with the previous scan in the first half of 2018. There were no reports unambiguously stating "*stable*" outside the period of chemotherapy – one report prior to October 2017 stated that there had been no evidence of progression but that the scans were unclear.

Everolimus, which can be thought of as quasi-chemotherapy, was begun in March 2015, shortly after the disease first became symptomatic. This moderated an apparently considerable degree of negligence hitherto. Nevertheless this was still as much as fifteen months after the first appearance of evidence of progression. This treatment does seem to have slowed progression initially. Nonetheless, no report of a scan during this period from April 2015 to September 2017 of the administration of Everolimus was without qualification "*stable*."

The alleged negligence, contributed to jointly by the clinicians and the Secretary of State, caused acute pain in, and the weakening of, one of the present patient's hips and its attached femur. As already suggested, it is likely that similar if not identical outcomes will have occurred among other patients in the Group. This being the case, it follows that an analogous additional joint negligence

may also have been inflicted at some stage on other members of the Group in regard to this aspect as well.

In 2017-19, the Secretary of State also lowered the tariff for hip replacement to well below cost. The tariff for major hip surgery in early 2019 was £6819 compared to £8904 in 2014/15 (see the National Tariff Payment System). For the years 2012 to 2019 inclusive, hip replacement surgery in NHS hospitals stagnated, despite the increase in population, according to a study at the Royal Liverpool Hospital[8].

In the present case, when it came to treating metastasis in the hip, after she received medical advice on the adverse risks and the good effects of alternative courses of treatment, the present patient's clear preference, strongly supported by her doctors, was to take on the risks of hospitalisation and surgery pre-emptively. She otherwise faced the certainty of continuing pain management and the risk of more serious surgery being required later, should fracturing occur.

Nevertheless, having been offered this alternative, the duty to deliver it was again not in the event met. And again, the alleged failure was in principle contributed to jointly by the clinicians and the Secretary of State. The Secretary of State's financial incentive to providers to avoid hip surgery meant that her operation was postponed for months. After an extra three months of excruciating pain following the initial cancellation, a more serious, difficult and therefore dangerous hip operation was done on an emergency basis, because the hip had fractured and the patient could not move. The patient successfully received stronger chemotherapy in the following weeks, necessitated by the spread of the disease to the liver, but, by then much weakened, she died three months later.

<u>Conclusion – Premature Onset of Pain, Hip Degeneration, and Anxiety for Dependent Children</u>

These failures meaningfully to enable the patient to undergo the *Montgomery* alternative which the patient had been offered to suit her distinct, salient patient risk profile and priorities, caused excess pain and lost years. Causation in relation to both types of failure has been confirmed in the present case by two medical consultants who are prominent in the field of oncology. In any event, however, one might well surmise as a lay person that such a conclusion is self-evident. Disease progression causes both pain and the acceleration of the approach toward end of life. Chemotherapy serves to slow both disease progression and the exacerbation of pain. Hip surgery serves to remove the pain, at least for a while, and to pause or slow the effects of disease progression by physically removing much of its destructive results.

As Baroness Hale said, in *Gregg* (2005) UKHL at [206]:-

"*The defendant is liable for any extra pain, suffering, loss of amenity, financial loss and loss of expectation of life which may have resulted from the delay. If, without the delay, the claimant would have achieved a longer gap before more radical treatment became necessary, then he should be entitled to damages to reflect the acceleration in his suffering. If the pain and suffering he would have suffered anyway was made worse by the anguish of knowing that his disease could have been detected earlier, then he should be compensated for that*."

The patient was offered "*reasonable alternative treatments*" in accordance with her priorities. The breaches occurred because she was not then enabled to "*undergo*" the chosen ones (quotations in

[8] Total Hip Replacement Numbers in NHS Hospitals, Sophie Kelly et al (Proceedings of the British Hip Society Annual Scientific Meeting 2020)

italics are from *Montgomery*). On the facts pertaining to each patient in the Group delineated in this article, damages from extra pain and lost years of life suffered caused by a breach of the *Montgomery* duty, contributed to in part by the clinicians and in part by a breach of private law duty by the Secretary of State, may be recoverable by or on behalf of the patient, or by any dependant or dependants of the patient.

In the case of the present patient, if these damages are recovered, it is intended that they are put towards an easy-to-interrogate website designed to offer advice and know-how within her wide range of areas of expertise.

If the reader recognises from this article similarities from their own knowledge of the direct personal experience of a member of the Group having gone through much the same stages of treatment and consequential outcomes identified, please contact the publisher of this article.

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